

Comprehensive, Continuous, Integrated System of Care (CCISC) Consensus Document 2010

Overview:

As part of its larger vision of recovery oriented system transformation to better respond to individuals and families needing services, the Michigan Department of Community Health (MDCH) has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) recovery oriented system transformation framework to improve outcomes for individuals and families with co-occurring substance use and psychiatric disorders. It is recognized that individuals with co-occurring disorders may also present with other co-occurring conditions or complexities. This model is based on clinical consensus best practice principles and core characteristics of system change.

The implementation of this initiative involves a commitment to the development of a recovery oriented, person and family centered co-occurring capable system of care and a partnership between the Michigan Department of Community Health (MDCH), the Pre-Paid Inpatient Health Plans (PIHPs), the Community Mental Health Service Providers (CMHSPs) and the Coordinating Agencies (CAs). This partnership has been exercised through the creation of the Integrated Treatment Committee (ITC), the Change Agent Leaders (CAL) group and the statewide Change Agent Teams. Additionally, the Internal Integrated Treatment Group (IITG) was formed to provide state level leadership for the design, promotion and implementation of CCISC within a quality improvement framework.

This document outlines the joint agreement between MDCH, PIHPs, CMHs, CAs to demonstrate leadership and commitment to the CCISC Principles, the CCISC Twelve Steps Program of Implementation, and to the performance of associated roles and responsibilities.

Foundation and Commitment:

MDCH, PIHP, CMHSP and CA Directors are committed to the core Principles of a Comprehensive, Continuous, Integrated System of Care for system change and an integrated treatment philosophy that views co-occurring conditions disorders as an expectation, not an exception. This expectation will be considered in all aspects of system planning, program design, and clinical interventions. See Attachment A.

The CCISC Twelve Step Program of Implementation provides guidance on the strategic planning and continuous quality improvement processes that are central to the organization of the system transformation. A system-wide understanding of and allegiance to the principles of continuous quality improvement is evidenced by collaborative relationships, a customer service orientation, collective engagement and empowerment, support of a developmental model of change, and the involvement of all participants working together towards common outcomes. See Attachment B.

Central to the system change process is the development of change agents in each local entity. At the local level, the role of the change agent includes the development of co-

occurring competency through training, supervision, and program consultation to facilitate quality improvement processes that support the development of co-occurring capability throughout the system. At the system level, the role of a change agent is to provide feedback to administration regarding barriers to integrated care that are operationalized at the system, program, or service delivery level. Conversely, change agents will assist administration with the implementation of policies that support integrated care.

Roles and Responsibilities

This common foundation and commitment includes various roles and responsibilities.

Local Change Agents

Local change agents are organized into teams within systems to link system leadership with front line workers and consumers to advocate for policy that supports good clinical practice and to assist in the implementation of practice at the service delivery level

- Co-occurring capability development at the local level
- Clinical practice development at the local level
- Identification of barriers to integrated treatment at the system, program, clinical practice, and clinical competency level and make recommendations for change to the CAL
- Communicate with local system leadership
- Make recommendations through local change agent leadership to the CAL and the ITC.
- Mutual support and TA

Change Agent Leadership

The CAL is organized to act as a representative group of the local change agent teams in each PIHP and CA service area.

- Act as a conduit between the local change agent teams and the ITC
- Function as a proactive group in support of system transformation
- Identification of barriers to integrated treatment at the system, program, clinical practice, and clinical competency level and make recommendations for change to the ITC
- Facilitate and provide mutual support for co-occurring capability development in local systems
- Facilitate and provide mutual support for clinical practice improvement in local systems
- The CAL has developed Mission and Vision Statements and conducted an Environmental Scan to identify and prioritize system issues, see Attachment C

Integrated Treatment Committee

The ITC is comprised of individuals who formally represent a diverse group of stakeholders from the mental health and substance use disorder treatment systems, consumers, physical health care and Medicaid. The ITC has been charged with the following tasks:

- Incorporate all the stakeholders to develop a continuous, comprehensive, integrated system of care for all individuals served by the public mental health and substance use disorder system
- Provide recommendations to DCH for policy direction and regulatory change that reflect the consensus of all stakeholders and represent the voice of local system change agents

- Develop consensus in addressing co-occurring disorder services at all levels of severity
- Work with local change agent groups to address areas where system change is necessary
- Identify and address barriers
- Address performance improvement, quality improvement and outcome monitoring
- Identify goals and objectives in the ITC Strategic Plan, see Attachment D

Internal Integrated Treatment Group

The IITG was established by MDCH to provide direction and leadership for the system transformation. The goal of the IITG is to create a framework to enhance the consistency of internal policy making and of external communications.

- The IITG will meet regularly to remain informed on matters pertaining to integrated treatment and recovery oriented co-occurring capability development
- MDCH/IITG will seek review and comment from the ITC on policy deliberations that address co-occurring conditions and recovery oriented co-occurring capable service delivery.
- MDCH/IITG adopt and issue guidelines regarding system requirements for integrated services
- MDCH/IITG will work with the ITC to identify, develop, and implement a statewide credentialing and training system

Pre-Paid Inpatient Health Plans (PIHPs), Community Mental Health Service Providers (CMHSPs) and Coordinating Agencies (CAs).

PIHPs, CMHs, and CAs have a leadership role in the change process for the design, promotion and implementation of CCISC within the context of a larger system-wide quality improvement transformation effort. Responsibilities related to the CCISC initiative include:

- Provide leadership and oversight of the systems change processes necessary to develop a recovery oriented person and family-centered co-occurring capable system of care
- Develop system expectations for core competencies for recovery oriented person and family-centered co-occurring capable treatment
- Identify and address system barriers to effective treatment services for individuals and families with integrated service needs
- Build consensus on policy direction related to evidence-based and clinical consensus best practice implementation
- Support and promote a continuous quality improvement approach to all system planning and transformation efforts

Practice Development Projects

Focused practice development projects provide integrated care to specific populations and contribute significantly to the development of co-occurring capability. The role of the practice development projects is to share information with the larger system about successes, challenges, barriers and effective solutions.

