#19

Continuous, Comprehensive Integrated System of Care (CCISC)

CCISC DESCRIPTION

The Comprehensive, Continuous, Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision driven system "transformation" process for re-designing behavioral health and other related service delivery systems to be organized AT EVERY LEVEL (policy, program, procedure, and practice) –within whatever resources are available - to be more about the needs of the individuals and families needing services, and the values that reflect welcoming, empowered, helpful partnerships throughout the system. The ultimate 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 – in partnership with each other, with system leadership, and with individuals and families who are receiving services - to become welcoming, recovery or resiliency oriented, and co-occurring capable. Further, 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, and will need to be welcomed for care, inspired with hope, and engaged in a partnership to address each and every one of those conditions in order to achieve the vision and hope of recovery.

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.

To create an environment where people seeking help for co-occurring issues can engage in partnerships with service providers that are grounded in the principles of recovery.

CCISC Annual Objectives

- Improve welcoming and service accessibility at BHD and its contract agencies.
- Teach service providers and people in recovery how to engage in recovery partnerships that are co-occurring capable.
- Train a corps of change agents, including people in recovery, committed to co-occurring, recovery-oriented capacity-building in their programs and across the system.
- Successfully implement NIATx projects to improve co-occurring capability/ recovery-oriented services.
- Showcase successes in a variety of media/ venues to encourage broader involvement in the movement.
- Establish a cross-walk capability among service providers and systems to provide accurate and timely data to monitor progress at the individual and program levels.
- Improve effective utilization of available financial resources to support co-occurring/ recovery-oriented services.

Annual Process Indicators

1. Number of BHD branches and contract agencies that undergo the CCISC assessment process, e.g. COMPASS-EZ and CODECAT-EZ.
2. Number of BHD branches and contract agencies that organize a Continuous Quality Improvement Process.
3. Number of change agents, including people in recovery, engaged in the CCISC process.
4. Number of NIATx process improvement projects implemented.
5. Number of NIATx projects showcased.
6. Establishment of co-occurring data capability at the individual, provider, and system levels.
7. Amount of funding expended on co-occurring/ recovery-oriented services.

Annual Project Outcomes

- Improved welcoming and service accessibility at BHD and its contract agencies.
  Indicators: provider self-assessment, feedback from people in recovery, and 'walk-through' assessment.
- Improved ability of service providers and people in recovery to engage in recovery partnerships that are co-occurring capable.
  Indicators: clinician self-assessment, feedback from people in recovery.
- Increased satisfaction with recovery expressed by people in recovery.
  Indicator: feedback from people in recovery.

  Increased provider satisfaction with the transition to CCISC.
  Indicator: feedback from providers.
- Increased provider satisfaction with the transition to CCISC.
  Indicator: feedback from providers.

annual

CCISC Long-Term (5 Year) Goals

1. Establish the Milwaukee County Behavioral Health Division and its contract agencies as an integrated service system capable of providing high quality recovery-oriented services that are co-occurring capable, person-centered, culturally competent, trauma-informed, family-involved and include peer to peer services.
2. Create momentum for progress that will attract other organizations to align with the principles and practices established by BHD and its contract agencies:
   - private hospitals and treatment providers;
   - higher education and professional development programs; and
   - funders (local, state and federal), licensing, and certification programs.

Long-Term (5-year) Client/Community Outcomes

- People are satisfied with their recovery.
  Indicator: feedback from people in recovery.
- Treatment resources support the delivery of services that are recovery-oriented; co-occurring capable, person-centered, trauma-informed, and family involved, and includes peer to peer services.
  Indicator: funding allocations and service utilization data.
- Other community systems, e.g. law enforcement, homeless services, and health care, participate in and show evidence of positive impact of CCISC.
  Indicator: arrests, service utilization data.

long-term

Proposed strategic planning process to achieve systemic co-occurring integration within Milwaukee County

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Section I: State of the Field

A. Introduction

Research has confirmed that co-occurring substance use and mental health disorders affect a substantial population that traditionally has been underserved (Substance Abuse and Mental Health Services Administration, 2003). Individuals with co-occurring disorders have multiple service needs that cut across a variety of service systems, making it difficult to navigate the systems due to impaired functioning and/or cognitive limitations, as well as potentially receiving duplicative services from different systems due to lack of coordination. Few individuals with co-occurring disorders have substantial social supports (Mueser, Noordsy, Drake, & Fox, 2003), thus making access and treatment that much more difficult to obtain.

Individuals with co-occurring psychiatric and substance use disorders are increasingly recognized as a population that is highly prevalent in both addiction and mental health service systems, and associated with poor outcomes and higher costs in multiple domains. In addition, they have long been recognized to be 'system misfits' in systems of care that have been designed to treat one disorder only or only one disorder at a time (Minkoff & Cline, 2006). Thus, instead of being prioritized for attention, these individuals with challenging problems are made more challenging because the systems of care in which they present have significant regulatory, licensing, and reimbursement barriers to the implementation of successful integrated treatment (Substance Abuse And Mental Health Services Administration, 2002).

While there are ample studies supporting the efficacy of integrated treatment for individuals with co-occurring disorders (Mueser et al., 2003; Substance Abuse And Mental Health Services Administration, 2002; Prince, 2005; Bellack, Bennett, Gearon, Brown, & Yang, 2006; Tsemberis, Gulcur, & Nakae, 2004; Brady, Myrick, & Sonne, 2003), separate service systems have been unable to meet their needs for a multiplicity of factors, including: (1) separate, uncoordinated mental health and substance use treatment providers and service programs, (2) an absence of a single locus of responsibility for treatment, (3) insufficient number of cross-trained staff, (4) differing treatment philosophies within the mental health and substance use communities, and (5) inadequate funding (Substance Abuse And Mental Health Services Administration, 2003). The philosophical underpinnings of appropriate treatment models across and even within systems are inconsistent, and are due to the fact that each treatment system grew independently of the other. Indeed, there is not even a universally accepted operational definition of 'recovery' amongst systems, much less the subset of each disability (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; White, 2004), regardless of the fact that systems and providers ascribe to the notion of recovery and seek to implement it in treatment planning.

