



HURON BEHAVIORAL HEALTH POLICY

Procedure #: **SD.1.15**
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Title: Services to Persons with Co-Occurring Disorders Policy

Prepared By: Clinical Director

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Purpose:

To define philosophies and practices for ensuring the highest quality and most effective system of care for individuals and families experiencing Co-Occurring Disorders (COD)/ Integrated Dual Disorders Treatment (IDDT) at Huron Behavioral Health (HBH).

Scope:

This policy applies to all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH). This procedure also applies to all individuals served by Huron Behavioral Health.

Information:

- It is the policy of Huron Behavioral Health that individuals and families, experiencing co-occurring psychiatric and substance use disorders, obtain integrated services that are accessible as well as recovery oriented. The services will be consistent with the Comprehensive, Continuous, Integrated System of Care (CCISC) model, and such services will be delivered in a welcoming and culturally-competent environment where staff embrace the philosophy that “no door is a wrong door” (see also “[Welcoming Policy SD.1.14](#)”). The integration of best practices with an individualized person centered philosophy, based on an accurate assessment of the needs, strengths, values, and preferences of consumers, is expected. Services are responsive to the degree of service coordination the individual requires, such that we are providing the most appropriate interventions throughout the continuum of care.
- HBH recognizes that the co-occurring population is associated with poor outcomes and high service costs in multiple clinical domains. While no single approach has been proven effective, research has demonstrated that integration of services with stages of treatment are most likely to produce desired outcomes. The main goal is to provide consumers with timely and easy access to the most current best practices and support services.
- It is expected that all HBH programs will achieve co-occurring capability, with the capacity for offering co-occurring enhanced services that provide some types of Evidence Based Practices (EBP) suited to the condition of individuals seeking mental health and/or substance use services. During the screening process, clinicians will attempt to identify any individual who could benefit from an EBP or a combination of EBPs, such as IDDT, Motivational Interviewing, Assertive Community Treatment (ACT)/Intensive Case Management (ICSM), Family Psycho-Education (FPE), Supported Employment (SE), or other EBP modalities. When an existing EBP is appropriate to a given individual, the EBP should be used.
- Integrated mental health and substance use interventions may be provided by the same clinician in one setting or by a multidisciplinary team of clinicians. At least one clinician shall be qualified to treat Substance Use Disorders (SUD).
- In accordance with the Michigan Department of Health and Human Services (MDHHS) Best Practices Guideline for Person-Centered Planning and HBH policy “[Person Centered Planning Policy](#)” (QI.1.05), all consumers will be assured of this process.

Policy:

A. Principles:

In order to provide services that are congruent with an integrated system, HBH has adopted the CCISC model developed by Minkoff, 1998, 2000. This model provides eight (8) research-based and consensus-driven principles that will guide the implementation of the CCISC as follows:

1. Co-occurring issues and conditions are an expectation, not an exception.

2. The foundation of a recovery partnership is an empathic, hopeful, integrated, and strength-based continuing relationship.
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. Treatment must be individualized utilizing a structured approach to determine the best treatment. The national consensus “four quadrant model” for categorizing individuals with co-occurring disorders will be used in treatment.
4. When co-occurring issues and conditions are present, each issue or condition is considered to be primary.
5. Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue.
6. Progress occurs through adequately supported, adequately rewarded, skill-based learning for each co-occurring condition or issue.
7. Recovery plans, interventions, and outcomes must be individualized. Consequently there is no one correct dual-diagnosis program or intervention for everyone.
8. All policies, practices, programs, and clinicians must become welcoming, recoveryoriented or resilience-oriented, and co-occurring capable.

B. Implementation Characteristics:

1. Using the eight principles identified in section “A” above, implementation of the CCISC is based on the following four (4) core characteristics:
 - a. System Change Level: The CCISC system requires a cooperative merger between mental health and substance use systems, with the goal of achieving co-occurring capability standards as well as the capacity to provide co-occurring enhanced services when needed.
 - b. Efficient Use of Existing Resources: The CCISC will be implemented within the context of existing resources. The goal is to establish a system that eliminates duplication of services while improving consumers’ outcomes.
 - c. Incorporation of Best Practices: An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus-based best practices for the treatment of all types of Individuals with Co-Occurring Psychiatric and Substance Disorders (ICOPSD) throughout the service system.
 - d. Integrated Treatment Philosophy: The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes common language and that makes sense from the perspective of the mental health and substance disorder clinicians.