- COD: Integrated Dual Disorder Treatment (IDDT) Subcommittee (acting as a subcommittee of the MDCH Practice Improvement Committee)
- Integrated Treatment Projects

We, the undersigned, agree to work with our system partners in a shared commitment to the development of a recovery oriented, person and family centered co-occurring capable system of care.

CA Director

CMHSP Director

PIHP Director

Agency Director

Change Agent Leader(s)

Change Agent(s)

January 8, 2010

ATTACHMENT A

In the context of statewide system transformation to develop person and family centered recovery oriented services, in order to provide welcoming, accessible, integrated, continuous and comprehensive services to individuals with co-occurring substance and psychiatric disorders and other co-occurring conditions,, PIHPs, CAs, CMHs, and providers (and consumers?) have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change to improve outcomes within the context of existing resources. The goal of CCISC is to help develop a system of care that is welcoming, recovery oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, every program and every person delivering clinical care engages in a quality improvement process to become welcoming, recovery or resiliency oriented, and co-occurring capable, and every aspect of clinical service delivery is organized on the assumption that the next person or family entering service will have multiple co-occurring conditions. This model is based on the following eight clinical consensus best practice principles (Minkoff and Cline, 2004, 2005) which espouse an integrated recovery philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system.

1. Co-occurring issues and conditions are an expectation, not an exception. This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues..
2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength based relationship. Within this partnership, integrated longitudinal strength based assessment, intervention, support, and continuity of care promote step by step community based learning for each issue or condition..
3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.
4. When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary. The best practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.

5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue. Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are both examples of chronic, biopsychosocial conditions that can be understood using a disease and recovery (or condition and recovery) model. Each condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.
6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue. For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. In order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective in promoting learning than negative consequences.
7. Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual diagnosis program or intervention for everyone. For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals, their specific diagnoses, conditions, or issues, and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.,
8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery or resiliency oriented, and co-occurring capable. Each program has a different job, and programs partner to help each other to be successful with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength based, stage matched, skill based community based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.

ATTACHMENT B

Twelve Steps for CCISC Implementation

1. **Integrated system planning and implementation process**: Implementation of the CCISC requires a system wide integrated strategic planning process ***and quality improvement partnership that creates an empowered partnership between all levels of the system, including consumers, families, and front line clinicians. This partnership*** can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, ***recovery oriented***, accessible, ***trauma-informed, and*** culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ***individuals in service and*** their families. The COFIT-100™ (Zialogic, Albuquerque, NM) [30] has been developed to facilitate this outcome measurement process at the system level.

2. **Formal consensus on CCISC implementation:** The system must develop a clear mechanism for articulating the CCISC **process**, 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, **chartering the quality improvement partnership and process**, and disseminating this consensus **for action** to all providers and consumers within the system.
3. **Funding plan within existing resources.:** CCISC implementation involves a formal commitment that each funder will promote **recovery oriented, co-occurring capable services** within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with CCISC principles, 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. **CCISC supports developing the flexibility to use limited resources more creatively to design services across a whole system that are more accurately matched to the needs of complex populations, and supports using any available incentives to support providers engaged in the transformative quality improvement process.**
4. **Strategic prioritization and population based planning.** **CCISC encourages alignment of all “initiatives” in a common transformation vision, and building energy for change from existing strategic opportunities or priorities, including funding increases or reductions. In addition.:** using the national consensus four quadrant model, the

system develops 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 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 start the process** with high need high cost priority populations (commonly in quadrant IV) that have no system or provider clearly responsible for engagement and/or treatment, As the CCISC process unfolds, the integrated system planning process is able to more easily create a plan for how to address the needs of these populations **within existing resources**.

5. **Development and implementation of recovery oriented co-occurring**

capable programs:. A crucial element of the CCISC model is the expectation that all child and adult programs in the service system must meet basic standards for **recovery oriented co-occurring** capability, whether in the mental health system or the addiction system. There needs to be consensus that **each program can begin its own quality improvement process to achieve recovery oriented co-occurring capability**. **As programs make progress, the system can develop co-occurring capability** standards, and, over time, those standards can be built into funding and licensing requirements. (see items 2 and 3 above), as well as a plan for **programs to make step by step progress toward implementation.. COMPASS-EZ (ZiaPartners, 2009) is a program self-**

assessment tool for recovery oriented co-occurring capability that can be helpful in *initiating the program quality improvement process.*

6. **Inter-system and inter-program partnership and collaboration:** 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 ***collaborative partnerships for 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 ***component*** of this process includes 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 ***partnerships to manage a shared population.***
7. **Development and implementation of recovery oriented co-occurring capable practice guidelines:** CCISC implementation requires system wide transformation of clinical practice in accordance with the above principles.. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (www.bhrm.org) are available to facilitate this process. Practice guideline implementation

must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. **Quality improvement processes** to facilitate **welcoming**, access and identification, and to promote **empathic, hopeful**, integrated continuous **relationships** are a particular priority for implementation,

8. **Facilitation of welcoming, access, integrated screening and**

identification of multiple co-occurring conditions:. This requires a **quality improvement partnership that:**

- 1. Addresses welcoming and “no wrong door” access in all programs;**
- 2. Eliminates arbitrary barriers to initial access and evaluation;**
- 3. Improves clinical and administrative practices of screening, clinical documentation, MIS reporting, and appropriate next step intervention for individuals and families with co-occurring conditions.**

9. **Implementation and documentation of integrated services**. Integrated treatment relationships are a vital component of the CCISC. Implementation requires **creating a quality improvement process in which clinicians and managers work in partnership on the process of developing and**

documenting an integrated treatment **or recovery** plan in which the client **or family** is assisted to **make progress toward hopeful goals by follow issue** specific and stage specific recommendations for each **issue** simultaneously.