B. Evolution of Co-Occurring Treatment

B.1. National Initiatives

In the late 1970's, practitioners began to recognize that the presence of substance abuse in combination with mental disorders had profound and troubling implications for treatment outcomes (Center For Substance Abuse Treatment, 2005). In those days, the term most often used was 'dual diagnosis'. Historically, individuals with co-occurring disorders received sequential or parallel treatment from the separate mental health and substance abuse treatment

systems, resulting in fragmented care. Neither system had developed the capacity to provide both mental health and substance abuse treatment within a single program (Center For Substance Abuse Treatment, 2005).

In 1989, Kenneth Minkoff unveiled the 'Comprehensive, Continuous, Integrated System of Care' (CCISC) model, built on eight evidence based principles of service delivery for co-occurring disorders, including the dictum that "dual diagnosis is an expectation, not an exception" (Minkoff, 1989). In 1996, the 'New Hampshire/Dartmouth Integrated Dual Disorder Treatment' (IDDT) model was published. It set forth the essential components of integrated treatment (assertive outreach, comprehensiveness, shared decision making, long-term commitment, stage wise treatment, and pharmacotherapy), described the stages of treatment, and constructed a fidelity scale to measure the adequacy of program implementation (Drake, Mueser, Clark, & Wallach, 1996).

In 1998, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) developed the national consensus 'Four Quadrant Model' to categorize service coordination by severity in the context of substance abuse and mental health settings. The Center For Substance Abuse Treatment (2000) highlighted the 'no wrong door' philosophy, and was followed by the Report to Congress on Co-Occurring Disorders in 2002. The report contained capacity building goals that underlie the Co-Occurring State Incentive Grant program, resulting in 19 grants awarded to different states since 2003.

In 2003, SAMHSA unveiled its Co-Occurring Center for Excellence (COCE - http://coce.samhsa.gov/) to support the adoption of evidence and consensus based practices in the field of co-occurring disorders, and in the same year issued the Integrated Dual Disorders Treatment Toolkit as part of its evidence-based practice series. The Center For Substance Abuse Treatment (2005) published Treatment Improvement Protocol (TIP) 42 on Substance Abuse Treatment for Persons with Co-Occurring Disorders, as well as an associated curriculum, to summarize for the clinician the state-of-the-art treatment in co-occurring disorders.

B.2 Wisconsin and Milwaukee County Initiatives

Philosophically, Wisconsin understands the importance of integrated and coordinated services. Wisconsin's Collaborative Systems of Care is an umbrella encompassing the Coordinated Services Team Initiative, Wraparound, the Integrated Services Project, and 'Children Come First' initiative. All involve approaches to respond comprehensively to individuals and families with multiple, often serious needs. Although wraparound services were initially designed for youth, they are now evolving to include clients of all ages, such as adults with mental illness (Adkins, Safier, & Parker, 1998) and adults with substance use disorders (Evenson, Binner, Cho, Schicht, & Topolski, 1998).

In 2003 the Department of Health and Family Services made the decision to merge the Bureau of Community Mental Health and the Bureau of Substance Abuse Services to better serve the citizens of Wisconsin with an integrated approach to funding and fostering staff at the state level with a familiarity of both mental health and substance abuse services and supports available to individuals who need them. In 2004, the newly designed Bureau (now Division) of Mental Health and Substance Abuse Services created a unit called Integrated Services

Development. Placed into this new unit were the management responsibilities for all community mental health programs, the adolescent and women's special substance abuse treatment programs, outpatient services, children's wraparound programs and the transformation planning for state wide revamping of both mental health and substance abuse service delivery.

As part of the state's mental health (MH) and alcohol and other drug abuse (AODA) redesign, a tool has been developed to enhance the screening and treatment of individuals with co-occurring disorders. This screen is referred to as the Mental Health and Co-Occurring Substance Abuse Screen (Bureau Of Mental Health And Substance Abuse Services, 2005). It is web-based, uses the short Global Appraisal of Individual Needs (GAIN) tool for identification of substance use, and establishes eligibility for a variety of community mental health and AODA programs. This screen is being promoted state wide in the county-based system to further the 'no wrong door' access to treatment.

Milwaukee County took a major step toward integrated services in 2002 when administrative and programmatic responsibility for AODA services was transferred from the Adult Services Division of the Milwaukee County Department of Health and Human Services to the Mental Health Division of the same department, becoming the Milwaukee County Behavioral Health Division. A major impetus for the merger was the desire to continue to move toward implementation of evidence-based practices with respect to co-occurring disorders. The Behavioral Health Division obtained authorization in August 2008 from its Advisory Council to embark on a process of system transformation by fully integrating the community mental health system and community substance abuse treatment system. The primary rationale is to create clinical, operational, and cost efficiencies within one system that would expand the scope of services and reduce redundancies when individuals are receiving parallel treatment from two different systems.

C. Prevalence and Scope of the Problem

For some time, national estimates of co-occurring disorders were drawn from two sources, which are now relatively dated:

1. The Epidemiologic Catchment Area (ECA) survey, initially administered in the period 1980 to 1984 (Reiger et al., 1984), found that individuals with serious mental illness were at a much greater risk for developing a substance use disorder. In particular, 47% of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population), and 61% of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).
2. The National Comorbidity Survey (NCS), administered between 1990 and 1992 (Kessler et al., 1994), found that 42.7% of individuals with a 12-month addictive disorder had at least one 12-month mental disorder, and 14.7% of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.

Estimates from both studies indicated that during a 12-month period, about 15% (approximately 6.6 million) adults with a diagnosable mental disorder have a co-occurring substance abuse disorder.

In more recent research, Epstein, Barker, Vorburger, and Murtha (2004) conducted the National Survey on Drug Use and Health (NSDUH) and found that in 2002 four million adults

with serious mental illness (SMI) also had a co-occurring substance use disorder; this represented 23.2% of all adults with SMI and 20.4% of all adults with a substance use disorder in the United States. It further found that 52% of persons with co-occurring disorders did not receive any treatment. Of those who received some type of treatment, 43% received mental health treatment only, 2% received addiction treatment only, and 12% received treatment for both disorder. The National Comorbidity Survey was replicated in 2002 (National Comorbidity Survey, 2005) and supported the findings of the NSDUH. It indicates that of those with both substance dependence and serious mental illness, only 19% receive treatment for both disorders. If treatment is received at all, it is most often for the mental disorder alone (49%).