C. Clinical Practice Guidelines:

1. Welcoming and Accessibility:
 - a. As stated in HBH’s “[Welcoming Policy](#)” (SD.1.14), a welcoming philosophy is an expectation in all elements of system access and care. HBH staff will work to accurately identify, report, and track individuals experiencing co-occurring disorders and connect them to the appropriate services.
 - b. Individuals who experience co-occurring disorders are considered a high risk, high priority population, therefore, staff will engage the consumer in an empathic, hopeful, and welcoming atmosphere where the individual is encouraged to identify barriers to receiving integrated services.
2. Screening and Referral
 - a. Initial screening is conducted, (including mental, medical, and substance use treatment history and mental status screening, Level Of Care Utilization System (LOCUS) scoring, provisional diagnosis, disability determination, and other pertinent information). The information is entered into the Electronic Medical Record (EMR) system.

- b. For screening, the integrated screening is a formal process of testing to determine whether a person does or does not warrant further attention at the current time in regards to a mental health disorder and a substance use disorder, each in the context of the other.
- c. Consumers are not required to have any length of sobriety to access screening, assessment, or psychiatric services.
- d. A uniform screening procedure is used for the purposes of promoting access, determining benefit eligibility, establishing medical necessity and level of care criteria, preauthorizing, and authorizing the provision of substance use and mental health and ancillary services for persons experiencing Severe and Persistent Mental Illness (SPMI), Severe Emotional Disturbance (SED) and Intellectual/Developmental Disability (I/DD).
- e. The referral process for consumers in an inpatient unit seeking substance use services provides uncomplicated access to those substance abuse services deemed clinically appropriate as determined by clinical screening and/or assessment. In addition, screening & assessment staff attempt to coordinate placement to ensure that services will be available on the day of discharge from the inpatient unit.
- f. Initial screening and assessment may determine that an individual receive co-occurring services, however clinicians and/or clinical teams may provide a more comprehensive assessment that serves as the basis for making a decision about offering services to individuals within a single agency or to offer some of the services directly, with additional services delivered in close coordination with other community agencies. Also, a determination about co-occurring enhanced services may be offered to the individual.
- g. Information is obtained relative to the consumer's mental health needs during the consumer's initial screening. Responses will be recorded in EMR in the consumer's "Access Screening". This includes whether or not the consumer meets eligibility criteria for mental health services through the Prepaid Inpatient Health Plan (PIHP).
- h. If the consumer has a Medicaid Health Plan (MHP), the PIHP will forward a letter of Coordination of Care to the consumer's MHP in the following situations: a) all new eligibility assessments and b) all service denials resulting in a notice of adverse action.

3. Integrated Assessment Process

- a. Upon referral to HBH, consumers receive an initial assessment using the Clinical Assessment Form (in EMR). This assessment includes mental, medical, and substance use treatment history as well as mental status screening, provisional diagnosis, disability determination, and a narrative section indicating other pertinent information. Information from the initial assessment is entered into the EMR system (see also ["Intake Assessment Procedure" ISP.2.02](#)). The initial assessment is used to determine whether a person warrants further attention at the current time in regards to a mental health disorder and a substance disorder, each in the context of the other.
- b. The integrated assessment and diagnosis take into consideration both mental illness and substance use disorders and identifies the nature of the disorders. This process begins immediately after the consumer has been welcomed into care, an assessment of safety has been completed, and the consumer and/or family is capable of giving information. Assessment of needs, preferences, and stages of change is an ongoing process throughout the course of treatment.
- c. Both mental health disorders and substance use disorders are considered primary diagnoses.
- d. Staff will collect information, such as a chronological description of the mental health and substance use disorder, and will include cultural implications, onset of disorders, interactions, effects of treatment, and contributions to stability or relapse for either disorder, as well as including a medication history of past and present use. Whenever possible, information will be collected from family members or other individuals whom the consumer agrees to give informed consent to for release of information.
- e. The assessment should include stage-wise treatment and recovery related items for each disorder including engagement, motivation, action, and relapse prevention.
- f. At least every ninety (90) days during the periodic reviews, staff re-evaluates the diagnosis and treatment responses.