This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorder [35, 36], and incorporated into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring **conditions**..

10. Development of recovery-oriented co-occurring competencies for all

clinicians: Creating the *expectation that all clinicians can make progress to develop* universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC process.. Available competency lists for co-occurring conditions, ***such as the 12 Steps for Clinicians***, can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms can be developed to establish competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure and support clinician attainment of competency. Competency self-assessment tools (e.g., ***CODECAT-EZ™ ZiaPartners, 2009***) can be utilized to facilitate this process.

11. Implementation of a change agent team: *In the CCISC Quality improvement process, both program capability development and clinician competency development occur through a top-down, bottom up partnership, in which front line clinician and consumer/family change agents in each program work in partnership with leadership to effect the change. Further, the change agents in a system ideally become an empowered team to represent the principles and values of front line service delivery and service recipients in the system planning and implementation process. ZiaPartners has developed a Change Agent Curriculum Manual for Michigan and provided initial training to hundreds of change agents statewide to initiate this process.*

12. Development of a plan for a comprehensive program array: The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of

competency with regard to provision of **recovery oriented co-occurring capable** service for people with co-occurring conditions, 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 process are:

- a. **Evidence based best practice:** There needs to be a specific plan for identification of any evidence based best practice for any mental illness (e.g. Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g. buprenorphine maintenance), or an evidence based best practice program model for a particular co-occurring disorder population (e.g. Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring clients that might be appropriately matched to that intervention..
- b. **Peer dual recovery supports:** The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous **has been identified in Michigan**) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as **recovery coaching**, peer outreach and peer counseling.
- c. **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing

resources through redesigning those services ***with the recognition that co-occurring conditions are an expectation.*** This range of programs should include:

1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs) [41].
 2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.
 3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
 4. Consumer – choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness. [42]
- d. **Continuum of levels of care:** All categories of service 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, ***hospital diversion programming***, and hospitalization. This can often be operationalized in managed care payment arrangements and may involve more sophisticated level of care assessment capacity

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

ATTACHMENT C

Change Agent Leaders

Mission Statement

The Michigan cadre of co-occurring change agent leaders is a self governed body whose vision is to advocate, facilitate and partner with others to create the continued transformation of co-occurring services which promote integrated treatment and recovery for all people.

Environmental Scan

System issues that have been identified by change agents as barriers to integrated care have been summarized in the Environmental Scan:

1. Credentialing
2. Clinical Standards documents
3. Communication flow between entities
4. Interface between CMH/SUD providers around clinical issues (integrated access, service authorizations, etc.)
5. Audit Standards and practices (internal and external)
6. Confidentiality
7. Rights
8. Data Reporting (HH modifier, disability designation, etc.)
9. Funding Source disparity
10. Recovery System Development (Peer Supports vs. Recovery Coaches, etc.)
11. Electronic Medical Record
12. Outcome measurement (planning and reporting)
13. Strengthen Partnership w/MH/SUD Change Agents
14. External Credentialing/licensing

System issues that have been prioritized by the Change Agent Leaders for FY10:

- Clinical Standards Documents (identification of those needed and completion)
- Recovery System Development (Peer Supports vs. Recovery Coaches, etc.)
- Outcome Measurement (identification of outcomes, collection and reporting)
- Strengthening partnership with MH/SUD Change Agents
- Staff credentialing (includes external credentialing/licensing and local credentialing processes)

ATTACHMENT D

Integrating Treatment for Co-Occurring Mental Health and Substance Use Disorders

2009

Prepared by
Michigan Department of Community Health
Integrated Treatment Committee

With assistance from
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Integrating Treatment for Co-Occurring Mental Health and Substance Use Disorders

The Michigan Department of Community Health (MDCH) established an Integrated Treatment Committee (ITC) in 2008 to identify and address needed system changes to support a comprehensive system of care for people with co-occurring mental health and substance use disorders. The ITC is part of the department's broad efforts to assure the continued progress of both the mental health and substance use disorder services systems to best meet the needs of individuals who have co-occurring disorders.

In fall 2008, the Integrated Treatment Committee engaged in a strategic planning process to identify goals, objectives, and strategies for aligning work at the state and local levels to move the state further toward its ultimate goal of integrated treatment services for persons with co-occurring disorders. This report provides background information on the current structure of publicly funded mental health and substance use services in Michigan, the need for integrated treatment services, and the ITC's strategic planning process, as well as presents the strategic plan developed by the ITC.

PUBLIC MENTAL HEALTH AND SUBSTANCE USE SERVICES IN MICHIGAN

The Mental Health and Substance Abuse Administration within the Michigan Department of Community Health carries out the responsibilities specified in the state's Mental Health Code. In Michigan, state funds for mental health and developmental disability services are contracted by MDCH with 46 regional Community Mental Health Services Programs (CMHSPs). Medicaid funds, which are paid on a per Medicaid eligible capitated basis, are contracted with Prepaid Inpatient Health Plans (PIHPs) which are CMHSPs, or affiliations of CMHSPs. Each region is required to have an extensive array of services which allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults and a person-centered planning process and family-centered care for children.

Mental health services for Medicaid recipients are contracted between MDCH and the 18 Prepaid Inpatient Health Plans in a carve-out managed care arrangement. A limited outpatient benefit for Medicaid recipients with mild or moderate mental health disorders is contained in the MDCH contract with the Medicaid Health Plans, which are responsible for primary health services. The eighteen PIHPs are responsible for administration of all Medicaid funded mental health and substance use disorder services for the region's Medicaid beneficiaries.

Michigan's Public Health Code assigns the duties and responsibilities for substance use disorder treatment and prevention to the Office of Drug Control Policy (ODCP) within the MDCH. In order to fulfill these duties the Code in turn authorizes the ODCP to contract with designated regional coordinating agencies. There are 16 regional coordinating agencies that contract with and receive funding from the ODCP. Eight of the 16 agencies are part of a CMHSP. In addition, each coordinating agency is affiliated with one of the 18 PIHPs.