Within Wisconsin, Milwaukee County has the largest number of people who require treatment for co-occurring disorders. It also has the largest gap between those in need of treatment and those who are able to obtain it (Welch & Quirke, 2002). Milwaukee County represents the most populous county in the State with a 2006 population of 915,097, or 16.5% of the state's population of 5,556,506 (U.S. Census, 2006). Milwaukee County has the highest prevalence estimate of serious mental illness within Wisconsin at 6.7% of the adult population age 18 or older, or 46,352 individuals (Wisconsin Department Of Health And Family Services, 2008).

Furthermore, Wisconsin has the largest percentage of drinkers in the population when compared to the other 50 states (Romell, 2008), and Milwaukee is second only to Austin, Texas in binge drinking throughout America (Durhams, 2008). As identified in Table 1, Milwaukee County (MC) ranks worse than the State of Wisconsin (WI) on virtually every substance abuse indicator (Epstein et al., 2004).

Table 1. Percentage of population using alcohol or other drugs in Milwaukee County versus Wisconsin

Substance Abuse Indicator	MC %	WI %
Any illicit drug use past month	9.49	7.64
Marijuana use past month	7.25	5.60
Cocaine use past year	3.11	2.68
Non-medical use of pain relievers past year	4.97	4.74
Binge alcohol use past month	32.18	30.26
Any illicit drug dependence past year	1.94	1.72
Alcohol dependence or abuse past year	11.77	10.65
Dependence or abuse any illicit drug past year	13.49	11.72
Need but didn't receive treatment alcohol use past year	11.04	9.29
Need but didn't receive treatment drug use past year	2.67	2.52
Serious psychological distress past year	9.24	8.58

Information collected in 2003 by the Milwaukee County Behavioral Health Division from the Addiction Severity Index on a representative sample of the Milwaukee population indicates that those who seek treatment for substance abuse have serious co-occurring issues that characterize their lives. Levels of abuse and poor psychological functioning reported by the males in the population are significant. The levels reported by the females are even more striking. As indicated in Table 2 for Milwaukee County residents seeking substance abuse treatment, a disturbance in mood concurrent with substance abuse is common with suicidal ideation and suicide attempt. A number of people endorsed having experienced symptoms that can be associated with more severe mental disorders.

Table 2. Percentage of Milwaukee County residents seeking substance use treatment and reporting psychiatric symptomatology

Characteristic	Male %	Female %
Experienced serious depression	58.5	88.4
Experienced serious anxiety	57.3	88.0
Experienced psychotic symptoms	17.1	42.6
Difficulties concentration/memory	43.9	76.4
Difficulty with impulse control	39.8	58.3
Experienced suicidal ideation	30.9	67.6
Attempted suicide	15.4	56.9

As evidenced by the tables above, there is a demonstrable need to integrate mental health and substance use services. Far too often however, the "fix" has been to add a single professional to a program (i.e. a substance abuse counselor to a mental health program or a mental health professional to a substance abuse program) and refer individuals with co-occurring disorders to that counselor/professional to address that specific need. The result is uncoordinated, parallel treatment within the same program, rather than truly integrated care.

D. Defining Co-Occurring System Integration

Integrated care represents appropriate treatment at the appropriate time via staged interventions through a coordinated approach using best-practice models (Mueser, Noordsy, Drake, & Fox, 2003; Drake et al., 2001). While there are program designs to implement co-occurring disorder treatment, most notably the Integrated Dual Disorders Treatment (IDDT) model (Center For Mental Health Services, 2003), it does not necessarily address systemic issues. In addition to integrating clinical capacity (such as screening, assessment, treatment, evaluation, monitoring, and workforce development), system integration must also include infrastructure development such as certification and licensure, information sharing and financing mechanisms (Co-Occurring Center For Excellence, 2008).

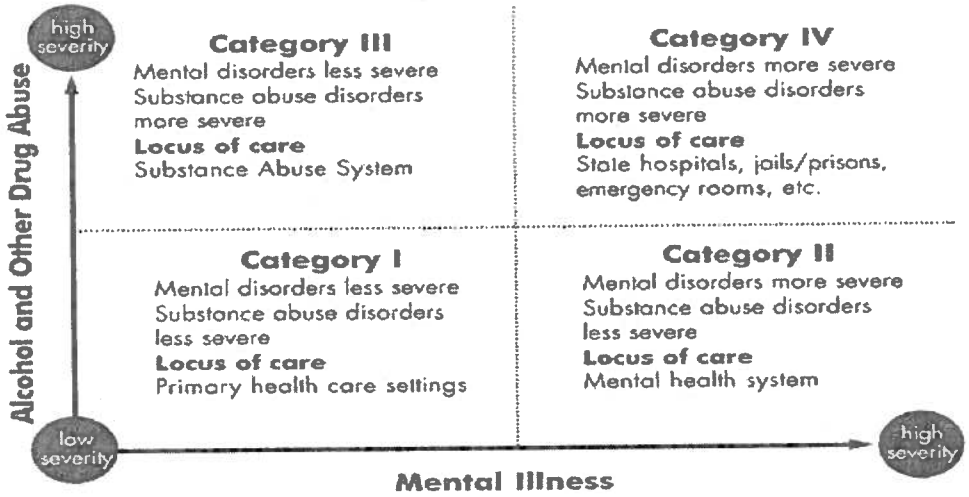
It should be noted that system integration is different from services integration. System integration is a functional process of developing organizational structures such as educational, fiscal and regulatory infrastructures so that the components of the system operate as a coherent whole to meet the needs of the entire population to be served. It also entails developing the capacity of the system to meet individual needs at each sub-component of the system, juxtaposed to services integration which merges previously separate clinical services into one seamless practice (Minkoff, 2006). A natural outcome of system integration is services integration.

The Report to Congress (Substance Abuse And Mental Health Services Administration, 2002) reviewed promising practices for systems development and referenced the Comprehensive, Continuous Integrated System of Care (CCISC) model developed by Ken Minkoff as a best practice model for system design of integrated services (Minkoff & Cline, 2004a). The model has two critical elements: a framework for system design to support universal delivery of properly matched integrated services, and a methodology for systemic implementation of that design. Every program becomes defined as a co-occurring program meeting at least minimal standards of dual diagnosis capability, but each program has a different 'job', based first on what it is already designed to be doing, and an organized plan to routinely provide matched interventions to individuals as a fundamental element of the program design. CCISC incorporates a structured implementation process based on application of recognized

management technologies of strategic planning and continuous quality improvement involving partnership between multiple layers of the system simultaneously, including system management, agency and program level, clinical practice, and clinician competency and training (Curie, Minkoff, Hutchings, & Cline, 2005).