- g. Individuals are assessed for co-morbid conditions. Individuals with co-occurring disorder may be asked about trauma history, cognitive disorders, personality traits, personality disorders, and medical conditions. If necessary, additional evaluation may be needed in specific areas. The extent of impairment is to be assessed as well as the level of care.
- h. Clinicians use the four (4) quadrant framework to consider the levels of coordination needed. These decisions are based on the nature and functional severity of the individual's disorder and the primary location of their care. Moving from consultation (lower left section of the framework) through collaboration (mid-range) to integrated care (upper right section), it is understood that increasingly serious disorders require greater and more intensive levels of expertise, such as staff trained in specific treatment modalities.
- i. If, during the assessment or re-assessment, a recommendation is made for the use of co-occurring enhanced services, the assigned clinical team or clinician will provide the appropriate EBP.

4. Treatment Interventions

- a. Treatment will be individualized using a structured approach to determine the best treatment. The "four quadrant" model for categorizing individuals with co-occurring disorder will be used as a first step to organize treatment.
- b. Effective interventions during the course of treatment need to be stage specific respective to: Phases of Recovery, Stages of Change, and Stages of Treatment: The literature on co-occurring disorders has identified four (4) Phases of Recovery (Minkoff 1989):
 - Acute stabilization
 - Motivational enhancement/engagement
 - Prolonged stabilization (active treatment/relapse prevention)
 - Rehabilitation and recovery.
- c. There are five (5) Stages of Change (Prochaska & DiClemente, 1992):
 - Pre-contemplation
 - Contemplation
 - Preparation
 - Action
 - Maintenance
- d. There are four (4) Stages of Treatment for seriously mentally ill individuals with substance disorders (Osher & Kofoed, 1989):
 - Engagement
 - Persuasion
 - Active treatment
 - Relapse prevention.
- e. Each person receives services and supports through one integrated plan of service that addresses mental health and substance use disorders.
- f. Safety is a primary concern and is assessed initially during the screening process, again at intake assessment, during Person Centered Planning Pre-Plan, during the PCP, and the Crisis Plan, as well as throughout the treatment process. If a safety concern arises, the primary worker will assist the consumer to develop or update the safety plan.

5. Continuity and Coordination of Care

- a. Often consumers are part of other systems of care. Therefore coordination, integration, and collaborative interactions with other systems on the consumer's behalf are expected. This goal to this approach provides the consumer with coordinated and integrated care.
- b. The consumer handbook references the coordination of care with the MHP procedure to communicate that each Medicaid enrollee is to have an ongoing source for a primary behavioral healthcare provider

appropriate to his/her needs and that there is a person formally indentified as being primarily responsible for coordinating the consumer's healthcare services.

- c. When the consumer has given written permission to coordinate care, the primary worker will ensure continuity and coordination of care with the consumer's primary care provider.