The responsibilities of the 16 agencies include the development of comprehensive regional plans for treatment, rehabilitation, and prevention services; technical assistance for local providers and organizations; data collection; evaluation and assessment of regional services; and the development and monitoring of contracts with local providers. A major responsibility of the coordinating agencies is to contract with local providers for an array of treatment and prevention services.

THE NEED FOR INTEGRATED TREATMENT SERVICES

The MDCH has recognized a growing concern among consumers, families, and other stakeholders regarding co-occurring mental health and substance use disorders. National data suggest that approximately 50 to 70 percent of people served by mental health and substance use disorder systems have co-occurring disorders. While mental illness and substance use disorders are closely related,

Michigan historically has had a parallel and/or sequential system of treatment for individuals with co-occurring disorders. PIHPs and CMHSPs are responsible for mental health services, and substance abuse coordinating agencies are responsible for substance use disorder services. Individuals requiring both mental health and substance use services are often seen by two or more separate providers in their community without any coordination, much less integration, of care. The MDCH believes, and research demonstrates, that this is an inefficient and ineffective use of resources and contributes to less than desirable outcomes for people with co-occurring disorders.

Where We Are Now

The MDCH places a high priority on the development and implementation of integrated services for persons with co-occurring mental health and substance use disorders. To this point, the department has worked to implement *Co-occurring Disorders: Integrated Dual Disorder Treatment (COD: IDDT)*, a nationally-recognized evidence-based practice for treating individuals who have a serious mental illness and a substance use disorder, throughout the state. The department's efforts have been supported by the use of a Comprehensive, Continuous Integrated System of Care model designed to support system-level change, promote efficient use of existing resources, incorporate best practices, and employ an integrated treatment philosophy.

In recognizing the need for integrated treatment services, the ODCP initiated changes to the substance abuse administrative rules that resulted in integrated treatment being added to the rules as a service category that can be added to an existing treatment license. Through contract requirements, all coordinating agencies are required to have integrated treatment services available in their provider networks by the end of FY 2009. In supporting this move, CAs have been encouraged to participate in the change agent initiative in partnership with the PIHPs and CMHSPs.

Where We Are Headed

Integrating treatment services is exceedingly complex, since it encompasses a wide range of policy, program, and technical areas, and it involves the participation of a wide range of stakeholders. The MDCH believes this will require:

- Combating stigma and respecting equality;
- Placing a high value on quality and efficacy;
- Embracing the use of information for continuous improvement;
- Identifying the needs for minors with COD and developing a family-centered practice;
- Measuring success using individual-specific recovery outcomes;
- Developing organizational structures to support the delivery of evidenced-based practices, emerging practices, and promising practices by a competent workforce; and
- Offering evidence-based practices in combination, based on individual need to produce the best outcome.

To sustain and improve a transformed mental health and substance use disorder services system, all stakeholders must work together to identify and take steps to improve the quality of services provided to all Michigan residents in need of public mental health and substance use services. To this end, the MDCH established an Integrated Treatment Committee (ITC) with representatives from a diverse group of stakeholders in the mental health and substance use services systems and Medicaid, and an Internal Integrated Treatment Group (IITG) to oversee the ITC work within the department. The overall mission of the IITG is to create a framework to enhance the consistency both of internal policy making and of external communications.

Local change agent teams from the state's prepaid inpatient health plans (PIHPs) and substance abuse coordinating agencies (CAs) have been charged with working within their communities to become an enduring statewide team of peers, clinical and administrative change agents to promote and support the implementation of co-occurring capability, integrated services, and co-occurring clinical competency into every level of the system of care infrastructure.

Whereas *COD: IDDT* is focused on persons with a *serious* mental illness and a co-occurring substance use disorder, the IITG, ITC, and change agent teams are focused on integrating treatment for *all* populations with a co-occurring mental illness and substance use disorder.

Integrated Treatment Committee Strategic Planning

PLANNING PROCESS

In fall 2008, the Integrated Treatment Committee engaged in a strategic planning process to identify goals, objectives, and strategies for aligning work at the state and local levels to move the state further toward its ultimate goal of integrated treatment services for individuals with co-occurring disorders. The process and outcomes of that planning are described below.

The ITC retained Public Sector Consultants Inc. (PSC) to facilitate the development of a strategic plan to identify (1) the best way to organize as a group, (2) a set of concrete objectives and prioritized strategies for carrying out the work, and (3) clear chains of communication and coordination among the various stakeholders in the integrated treatment initiative.

The ITC consists of representatives of persons in recovery, providers, and regional and state administrators from the mental health system, substance use disorders system, and Medicaid arenas. Given the range of knowledge and awareness of the issues to be addressed by the ITC, PSC interviewed each ITC member to elicit their thoughts on the goals of integrated treatment, potential concrete steps for the committee, and perceived barriers to integration.

PSC compiled all of the interview data into a report that was shared with the ITC members prior to the strategic planning session. PSC used the interview data to develop a draft set of goals, objectives, and strategies for the ITC. On November 24, 2008, PSC facilitated a dialogue of ITC members to identify an initial set of goals and objectives for the committee, and to prioritize a set of strategies for accomplishing those goals and objectives.

THE COMMITTEE'S CHARGE

The ITC has been charged with the following tasks:

- Incorporate all the stakeholders to develop a continuous, comprehensive, integrated system of care for all individuals served by the public mental health and substance use disorder systems
- Develop consensus in addressing co-occurring disorder services for people at all levels of severity
- Work with the local change agent groups to address areas where system change is necessary to ease implementation
- Identify and address barriers
- Address performance improvement, quality improvement, and outcome monitoring

MISSION STATEMENT

In their communications regarding integrating treatment for individuals with COD, the Mental Health and Substance Abuse Administration (MHSA) and Office of Drug Control Policy¹ (ODCP) have set forth the following mission for service integration:

¹ Effective October 1, 2009, the Office of Drug Control Policy is being integrated into the Mental Health and Substance Abuse Administration. The functions of the office will continue under this administration and, therefore, any references to the ODCP in the Integrated Treatment Committee's strategic plan will refer to the substance use disorder functions of that office, the name of which is yet to be determined.