Implementation of the CCISC model will enhance services for those individuals whose level of functioning approximates Quadrants II and III of the four-quadrant model by achieving dual diagnosis capability. The national consensus four-quadrant model (Substance Abuse And Mental Health Services Administration, 2002) can be conceptualized in figure 1.

Figure 1. Level of care quadrants



Quadrant I includes individuals with low mental health and substance use needs that can be adequately treated in an outpatient primary care setting. Quadrant II includes individuals with high severity mental disorders who are usually identified as priority clients within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management. Quadrant III includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level substance abuse treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders. Quadrant IV includes individuals that have severe mental disorders and substance dependence, and requires a fully integrated, or dual diagnosis enhanced, program.

Therefore, central to the concept of an integrated system is the movement of the entire system to at least a dual diagnosis capability. While many programs believe that they have co-occurring capability due to the individuals that are served in their program and/or holding dual certifications in mental health and substance abuse treatment (Minkoff, 2006), fewer rise to the level identified in the American Society Of Addiction Medicine (2001) definition. Specifically, ASAM defines dual diagnosis capable (DDC) as:

> "Treatment programs address co-occurring… disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning… (by) having arrangements in place for coordination and collaboration with mental health services. They also can provide psychopharmacologic monitoring and psychological assessment and consultation, either on site or through coordinated consultation with off site providers. Program staff are able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change – as well as relapse and recovery environment issues – through individual and group program content. Nevertheless, the primary focus of DDC programs is the treatment of substance-related disorders. (pp. 9-10)"

In contrast to DDC services, dual diagnosis enhanced (DDE) services place their primary focus on the integration of services for co-occurring disorders in their staffing, services and program content. DDE programs incorporate those elements into the program that DDC programs address through coordination and collaboration. Furthermore, Minkoff and Cline (2006) have developed similar DDC and DDE criteria for mental health providers. DDC programs are able to effectively serve individuals identified in quadrants II and III, while DDE is designed to serve those in quadrant IV.

E. Major Limitations and Challenges to Systemic Integration

While there is an increasing awareness to promote co-occurring treatment, there remain significant hurdles to overcome. The Report to Congress on Co-Occurring Disorders (Substance Abuse And Mental Health Services Administration, 2002) cites policy, funding, program, clinical and consumer/family barriers to providing co-occurring disorder treatment. Milwaukee County faces similar barriers, including:

- Boundaries, organizational responsibilities and program philosophy. Both the community mental health and substance abuse service systems have strict eligibility criteria, which can make access to services difficult for persons with co-occurring disorders. There are also theoretical differences in treatment protocols and approaches between the two systems of care.
- Assessment and diagnosis. Providers often overlook assessing and diagnosing both substance abuse disorders in persons with mental illness and mental illness in persons with substance use disorders. There is a need for an identified comprehensive screening and longitudinal assessment tool and a need to promote the use of such tool, which would lead to effective service planning.
- Training and attitudes. There is uneven knowledge, skills and experience between staff in the two systems. Staffs are most often trained in their respective field with limited training in the other discipline. In particular, there are a limited number of qualified, culturally competent and cross-trained staff, and limited collaboration among appropriate and qualified providers who understand both areas. Staff from one discipline may resist partnership with the other discipline.
- Separate funding requirements. Mental health and substance abuse service providers operate with limited budgets and there is some reluctance to jointly fund services (Wisconsin Department Of Health And Family Services, 2008). There is a fear that one discipline will be subsumed by the other discipline. Likewise, there are limitations on reimbursement due to categorical funding requirements.

- System bifurcation issues. In addition to the different payment structures, there is not a coherent set of service arrays and definitions spanning both systems, as well as separate processes for certification and licensing.

F. Lessons Learned from other Co-Occurring System Implementation Initiatives

In recognition that individuals with co-occurring disorders are 'system misfits' in both mental health and substance abuse treatment systems (Minkoff & Cline, 2006) due to systemic barriers, the Substance Abuse and Mental Heath Services Administration (SAMHSA) has funded Co-Occurring State Incentive Grants (COSIG) to assist systems develop infrastructure related to co-occurring disorder treatment with an emphasis on serving quadrants II and III. A total of 19 states have been awarded COSIG grants since 2003, and 11 of the 19 states are implementing Minkoff's Comprehensive Continuous Integrated Systems of Care (CCISC) for individuals with co-occurring disorders.

Lessons learned from the COSIG states reveals that implementing the concept of 'welcoming' into agency structures does not equate to Dual Diagnosis Capability (DDC) (Substance Abuse And Mental Health Services Administration, 2008). 'Welcoming' is a strategic starting component of CCISC to begin more comprehensive system change processes, and is akin to the 'no wrong door' policy (Minkoff & Cline, 2004b). The concept of 'welcoming' or 'no wrong door' is that an individual can enter the system at any point by the welcoming provider with a sincere desire to engage the person and make a connection with the right component of the system, even if the individual cannot be immediately served in the program to which they first made contact with the system. The COSIG states found that incorporating 'welcoming' or 'no wrong door' alone does not equate to programmatic DDC.

The Substance Abuse And Mental Health Services Administration (2002) identified collaboration amongst providers as an integration strategy consistent with DDC, and interdisciplinary collaboration can be viewed as a complex clinical skill (Zweben, 2003). Oklahoma noted that an accessible infrastructure was slowly developing in its state, and the primary barrier to interagency cooperation and collaboration is related to financial issues (Cherry, Byers, Dillon, & Barnett, 2007).

Oklahoma was also able to demonstrate that integrated programs identified more people with co-occurring disorders and these individuals spent less time in treatment than individuals in control programs (Substance Abuse And Mental Health Services Administration, 2008). All COSIG states identified workforce development, recruitment and training as a major initiative in their respective systems.

Some states, particularly Vermont and Hawaii, have integrated recovery supports into their system, as well as a number of peer initiatives. This has reduced stigma and barriers to care for people seeking services. States are also becoming more cognizant that there is a growing need to provide trauma-informed services, rather than providing trauma education to agency staff, recognizing that there is a difference between knowledge (trauma education) and practice (trauma-informed service).