6. Recovery and Relapse Prevention

- a. The treatment of co-occurring disorders must blend both substance use and mental health issues, with each applied at appropriate times and situations according to consumer's needs. The goal is to integrate individuals into community settings, encourage them to use their natural supports in their communities, and promote awareness and resilience.
- b. Individuals are provided with an integrated system of care in which psychiatric care, physical care, housing, education, and employment services are coordinated and explored as appropriate to the consumer's needs.
- c. The process of recovery focuses on valuing and building strengths. It takes into consideration self-direction, person-centered and individual-driven approaches which empower the individual to participate in all decisions that will affect their lives. HBH staff will seek to create an environment supportive to the recovery process by emphasizing a holistic approach, family involvement (where appropriate and desired by the individual), community integration, peer support, and sensitivity to diversity in service access and delivery processes. Service access and planning activities will operate from a strength/asset based perspective and individual choices will be emphasized. The recovery process also is associated with a holistic approach in which mind, body, and spiritual needs as well as community inclusion are explored.
- d. HBH will support the consumer in their desire to have meaningful employment and will assist the working age consumers who experience mental illness, intellectual/developmental disabilities, and serious emotional disturbances in pursuing competitive employment. This philosophy is also extended to individuals with co-occurring disorders. Furthermore, employment opportunities will be explored when an individual requests it, even when an individual is actively using substances.
- e. HBH embraces and actively utilizes Peer Support Specialists whenever possible including co-occurring situations. Peer support specialists provide insight and perspectives that help the consumer feel comfortable with the treatment process.
- f. The recovery process includes respect for individuals, including protecting their rights and eliminating discrimination and stigma. Individuals assume responsibility for their own self care and journey toward recovery. Recovery provides a sense of hope.
- g. HBH staff support individuals who experience mental illness in assuming active control of their recovery process and prevention of relapse. HBH staff will structure the service delivery to minimize dependency. HBH staff and contract providers will actively engage consumers in the recovery process. Consumers will direct the recovery process and provide input throughout the process.
- h. HBH staff will collaborate with the individual to identify a recovery management plan through the Person Centered Planning process. This will focus on interventions that will facilitate recovery and resources that will support the recovery process. The plan will define stages of recovery to provide structure to the process and provide indicators of progress for the individual. The plan will describe the individual's status in regard to recovery and the staff's specific role in the process. The plan will also include interventions in the event that the individual is unable to make decisions during a period of exacerbated symptoms.
- i. HBH staff is trained and knowledgeable regarding recovery models and best practices. Consumers and their family and natural supports, as appropriate, are educated regarding the stages of recovery, recovery management planning, and related concepts.
- j. HBH periodically reviews and revises their service delivery systems to reduce/eliminate practices that foster dependence, limit choice, contribute to stigma, and are otherwise contrary to principles of recovery. (See also "[Service Delivery Policy SD.1.03](#)")

- k. HBH participates in local community education activities that promote understanding of mental illness as a disability, emphasize recovery principles, and decrease stigma.

7. Interventions for Substance Use Disorder Treatment Non-Responders

- a. HBH makes every effort to re-engage consumers who are not responding to treatment (see "[Welcoming Policy](#)" SD.1.14).
- b. If after a review of progress, and several attempts with various intervention strategies, the individual does not respond to treatment, interventions will be used that are consistent with the IDDT model and co-occurring best practices. These interventions could include, but may not be limited to, co-occurring treatment group, case management, peer supports, etc. These interventions are more intensive and require a higher level of care.

8. Discharge

- a. Planning for discharge begins at the time of the initial assessment. The process involves careful planning to assist an individual to become more independent and self sufficient. This process has no established time line and is based on the individual's needs. Individuals are actively involved in discharge planning and this is conducted in a person centered approach. (See also "[Closing from HBH Services Policy](#)" CSM.2.07 and "[Appeal & Grievance Procedure](#)" RR.2.36).

Definitions/Acronyms:

Acronyms:

ACT – Assertive Community Treatment

CCISC – Comprehensive Continuous Integrated System of Care

COA – Council on Accreditation

COD – Co-Occurring Disorders

DSM – Diagnostic and Statistical Manual (of Mental Disorders)

EMR – Electronic Medical Record

EPB – Evidence Base Practice

FPE - Family Psycho-Education

HBH – Huron Behavioral Health

ICOPSD - Individuals with Co-Occurring Psychiatric and Substance Disorders

ICSM – Intensive Case Management

I/DD – Intellectual/Developmental Disability

IDDT - Integrated Dual Diagnosis Treatment

LOCUS – Level of Care Utilization System

MH – Mental Health

PCP – Person Centered Plan

SA – Substance Abuse

SED – Severe Emotional Disturbance.

SPMI – Severe and Persistent Mental Illness.

SUD – Substance Use Disorders

Definitions:

Comprehensive, Continuous, Integrated System of Care (CCISC): The CCISC model for organizing services for Individuals with Co-Occurring Psychiatric and Substance Disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity (Minkoff, 2000).