To create a person-centered system that is welcoming, culturally competent, recovery oriented, trauma informed, and capable of providing integrated treatment services for individuals with co-occurring disorders.

VISION STATEMENT

During its planning session on November 24, 2008, the ITC was presented with a vision statement (developed from phone interviews conducted by Public Sector Consultants with ITC members) that it then made broader and more inclusive of systems outside of public mental health and substance use disorders. The following statement reflects this discussion:

Every resident of the state will have appropriate access to integrated mental health and substance use disorder services, consistent with their needs. Services will be welcoming and responsive to residents' hopes and needs and will be driven by person centered recovery plans. Recovery will be supported by the mental health and substance use disorder systems, primary care providers, health plans, and other stakeholders as appropriate. These systems and stakeholders will work together and assist and support each other in achieving an integrated service delivery system.

GOALS, OBJECTIVES, AND STRATEGIES

When the Integrated Treatment Committee met on November 24, 2008, the members agreed to two primary goals for the committee:

- The infrastructure of the public mental health and substance use disorder systems will support the recovery of individuals with co-occurring disorders.
- Individuals with co-occurring disorders will easily access and engage in effective integrated treatment services that support their recovery.

For each goal, the ITC identified a set of objectives as well as strategies and first steps for achieving each objective. In addition, the committee identified roles for the ITC, the state, and change agent teams, where appropriate. The "state" includes any, or all, of the MDCH, the MHSA, and the Internal Integrated Treatment Group (IITG). The role of the ITC can be accomplished, as appropriate, by the full committee, the co-chairs, or an assigned subcommittee. When the change agent teams have a role, the ITC will seek input and participation from change agent team leaders, who will be responsible for identifying the level of participation necessary from additional change agent team members and providers in the team's region.

Quality Improvement Partnerships

The ITC recognizes that the human and financial resources necessary to accomplish this plan are not insignificant. The jobs of mental health and substance use services providers are not easy. Asking these individuals to change the way they do their jobs, to acquire additional training, and to add new responsibilities to their already full workload is asking a lot.

The ITC is committed to engaging in quality improvement partnerships with change agent teams leaders as well as directors of PIHPs, CMHSPs, and CAs. These individuals and organizations are critical to the integration of mental health and substance use treatment services. They have the opportunity to identify needed changes and share them with the ITC and with each other. Many have already met with successes and challenges in their integration efforts; these experiences must be shared across regions and the state to continually make progress on building recovery oriented co-occurring capability.

It is the ITC's hope and belief that integrated services for people with co-occurring disorders will increase efficiency and ultimately improve outcomes for these individuals. The ITC has been established because there is evidence that integrated services improve outcomes for individuals with co-occurring disorders. The ITC looks toward improved investment of resources in support of integrated services by engaging stakeholders throughout the state in quality improvement partnerships.

The ITC Strategic Plan

Goal 1: The infrastructure of the public mental health and substance use disorder systems will support the recovery of individuals with co-occurring disorders

Objective 1.1. Improve communication, coordination, and partnership among system stakeholders

Strategies

- 1. Create coordinated communication and partnerships at all levels, and create an environment that facilitates communication among all providers of care. This includes creating opportunities for dialogue and discussion in ITC and other stakeholder meetings.** This strategy can be supported by:
 - Building consideration of integrated treatment into all policy discussions and development (e.g., How will this work in an integrated system? How will it support integration of services?)
 - Seeking input from the field on policies that impact integrated treatment
 - Identifying opportunities to build integration into current system change efforts

First steps:

Establish a sustainable quality improvement partnership between all levels of the system (MDCH, CA, PIHP, CMHSP, providers, change agents, clinicians, and consumers/families) to continually make progress on building recovery oriented co-occurring capability to deliver integrated services into all aspects of service delivery. A plan for regular communication and strategic coordination will be developed to ensure that efforts to integrate treatment services are coordinated and mutually supportive.

Role for the ITC:

The ITC will develop a plan for ensuring that there are opportunities for information sharing, dialogue and discussion at a minimum among the IITG, ITC, and change agent team leaders. A more detailed plan will describe the flow of communication among coordinating agencies, community mental health services programs, prepaid inpatient health plans, Medical Service Administration and Medicaid Health Plans, primary care providers, and other stakeholders.

Role for the state:

The Internal Integrated Treatment Group will meet regularly to remain informed on matters pertaining to integrated treatment at the state level, and to review any information received from the ITC. The IITG will communicate regularly with other stakeholders as appropriate.

To the extent possible, the MDCH will seek review and comment from the ITC on policy deliberations that address co-occurring disorders and integrated treatment.

Role for change agent teams:

Local change agent teams will meet on a regular basis and share their agendas and plans with the ITC.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

Objective 1.2. Build core competency in the service delivery system to provide treatment and services for individuals with co-occurring disorders

This objective includes building a greater understanding of what integrated services include and increasing the skills and competencies of all the people in the system who interact with and treat individuals with co-occurring disorders.

Strategies

1. Develop an ongoing, coordinated, statewide system for core competency development. This includes, but is not limited to:

- Developing an understanding of the need to provide integrated treatment for individuals with co-occurring disorders
- Providing cross-discipline training for substance use and mental health providers
- Creating a credentialing process/system that is aligned with the skills providers need to treat co-occurring disorders

First steps:

PIHPs/CMHSPs and CAs are at different stages in the process of implementing integrated treatment. ITC members recognize that not all levels of the system have made the same amount of progress in instituting a model of integrated treatment for mental health and substance use disorders. Thus, the first step is to identify the extent to which providers are engaged in the quality improvement process to implement integrated treatment based on assessments conducted using COMPASS, COFIT, and CODECAT. This information will enable the ITC to develop a technical assistance and competency development plan that will be the most effective for the population it reaches.