Section II: The Milwaukee County System: An Opportunity for Improvement

A. Behavioral Health Division's Community Services Branch

Pursuant to Sections 46.03(1), 46.21, 51.08, 51.35, 51.42 and 51.437 of the Wisconsin Statutes, the Milwaukee County Department of Health and Human Services – Behavioral Health Division provides care and treatment of persons with disorders related to alcohol and other drug abuse (AODA), as well as developmentally, emotionally and mentally ill adults and children. The mission of the Behavioral Health Division is to provide a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders. The Division is comprised of several Branches, including Nursing Facility Services, Inpatient Services, Crisis Services and Adult Community Services.

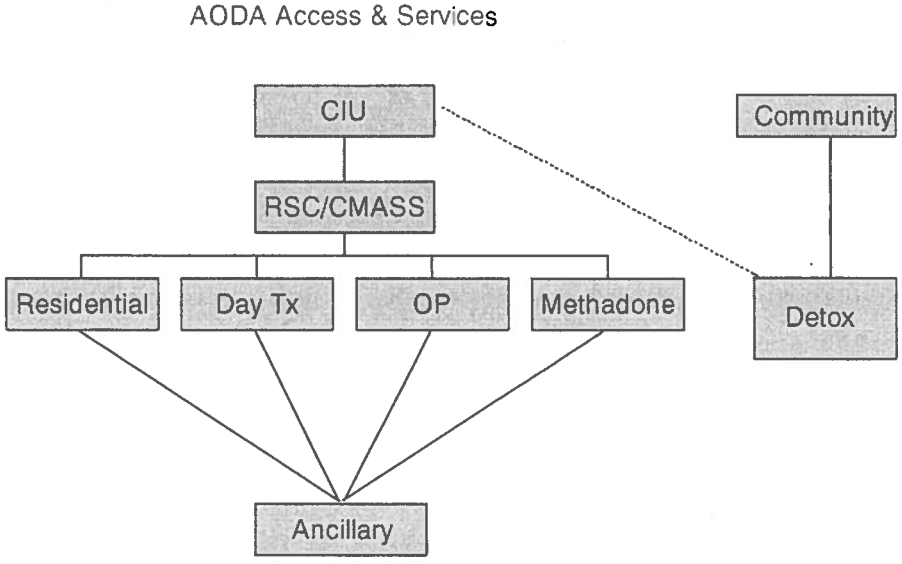
In December, 2001 the Milwaukee County Board of Supervisors passed a resolution that resulted in the administrative merger of public sector Adult Mental Health and Adult AODA services. Prior to adoption of this resolution, public sector Adult Mental Health services were the responsibility of the Milwaukee County Mental Health Division, whereas administrative and program management responsibility for public sector AODA services belonged the Adult Services Division of the Milwaukee County Department of Health and Human Services.

With the passage of the enabling County Board resolution, the Adult Mental Health Division became the responsible party for both Adult Mental Health and Adult AODA services. Simultaneously, the Mental Health Division had its name changed to the Behavioral Health Division to better reflect the merger and its expanded behavioral health responsibilities. These organizational changes became administratively effective on January 1, 2002.

A.1 Community Substance Abuse System

The alcohol and other drug abuse (AODA) services area includes detoxification, residential, day treatment and outpatient clinical treatment services represented schematically in figure 2. Appendix A provides a brief clinical service description for each level of care. In addition, ancillary services such as housing assistance, transportation, child care and employment training as well as Recovery Support Coordination are provided. The majority of funds provided to community agencies are through a fee-for-service voucher system.

Figure 2. Milwaukee County AODA Service System



The AODA system is designed with the central intake unit (CIU) as the system's front door to services. Currently, there are four community contracted CIUs. CIU sites are geographically dispersed to increase accessibility in terms of transportation, culture and language. Individuals must meet Axis I diagnostic criteria for a substance use disorder (American Psychiatric Association, 2000) and are determined to be in need of substance abuse treatment through the application of the ASAM Patient Placement Criteria (American Society Of Addiction Medicne, 2001), although all information is self-reported and collateral information is not used to verify the self reports.

The comprehensive screen conducted by the CIUs use the Addiction Severity Index (ASI) as the core measure enhanced by several supplementary items constructed to provide additional information relevant for ASAM placement decisions and covering such critical areas as readiness to change, mental health status, and key factors potentially influencing the individual's treatment and recovery course including gender, culture, ethnic origin, and spiritual concerns (McClellan, Luborsky, Woody, & O'Brien, 1980). The ASI was also identified by SAMHSA as an instrument with a combined substance use and mental health disorders focus, receiving positive ratings in critical areas related to clinical utility in all phases: detection, placement, treatment planning, outcomes, and severity measurement (Center For Substance Abuse Treatment, 2005). Information gleaned from this process insures the best match between individual needs and providers in terms of the appropriate level of substance abuse treatment required and the level of recovery support services needed.

Once the appropriate level of substance abuse treatment is determined, the CIU provides the client with a list of appropriate treatment providers for the determined level of care (residential, day treatment or outpatient, and recovery support coordination). The CIU assists the client in evaluating providers and making a free and informed choice. The CIU then issues an initial, time-limited authorization to the provider and submits the information electronically to the Behavioral Health Division (BHD) to activate the authorization for payment after confirmation from the provider that the individual is engaged in treatment. Providers use the ASAM patient placement criteria to request extensions in service or movement in level of care (either to a higher or lower intensity) to BHD based on clinical considerations while the individual is enrolled in the system.

The individual also chooses a Recovery Support Coordinator (RSC) at the CIU. RSC is an evidence-based practice (Center For Substance Abuse Treatment, 1998) that employs a strengths-based perspective to case management. Strength-based case management, a model initially developed to address the needs of persons with mental illness (Rapp & Chamberlain, 1985), has also been demonstrated as effective with individuals receiving substance abuse treatment (Center For Substance Abuse Treatment). The RSC plays a central coordinating role with the paramount obligation of insuring that the individual can access the resources, services, and support he/she needs to achieve treatment goals.