Co-occurring Disorders: Co-occurring disorders, also known as Dual Diagnosed disorders, are defined as one or more diagnosable mental illness, severe emotional disorder or intellectual/developmental disorder occurring for an individual who also experiences a diagnosable substance use disorder. Diagnosable illnesses are defined by the American Psychiatric Association Diagnostic and Statistical Manual current edition (DSM-IV).

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

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

Evidence-Based Practice (EBP): Reduced to the most core understanding, EBP is defined as the coming together of these elements: the knowledge and skills of the practitioner; the desires and values of the consumer; and the best research evidence that links a particular intervention with a desired outcome (Turning Knowledge Into Practice, 2003). A general definition of EBP found in the Michigan Mental Health Commission, Part I: Final Report, October 15, 2006, page 54, defines EBP as, "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, S.E. Strauss, WS Richardson, 2004).

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

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

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

Integrated Dual Disorder Treatment (IDDT): It is a model of EBP used to help in the treatment of individuals with co-occurring disorders. It also refers to the "no wrong door approach" to services. That is, services must be available, accessible, and provided in an integrated manner no matter how or where an individual enters the system.

Mental Health Recovery: "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

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

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

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

Forms:

Clinical Assessment Form (in EMR)

Records:

Records of service delivery on documented in the appropriate format and on the appropriate form as defined in the respective policy/procedure for the activity defined and retained in accordance with the "HBH Record Retention & Storage Policy" ([QI.1.23](#)).

Reference(s) and/or Legal Authority

COA standards

[CSM.2.07 Closing From HBH Services Procedure](#)

[ISP.2.02 Intake Assessment Procedure](#)

[QI.1.05 Person Centered Planning \(PCP\) Policy](#)

[QI.1.23 HBH Record retention & Storage Policy](#)

[RR.2.36 Grievance and Appeals Procedure](#)

[SD.1.03 Service Delivery Policy](#)

[SD.1.14 Welcoming Policy](#)

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Change History:

Change Letter	Date of Change(s)	Changes
None		New policy to comply with regional policy which was adopted 08/21/08 and required to comply with MDCH Site Review October 20- November 7 20/08.
A	05/29/13	Reviewed and revised to comply with 8 th edition COA standards – removed AAM references, added “IDDT” to “Purpose” section, added “100-006” to “Forms” section, removed “Gallery” from “Records” section, in first bullet in “Information” section added “integrated”, in C.1 added “where the individual is encouraged to identify....”, in C.2.a, C.2.d, & C.2.g, in 3.a removed “or Substance Abuse Intake Form (20-005)”, and added reference to ISP.2.02, removed “AAM”, removed 3.j which referred to the Substance Abuse Recipient Rights handbook, in 5.c removed reference to SD.2.04 (wrong procedure referenced),
B	10/21/14	Removed references to “AAM” throughout document (4 places), changed “CMHC” to “EMR” throughout document (3 places), in “Acronym” section added “FPE”, “EMR”, “/DD”, & “ACT, removed reference to “100-006”
C	08/16/16	Changed “developmental disabilities” to “Intellectual/developmental disabilities” (3 places), changed “MDCH” to “MDHHS” (2 places), in “Information” section 3 rd bullet added “Motivational Interviewing” and removed sentences relative to utilizing a treatment based on science rather than random choice, in C.2.a removed “or Calocus”, in C.2.b added “use” between “substance” & “disorder”, in 3.i removed “initiate an assessment utilizing tools compatible to EBP criteria” and replaced with “provide the appropriate EBP”, in 7.b changed “relapse prevention group” to “co-occurring treatment group”, in “Acronym” section added “DSM”, in “References” section added “RR.2.36”, made several other wording changes throughout document without changing sentence content, corrected hyperlinks.
D	05/23/18	In “Information” section 3 rd bullet added “Intensive Case Management (ICSM)”, in “Policy” section “Principles” # 2 through 8 completely to coincide with Minkoff’s website definitions, in “Acronym” section added “ICSM” and “LOCUS”, made several additional minor wording/grammatical changes/corrections throughout document without changing sentence content.