Providers will assess their readiness to change and adopt integrated treatment principles. Training and technical assistance will be matched to needs and level of progress of the PIHP/CA/CMHSP/provider.

Role for the change agent teams:

Change agent team leaders will work with team members and providers to (1) assess the current readiness to provide integrated treatment services in their regions and (2) identify what is needed to increase co-occurring capability. Change agent team leaders will share with the ITC the barriers to integrated treatment services as well as successful efforts to integrate services.

Role for the ITC:

The ITC will assist change agent team leaders in identifying regional capacity for integrated treatment services, perhaps identifying an assessment tool or questionnaire. The ITC will also promote and support the sharing of information among the change agent teams regarding promising approaches to integrating treatment services for individuals with co-occurring disorders.

Role for the state:

The MDCH will adopt and issue guidelines regarding system requirements for integrated services. The MDCH will work with the ITC to identify, develop, and implement a statewide training and credentialing system.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

Objective 1.3. Create funding and regulatory structures that support integrated treatment

The ITC recognizes that it cannot wait to move forward until a perfect funding and regulatory system is in place to support integrated treatment. In addition we are committed to the vision that all levels of the system can and should move forward within the framework of increasingly limited resources, because many PIHPs/CAs/CMHHSPs have demonstrated that improving services for individuals with co-occurring disorders is directly connected to more efficient resource utilization to meet the needs of our consumers and families. However, it also recognizes that over the long term, having funding and regulatory structures and data-reporting mechanisms that are aligned with the goal of integrated treatment will be essential to success. Thus, this is a long-term objective that will involve immediate action to review current policies and data-collection and reporting mechanisms to identify where changes may need to be made to support the state's vision for integrated treatment.

Strategies

- 1. Create broad, system-based policies and structures that *support* rather than hinder the integration of services for individuals with co-occurring disorders.** This includes:
 - Promoting resource sharing between mental health and substance use providers to meet the needs of individuals with co-occurring disorders
 - Identifying opportunities for cost-sharing and financial incentives for the provision of integrated treatment services
 - Improving data collection and reporting related to co-occurring disorders and integrated treatment services to enable stronger measurement of the associated costs and outcomes

First steps:

Data on treatment and outcomes for people with co-occurring disorders is currently limited. It will be important to improve data collection and reporting to identify opportunities for improving treatment outcomes and costs associated with treating individuals with co-occurring disorders. Policies on integrated services for individuals with co-occurring disorders will also need to be researched to identify changes that need to be made to state, regional, and local policies to support an overarching structure that supports integrated treatment services.

Role for the change agent teams:

The change agent teams will inventory PIHP/CMHSP and or CA policies and identify barriers for integrated treatment. With assistance from the ITC, the change agent teams will also prioritize policies for revision/update based on their current environment.

Role for the ITC:

The ITC will identify any existing state policies that appear to be problematic and work with the MDCH to determine whether they are federal and/or state requirements. The ITC may recommend changes in policy to MDCH when there is flexibility within existing mandates.

Role for the state:

The MDCH will work with the ITC to clarify whether identified policies are federal requirements, state requirements, or both. The MDCH will consider policy revision recommendations, and issue technical assistance bulletins.

The MDCH will work with the ITC to review current data collection/reporting mechanisms to identify where data collection and reporting can be improved.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

Goal 2: Individuals with co-occurring disorders will easily access and engage in effective integrated treatment services that support their recovery

Objective 2.1. Help systems provide person-centered integrated treatment and recovery services in a comprehensive, continuous, integrated way

Strategies

- 1. Provide a welcoming, “no wrong door” message to clients who enter the system.** This includes:
 - Providing a helpful assessment and referral (i.e., “warm transfer” where clients are ushered through the system rather than sent away)
 - Coordinating care for clients whose needs cannot be met at a single location

First steps:

Create a system standard for a welcoming, “no wrong door” policy. The standard will create a baseline for what should be addressed in a “no wrong door” policy, but will not prescribe exact policy language.

The standard will be developed through a review of MDCH documents and regional and local policies that address the concepts of “welcoming” and “no wrong door,” and a dialogue among all stakeholders to discuss the principles and how they can be put into practice in the various levels of the system.

Role for change agent teams:

Change agent teams will provide information to the ITC that describes current policies, and inform the ITC about what would be most helpful to include in a standard policy. Change agent teams will provide a perspective from the field as to whether current policies are working, and will document effectiveness where possible.

Role for the ITC:

The ITC will collect information from the change agent teams and will conduct a review of MDCH documents and local and regional policies. The ITC will also facilitate the dialogue on the principles. The ITC will use the document and policy review and results of the dialogue to develop a system standard for a “no wrong door” policy and recommend the language to the Internal Integrated Treatment Group.

Role for the state:

Upon review and approval of the policy, the IITG will disseminate the system standard throughout the system through MDCH/ODCP communication channels.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

- 2. Support the coordination and integration of the treatment and recovery planning process for individuals with co-occurring disorders.** This may be accomplished by the development of an integrated treatment and/or recovery plan based on an integrated assessment that is used by both

mental health and substance use disorder treatment providers. At a minimum, the current plans that exist among the multiple providers who see an individual client should be shared among providers.

First steps:

Discussions must take place at all levels (state, ITC, and local) to clarify the need and desire for an integrated treatment and/or recovery plan to better meet the needs of individuals with co-occurring disorders.

Role for change agent teams:

The change agent teams will engage in dialogues to discuss the potential for developing regional treatment and/or recovery plans. They should identify the extent to which having an integrated recovery plan for individuals with co-occurring disorders would enhance the integration of treatment services, and look for ways to share treatment information among providers if an integrated recovery plan is not developed.