The RSC works with the individual to form a Recovery Support Team comprised of formal systems (i.e. criminal justice system, child welfare system, state vocational system, etc.) and informal supports (i.e. relatives, friends, clergy, etc.). The purpose of the team is to assist the individual develop and achieve the goals of a Single Coordinated Care Plan (SCCP) that

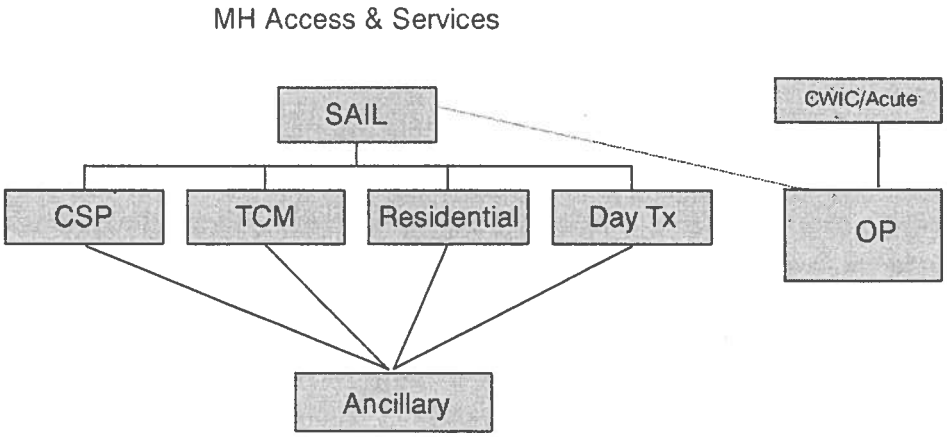
incorporates the needs of the individual and the requirements and resources of all involved systems. The SCCP insures that services and requirements are coordinated, and that systems are not working at cross-purpose. The SCCP also identifies Recovery Support Services needed by the individual to remove barriers to care and achieve their treatment plan goals, including but not limited to childcare, housing assistance, medical care, transportation, legal services and food stamps. Recovery Support Services that are not provided by other systems are authorized by BHD for payment based on the SCCP.

Funding for the AODA system comes from a variety of sources, including block grants, federal and state grants, and local tax levy. The system uses a braided funding concept, that is, categorical and flexible funds are braided together to purchase services based on the individual's eligibility for each individual fund source. Technical eligibility is initially determined at the CIU. An individual may be eligible for multiple fund sources, but each fund source may not pay for all services. Therefore, the system uses a funding matrix to determine which services can be paid for by which fund source, hence the braided concept. In this way, flexible funds are utilized to pay for services that are not allowed by grant funds. BHD is able to track all reporting requirements established by fund source in this manner. This process is invisible to the individual receiving services and also to the providers being paid for services. This also allows BHD the ability to track expenditures in real time by applying 'burn rates' to each fund source. A burn rate is the actual amount of authorizations paid versus the maximum authorization amount. Since providers do not typically exhaust all of the units on any given authorization, monitoring the burn rate provides accurate financial data to track over/under spending in any given fund source.

A.2 Community Mental Health System

The majority of community-based services for persons having a serious and persistent mental illness are provided through contracts with community agencies. However, BHD also directly operates several community-based health programs. Within the Community Services Branch, the Service Access to Independent Living (SAIL) unit centrally manages access to all long-term community-based mental health services. The community mental health system is represented schematically in figure 3.

Figure 3. Milwaukee County Mental Health Service System



The mental health program area is composed of several major program areas for the medical and non-medical care of individuals in the community. These program areas are Community Support Programs (CSP), residential programs, Targeted Case Management (TCM), Day Treatment and Outpatient (OP). Appendix B provides a brief clinical services description for each program area. Services are designed to provide for a single mental health delivery system that reduces institutional utilization and promotes recovery in the least restrictive setting.

SAIL is the central access point for Milwaukee County residents requiring long term community support, except that outpatient services are accessed through BHD's crisis walk-in clinic (CWIC) and inpatient hospital. The target group for long term community support are individuals who have not been adequately served through traditional outpatient services. The defined target population for these services are:

- Group 1 – Persons with severe and persistent mental illness. Persons in this group are recently severely impaired and the duration of their severe impairment totals six months or longer.
- Group 2 – Persons with severe mental illness. Persons in this group are recently severely impaired and the duration of their severe impairment totals less than six months.
- Group 3 – Persons who were severely impaired. Persons in this group are not recently severely impaired but have been severely impaired in the past and need some ongoing services to prevent relapse.
- Group 4 – Persons with mild or moderate mental disorders. Persons in this group either 1) have disorders that are not as severe in terms of diagnosis, duration or disability as those in the first three groups or 2) formerly had a mental illness resulting in severe impairment but no longer need intensive services to prevent relapse. Persons in this group are typically individuals whose lives are extremely stressed by the combined effects of poverty, violence and drug abuse, and present with exacerbations of mental disorders due to these stresses or acute emotional reactions to interpersonal conflict or disruption. As such, these individuals do not have a severe mental illness, but they do need services to avert a greater need.

The purpose of these categories is to target public resources to persons most in need (i.e. people with severe mental illness).

Only behavioral health and medical providers can initiate a referral to SAIL, and the referral must include a psychiatric evaluation completed within the last year and copies of the last two psychiatric hospital discharge summaries, as well as a SAIL assessment. SAIL makes the level of care determination, and assigns individuals to a particular agency. Likewise, agencies must submit prior authorization requests to SAIL for additional services and cannot discharge individuals from programs without prior SAIL approval.

Admission to a Community Support Program (CSP) is limited to an individual who has a chronic mental illness which by history or prognosis requires repeated or acute treatment or prolonged periods of institutional care, and who exhibits persistent disability or impairment in major areas of community living. CSPs are intensive case management regulated by an administrative code, and are founded on the Assertive Community Treatment (ACT) model intended to utilize a team approach, a SAMHSA evidence-based treatment program (Phillips et

al., 2001), although CSPs are not true ACT programs. Individuals may be seen by the CSP up to twice a day, seven days a week and their primary psychiatrist is located within the CSP.

Targeted Case Management (TCM) is a less intensive case management regulated by Wisconsin Medicaid. Admission is limited to individuals that have an Axis I diagnosis of psychotic or major affective disorder, or an Axis II diagnosis in cluster A or B based on the DSM-IV-TR (American Psychiatric Association, 2000). They must also have demonstrable functional limitations within the last six months, and not have a primary diagnosis attributed to alcohol or drug abuse. Their case manager typically sees individuals in TCM once a week to coordinate services, and Medicaid reimbursable services are limited to assessment, case plan development, and ongoing monitoring and service coordination.

Funding for mental health services consists of categorical funding through the federal mental health block grant, as well as flexible funding through an allocation received from the State for Community Aids and also local tax levy. Providers are reimbursed very differently from the substance abuse system through contractual agreements with BHD. That is, they are reimbursed one twelfth of the contract each month based on cost, regardless of the number of units provided. There is also a provision in the contract that recognizes they could have up to ten percent vacancy and still receive full payment. The Management Information System is an older platform when compared to the substance abuse system, and cannot provide the same level of detail on expenditures and forecasted costs.

B. Strategies for Pursuing Local Integration

As one can see from the system schematic diagrams in the previous section, there are similarities between Milwaukee County's public sector community substance abuse and mental health systems. However, there are significant barriers to overcome before achieving an integrated system, such as aligning funding infrastructure, Management Information Systems (MIS), business processes, screening and assessment, clinical models, and workforce development. Even though it was not explicitly stated in the previous section, there is a fundamental difference between the two service systems that drives the provision of service: short-term care (substance abuse system) versus long-term care (mental health system).

The National Association Of State Alcohol And Drug Abuse Directors And The National Association Of State Mental Health Program Directors (2005) recognized this deep-seated dissimilarity and recommend establishing operational guidelines that define the four quadrant model. Once operationalized, benchmarks can be established for systemic consistency. The key would be for both providers and the system to understand the quadrant model as a fluid rather than static dynamic, and plan the service system accordingly.

A substantial effort is currently underway to more closely align the infrastructure and Management Information Systems of the two systems as the result of implementing a new Medicaid initiative known as 1915(i) in the mental health system. The Deficit Reduction Act of 2005 added a new section 1915(i) to the Social Security Act that allows states the option to provide home and community based services for people considered disabled by a mental illness. Services can include (but are not limited to) case management, habilitation services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental

illness. 1915(i) allows states to establish Medicaid rates on a cost reimbursable methodology, which is expected to significantly enhance the current Medicaid rate structure.

To take full advantage of these enhanced rates, direct clinical services in the mental health system will be converted from contracts to fee-for-service agreements. Some of the requirements of 1915(i) also mirror the practice in the AODA system, such as individual free and informed choice of providers (Centers For Medicare & Medicaid Services, 2008) and an expanded array of support services. The Management Information System, business processes and reimbursement mechanism in the mental health system will be much more closely aligned to the same processes used in the AODA system.

However, alignment of certain infrastructure and business processes alone does not represent systemic integration. Other strategies would be required to achieve co-occurring system integration. Commonly used system level strategies to achieve integration include building a consensus among identified stakeholders who participate in the planning process. This process would include structural, regulatory and reimbursement considerations, specifying contracting mechanisms, defining standards, and implementing training initiatives for identified core competencies (Drake et al., 2001; Substance Abuse and Mental Health Services Administration, 2003).

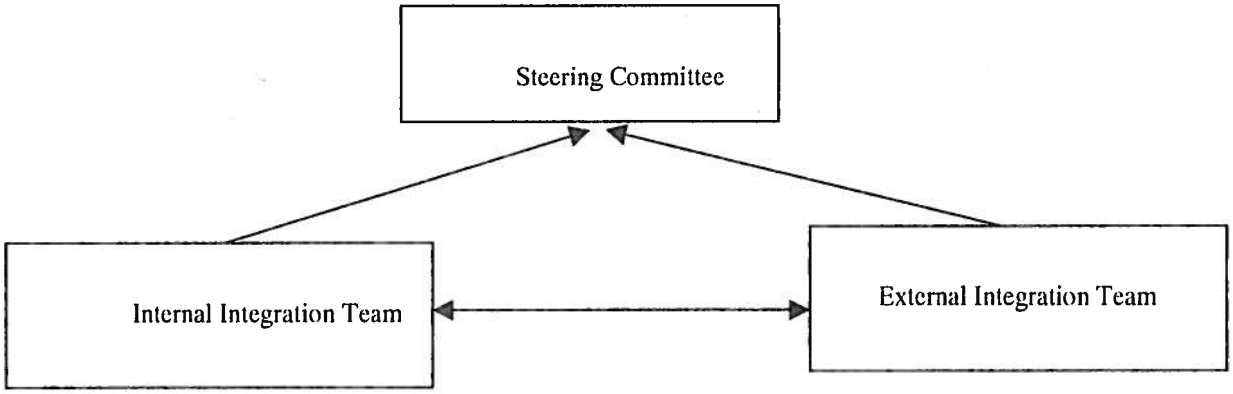
Minkoff and Cline's (2004a) Comprehensive, Continuous, Integrated System of Care (CCISC) incorporates these aspect at a system level. It is a recognized best practice for system integration of co-occurring disorders (Substance Abuse And Mental Health Services Administration, 2002). The CCISC model is based on four characteristics: (1) system level change, (2) efficient use of existing resources, (3) incorporation of best practices, and (4) integrated treatment philosophy (Minkoff, 2005), as well as eight research and consensus derived principles (Minkoff, 2001). The eight principles are:

1. Dual diagnosis is an expectation, not an exception.
2. The national consensus four quadrant model for categorizing disorders can be used as a guide for service planning on the system level.
3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting.
4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each individual and in each service setting.
5. When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated or multiple primary diagnosis-specific treatment is recommended.
6. Both mental illness and addiction can be treated within the philosophical framework of a disease and recovery model with parallel phases of recovery, in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.
7. There is no single correct intervention; each intervention must be individualized according to quadrant, diagnosis, level of functioning, external constraints or supports, phase of recovery/stage of change, and multidimensional assessment of level of care requirements.
8. Clinical outcomes must also be individualized, based on similar parameters for individualizing treatment interventions.

In essence, implementation of the CCISC model requires a system-level strategic planning process that incorporates a continuous quality improvement (CQI) program, and occurs incrementally over time, from 18 to 24 months on average according to K. Minkoff and C. Cline (personal communication, November 9, 2005). The first step in the organized strategic planning process is the creation of a steering committee comprised of key stakeholders including consumer/family representation to oversee continuing implementation. The Behavioral Health Division's Advisory Council approved the formation of such a committee in August 2008. The first concrete goal of the steering committee is to draft a quality improvement charter that would be disseminated throughout the system which identifies goals to be achieved while pursuing integration both at the system and agency levels.

Subordinate to the steering committee is an internal and external integration team. The role of the internal integration team is to determine and oversee the processes and activities required to integrate mental health and substance abuse infrastructure such as certification, information sharing and financing mechanisms; whereas the external integration team extends the strategic planning process to develop specific strategies that will insure cohesion to the change process at the service delivery level. Schematically, it is represented in figure 4.