Role for the ITC:

The ITC will research the use of an integrated treatment and/or recovery plans in other states or regions and will share its findings with change agent team leaders.

Role for the state:

The state will support the ITC research, providing expertise if it is available, and will enable the sharing of ideas and information among the change agent teams.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

3. Establish policies and procedures for reporting integrated treatment and universal screening for co-occurring disorders throughout the system.

First steps:

Identify a set of data that should be collected to identify individuals with co-occurring disorders and create a policy requiring providers of public mental health and substance use services to screen all clients for both mental health and substance use disorders.

Role for the change agent teams:

Change agent teams will make recommendations to the ITC regarding information that should be collected or questions that should be asked to identify clients with co-occurring disorders.

Role for the ITC:

The ITC will facilitate the sharing of the information the change agent teams recommend for inclusion in screening tools.

Role for the state:

The MDCH will support and promote universal screening for mental health and substance use disorders for everyone seeking services within the public system.

Role for PIHPs, CAs, and CMHSPs:

PIHPs, CAs, and CMHSPs are critical quality improvement partners in the implementation of this plan and this objective. Specific roles will be identified as part of the workplan/implementation process

IMPLEMENTING AND MONITORING THE PLAN

The Integrated Treatment Committee will develop a work plan to lay out the specific steps that need to be taken to accomplish the goals, objectives, and strategies in this plan. The ITC will also develop a communication plan to share its strategic plan with additional stakeholders, including change agent teams whom the ITC will support in developing their own plans to accomplish the tasks required to support the strategic plan.

Once an implementation strategy is developed, the ITC will use the strategic plan as the basis for monitoring progress at each meeting. At every meeting, subcommittee leaders can provide updates on progress, using the plan as a guideline. The committee members will select the indicators they will use to assess progress and develop baseline measures where applicable. As indicators are measured, the ITC will use the data to adjust the implementation of the strategic plan, creating a new set of activities that can be used to measure progress. As such, the ITC views the strategic plan as a dynamic document that may be revised as necessary to reflect new activities and strategies.

While the ITC is responsible for assuring that the strategic plan is carried out and for monitoring progress on the plan, ITC members will engage the support and action of additional stakeholders as necessary and foster a collaborative approach to accomplishing its goals and objectives.

Indicators of Success

Evaluating progress will be essential to the success of efforts to integrate treatment services for individuals with co-occurring disorders. The ITC will monitor progress on its implementation plan as well as the overall strategic plan through the identification of indicators of success for each strategy.

The ITC identified the following potential indicators of progress toward achieving the strategies when they met in November:

- Partnerships are developed with primary care physicians.
- The MHSA and ODCP issue joint, coordinated information and communications.
- Individual recovery plans are developed and utilized by providers.
- Memoranda of understanding are used to coordinate activity among stakeholders.
- Policies governing new partnerships are implemented.
- The number and variety of stakeholders participating in partnerships increases.
- Care coordination meetings are held.
- Shared measures of success are developed.
- Stakeholders report knowing how to access services for co-occurring disorders (COD).
- Individuals are certified to provide COD care.
- Peer support specialists play a routine role in customer care.
- Screening for COD is occurring universally.
- Substance abuse and mental health screening and brief interventions are used by primary care physicians.
- Integrated treatment services are being provided as evidenced by consumer encounter reports.
- Individuals who visit the ER and crisis centers are screened for COD.
- A welcoming, “no wrong door” policy is implemented statewide at the local provider level.
- Consumers and their families report receiving care that is comprehensive, continuous, and integrated.

- All domains of an individual's health are considered when recovery plans are developed and treatment is provided.

CCISC: *Comprehensive Continuous Integrated System of Care (Developed by Dr. Kenneth Minkoff and Dr. Chris Cline)*

COD: *Co-occurring Mental Health and Substance Use Disorders*

CODECAT: *Co-occurring Disorders Educational Competency Assessment Tool*

COFIT: *CCISC Outcome Fidelity and Implementation Tool*

Community Mental Health Services Program (CMHSP): *A program operated under Chapter 2 of the Michigan Mental Health Code as a community mental health agency, a community mental health authority, or a community mental health organization.*

COMPASS: *Co-morbidity Program Audit and Self-Survey*

Co-occurring Disorders: *In the context of the Co-occurring Disorders Initiative, co-occurring disorders (COD) refers to the presence of both mental health and substance use issues concurrently, although this does not necessarily mean that both have to be currently active. Problems may be identified as co-occurring even if one is seen as having been active in the past only. Co-occurring disorders is also referred to variously as dual diagnosis, co-morbidity and concurrent disorder.*

Co-occurring Disorders: Integrated Dual Disorders Treatment (COD:IDDT):

This is a SAMHSA endorsed evidence-based practice for individuals with a serious mental illness and a co-occurring substance use disorder. This EBP is for individuals in the public mental health system. The same clinicians or team of clinicians provide a personalized treatment plan for both mental health and substance use problems. A wide variety of services are offered in a stage-wise fashion because some services are important early in treatment, while others are important later on. Individualized treatments are offered depending on what stage of recovery a person is in. Examples of services include basic education about the illnesses, case management, help with housing, money management, or relationships, and specialized counseling specifically designed for people with co-occurring disorders. This is a comprehensive and long-term approach to treatment that has hope and optimism as core beliefs. Services are offered in a positive atmosphere and people are encouraged to believe that they can recover as many others have. Ultimately, the goal of integrated dual disorders treatment is to help people learn to manage both their mental illness and substance use problems so that they can pursue their own meaningful life goals.