Figure 4. Integration Committee Structure



The systemic goal of pursuing integrated treatment would be to achieve dual diagnosis capability (DDC) throughout the system, and the strategic plan could reasonably be expected to include the following objectives in support of the system goal:

- Screen all individuals for the presence of co-occurring disorders,
- Assess all individuals who screen positive to determine level of severity relative to the four quadrant model, level of care and initiate treatment planning,
- Train all providers in co-occurring competencies to achieve DDC, and
- Treat both disorders in a comprehensive and coordinated manner.

Utilizing a continuous quality improvement (CQI) process to measure adherence to nationally recognized DDC competencies (American Society Of Addiction Medicine, 2001), as well as ongoing fidelity to the CCISC model, will also assist in defining measurable targets for each objective listed above at benchmark periods of time for system, program and clinician level competencies.

Development and implementation of program standards to meet DDC for all providers also necessitates the development of clinical consensus best-practice guidelines and competencies for all clinicians to meet DDC expectations. The guidelines and competencies are incorporated into the program standards so that change is sustained over time. In other words, integration is achieved at the system level through the CQI structure of adherence to DDC standards that incorporate core competencies across all programs; at the program level through development an internal QI structure that define integrated treatment within the context of that program in accordance with CCISC principles and as evidenced in integrated treatment planning, progress notes, best practice models, and programmatic training plan; and at the clinician level through documentation of integrated treatment and demonstration of specific clinical competencies identified in the program training plan.

The CCISC model has three evaluation tools developed by Minkoff and Cline to measure implementation at the system, program and clinician levels. All three tools employ a Likert scale and can be used either as self-surveys or through the QI process.

The system measurement tool is the CCISC Outcome Fidelity and Implementation Tool, which measures both implementation and system outcomes. Both quantitative and qualitative evaluations can be ascertained through the use of this tool. Questions allow for periodic quantitative measurement of successful system change against a baseline, while periodic semi-structured interviews with key stakeholders will allow more qualitative narratives about system change that may bring to attention both unexpected side benefits and unforeseen deviations or barriers to change, allowing these to be taken into account in subsequent quality improvement and evaluation activities.

The program level tool is the Comorbidity Program Audit and Self-Survey for Behavioral Health Services. At the system level, the tool can be used for system planning and development, identification of training and technical assistance, and defining quality improvement practices. At the program level, it focuses on strategic, incremental, measurable and sustainable change toward the goal of DDC. It can be used to compare programs of similar types within the system through collection of domain scores to compare program performance to the system mean for that domain.

The clinician level tool is the Co-Occurring Disorders Educational Competency Assessment Tool. It identifies the eight CCISC principles listed earlier and the expected clinician core competencies associated with each principle. The tool provides an integrated framework to evaluate clinicians' training needs and a framework within which disorder-specific treatment can be understood and applied more effectively. It also provides a format for either supervisory evaluation or clinician self-evaluation of these competencies.

Implementation of these measures within the CCISC framework at a system level can produce an integrated network that achieves dual diagnosis capability that is sustained over time. It will require a concerted effort on the part of the Behavioral Health Division and all providers within its network to pursue integration, but the expected outcomes would be lower utilization of high-cost services such as hospitalization and correctional institutions, and, conversely, maintaining stability in a community setting through efficiencies of collaboration and account for redundancies by providing a seamless service delivery system.

Appendix A – AODA Clinical Service Descriptions

Outpatient – A non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention, and may include group/family therapy.

Day Treatment – A medically-monitored, non-residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and office-based case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week.

Transitional Residential - A clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides substance abuse treatment in the form of counseling for 3 to 11 hours per patient per week, immediate access to peer support through the environment, and intensive office-based case management which may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

Medically Monitored Residential – A 24-hour, community-based service providing observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient.

Biomedically Monitored Residential - A 24-hour, community-based service providing observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, and staffed 24 hours a day by nursing personnel.

Methadone – A narcotic treatment service for opiate addiction that provides for the management and rehabilitation of selected narcotic agents through the use of methadone and a broad range of medical and psychological services, substance abuse counseling and social services.

Detoxification - Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Detoxification seeks to minimize the physical harm caused by the abuse of substances. Detoxification alone is not defined as substance abuse treatment and rehabilitation per se, but it is a basic component of the substance abuse treatment system.

Appendix B – Mental Health Clinical Service Descriptions

Outpatient - Mental health outpatient services consists of medication management only, medication management along with individual and or group therapy and those receiving therapy only. Individuals in need of adult mental health outpatient have an array of diagnoses including the majority of individuals experiencing affective disorders such as major depression, bipolar disorder, and some situational depressions. The remaining individuals are persons who experience major thought disorders such as schizophrenia. It is estimated that sixty to eighty percent of individuals served in MH outpatient have an accompanying substance use disorder.

Community Support Program - This program represents the most comprehensive and intensive community treatment service model. A Community Support Program or "CSP" is a coordinated care and treatment program that provides a comprehensive range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement individualized participant centered treatment, rehabilitation and support service in the community where participants live, work, and socialize. Treatment and rehabilitation services are individually tailored with each participant through relationship building, individualized assessment and planning, and active involvement with participants to achieve individual goals, to better manage symptoms, to maintain hope and optimism, and to live and work in community settings of their choice.

Targeted Case Management - A modality of mental health practice which addresses the overall maintenance of a person with mental illness including his / her physical, psychological and social environment with the goal of facilitating physical survival, personal health, community participation and recovery from or adaptation to mental illness. Targeted case management puts primary emphasis on a therapeutic relationship and continuity of care.

Community Based Residential Programs - Group homes that provide services to persons having a serious and persistent mental illness with a living environment that: 1) provides the support necessary for an individual to live as independently as possible in a structured group residential setting; 2) continually promotes the acquisition of skills necessary for the consumer to transition to more independent living; and 3) actively pursues movement to a more independent living environment in conjunction with the consumer and other members of the consumer's support network. Services provided by CBRFs will include the provision of twenty-four hour supervision, the provision of meals and dietary management, individual counseling, support groups, medication education and monitoring, financial management (benefit advocacy and representative payee-ship), care coordination, and crisis prevention. These services are provided by the community-based residential facility staff in conjunction with other members of the consumer's support network.

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