DSM: *Diagnostic and Statistical Manual of Psychiatric Disorders (American Psychiatric Association). Latest edition is DSM-IV-TR*

Dual Diagnosis or Co-occurring Enhanced (DDE): *This refers to DDC programs enhanced to accommodate individuals with more severe symptoms or disability and provide more specialized programming and staff skills.*

Dual Diagnosis Capable (DDC) or Co-occurring Capable: *This refers to mental health or substance abuse programs that are modified to address the needs of persons with co-occurring disorders. Basic modifications for all programs would include welcoming policy and practices, and universal*

screening and assessment. Depending on the range of services that are part of the normal scope of practice for a given program, modifications may also include integrated treatment planning, supportive psychopharmacology policies, augmented program content, and inter-program coordination of care efforts. A program would be considered DDC to the extent that it addresses the needs of these persons within the context of, and employs modifications that fit with, its normal range of services functions.

Dual Diagnosis: This term is often synonymous with co-occurring disorders and concurrent disorders.

Integrated Program(s): The organizational structure for providing integrated treatment where the mental health and/or substance use disorder program is responsible for ensuring an array of staff or linkages with other programs to address all of the needs of its clients. The program is responsible for ensuring that services are provided in an appropriate and easily accessible setting, services are culturally competent, etc. (SAMHSA, 2002)

Integrated System: The organizational structure for supporting an array of programs for people with different needs, including individuals with co-occurring substance use disorders and mental disorders. The system is responsible for ensuring appropriate funding mechanisms to support the continuum of services needs, addressing credentialing/licensing issues, establishing data collection/reporting systems, needs assessment, planning and other related functions.

Integrated Treatment Plan (Individual Plan of Service, Recovery Plan): A treatment plan developed through person-centered planning process that documents and addresses both mental health and substance use disorders specifically with appropriately matched interventions to achieve recovery.

Integrated Treatment Services: These services are accommodated by a program design that offers and provides both substance use disorder and mental health treatment in an integrated manner as evidenced by staffing, services and program content. Services must be provided through one service setting and through a single treatment plan and represent appropriate clinical standards including stage-based interventions.

MDCH: Michigan Department of Community Health

Mental Health Code: It is the legal requirements and regulations that govern the provision and administration of mental health services within the state of Michigan.

MHSA: Mental Health and Substance Abuse Services Administration, MDCH

Minor: An individual under the age of 18 years

Person Centered Planning and Family Centered Practice: Person-centered planning is a process through which Individual Plan of Services (IPOS) are developed. A process for planning and supporting the individual and family receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person centered planning and family centered practice involves families, friends, and professionals as the individual desires or requires.

Public Health Code: It is the legal requirements and regulations that govern the provision and administration of public health services (including substance use disorder services) within the state of Michigan.

SA: Substance Abuse

SAMHSA: *Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services*

Serious emotional disturbance: *Means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:*

- (a) A substance abuse disorder.*
- (b) A developmental disorder.*
- (c) "V" codes in the diagnostic and statistical manual of mental disorders.*

Serious Mental Illness (SMI): *Means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness:*

- (a) A substance abuse disorder.*
- (b) A developmental disorder.*
- (c) A "V" code in the diagnostic and statistical manual of mental disorders.*

Substance Abuse Coordinating Agency (CA): *A city, county, or regional agency designated by the MDCH/ODCP to develop and administer a comprehensive substance use disorder treatment and prevention plan.*

Substance Use Disorders: *This a general reference to any or all of the various substance-use disorders that are listed in DSM-IV or DSM-IVTR. The two primary diagnostic categories of substance use disorders are substance abuse and substance dependence.*

Stages of Change (Prochaska and DiClemente): *A change process model recognizes that change typically involves people progressing through various stages of motivation or interest in changing. The stages of change identified by this model are as follows:*

- *Precontemplation : Not considering or thinking about a need to change*
- *Contemplation: Considering or thinking about change at some time in the future*
- *Preparation: Preparing to undertake a change*
- *Action: Initiating and achieving change*
- *Maintenance: Maintaining change over extended period of time*
- *Termination: No longer feel threatened by a relapse to pre-change states*

Stages of Treatment [Osher & Kofoed]:

- *Engagement: Developing a trusting relationship or working alliance*
- *Persuasion: Helping the client to acknowledge a problem and interest in change*
- *Active Treatment: Helping the client to achieve stable recovery (abstinence/ reduced use)*
- *Relapse Prevention: Helping the client to maintain stable recovery*

Stages of Recovery (K. Minkoff, 1994)

- *Acute Stabilization:*
 - *Stabilization of active substance use or acute psychiatric symptoms*
- *Engagement/ Motivational Enhancement*
 - *Interventions designed to establish a primary clinical relationship and to facilitate the person's ability and motivation to initiate and maintain participation in a program of stabilizing treatment.*
- *Prolonged Stabilization / Active Treatment*
 - *Interventions of any type which are designed to stabilize the symptoms of the disorder, prevent relapse, and help persons to maintain a stable baseline and optimal level of functioning.*
- *Recovery & Rehabilitation*
 - *Interventions designed to help persons to develop new skills, reacquire old skills, and achieve personal growth and serenity, once prolonged stabilization has been consistently established.*

Quadrant Model: *A four-cell table used for identifying diagnostic subtypes of co-occurring disorder. The identification of subtypes is helpful for determining what service specializations need to be involved and when, and what level of care is appropriate.*

- **Quadrant IV: High Mental Health / High Substance Use**
Persons with severe acute psychiatric disturbance (non-SPMI) and substance dependence.
- **Quadrant III : Low Mental Health / High Substance Use**
Clients with alcoholism and/or drug addiction who have significant mental health disability but who do not have serious mental illness.
- **Quadrant II: High Mental Health / Low Substance Use**
Consumers with serious mental illness which are complicated by substance use or abuse
- **Quadrant I: Low Mental Health / Low Substance Use**
Individuals who usually present in outpatient setting with various combinations of mild to moderate mental health issues (e.g. anxiety, depression, family conflict) and patterns of substance misuse and abuse, but not clear-cut substance dependence.

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