Community Mental Health Partnership
of southeastern michigan

September 1, 2004

Dear Colleague,

We are pleased to introduce the enclosed Co-Occurring Initiative Consensus Document, prepared by the Co-Occurring Initiative Work Group. The document reflects their willingness to work together and formalize a commitment to creating a better system for the treatment of people with Co-occurring psychiatric and substance disorders.

The Work Group, initiated in January, 2003 was formed by inviting identified individuals with personal history, family members, persons with expertise from the community, and the provider network. It also includes representatives from Community Mental Health Partnership of Southeastern Michigan. And it should be noted, that by working at the four-county regional level, we overlap with three Substance Abuse Coordinating Agencies: Mid-South Substance Abuse Commission, Southeast Michigan Community Alliance and the Livingston-Washtenaw Coordinating Agency.

The Work Group is using Kenneth Minkoff's Best Practice Model and systems approach to services (www.athealth.com/practioner/particles/fr_substanceabuse.html). Recognizing that every community is different, the Consensus Document and the eight principles were written in a way that would allow us to engage in dialogue. In this year's plan, the Work Group is addressing five goal areas: 1) Building Relationships with people and providers, 2) Developing consistency at the front door or point of access to services, 3) Evaluation of training needed by community providers, 4) Development of a Training Plan, and 5) Identifying best prescribing protocols for clinicians.

By sending you this document, we are inviting you to become part of the Initiative. If you would like to sign on to the Consensus Document, we hereby ask you to contact us and register your support. This is not a contract but a statement of collaboration. We are committed to a vision to better serve persons with co-occurring disorders. If you have questions or would like to participate in some other way, please contact either of us and we will help to get you connected!

Sincerely,

Susan Cares, RN, MPH
Manager of Integrated Initiatives
caress@ewashtenaw.org
734 544-3082

Shauna Reitmeier, MSW
Regional Affiliation Coordinator
reitmeiers@ewashtenaw.org
734 544-3058


# Co-Occurring Initiative Consensus Document

## Purpose:

The purpose of this document is to provide the philosophy and principles that have been established by the four-county regional co-occurring initiative. It will serve as the foundation for planning and implementation of system changes and enhancements across the four-county region. It is the intent for those who share in this purpose and philosophy to sign and commit to this initiative.

## Statement of Commitment:

It is our commitment that consumers are best served using care models of demonstrated quality in the areas of clinical outcomes, consumer/family satisfaction, resource efficiency and program processes. The consumer's access to services and the timeliness from the initial screening to the clinical assessment and service start-up are crucial. We are committed to developing opportunities for the mutual strengthening and enhancing of services within the four-county region.

In order to improve outcomes and effectively utilize resources, programs that commit to this initiative recognize that there will need to be changes in the way in which individuals with co-occurring disorders are identified and provided with treatment and support services.

Each of the involved Community Mental Health and Substance Abuse Treatment programs, providers and individuals commit to make the necessary changes to meet the purpose and philosophy of this initiative.

## Philosophy:

Consumers with co-occurring disorders are currently being treated in both the mental health and substance abuse treatment systems. Individuals with co-occurring disorders traditionally experience a limited scope of treatment. This is based on where they enter this independently funded system of mental health or substance abuse. Because of this, it can greatly affect the efficacy of their treatment and recovery process.
It is our belief that by being open, welcoming and initially assessing for co-occurring disorders and evaluating the necessity for co-occurring treatment, we can minimize the need for repeated treatment episodes and effectively utilize our resources. This can also facilitate the reduction of personal, family and community difficulties that arise from treatment that fails to identify and treat co-occurring disorders.

Treatment for co-occurring disorders is best viewed in the context of a collective recovery system. That includes supports from family, friends, providers and community members that focus on a

"we" rather than "I" perspective. The following best practice principles are the guideposts for implementing and continually assessing needs of this collective recovery model. As new evidence and best practices arises around co-occurring disorders, it will be incorporated into these set of guideposts.

1. Co-occurring disorders is an **expectation**, not an **exception**. This has to be included in system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.

2. The core of treatment success is the availability of **empathic**, **hopeful treatment relationships** that provide **integrated treatment** of both substance abuse and mental health and **coordination of care** during each episode of care, and, for the most complex patients, provide **continuity of care across multiple treatment episodes.**

3. Assignment of responsibility 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. It is recognized that there are those persons seeking treatment that will need only Substance Abuse or only Mental Health treatment.

4. Within the context of any treatment relationship, a system of care must be based on the client's strengths, goals and impairment or disability; balanced with **empathic detachment , confrontation,** the making of agreements with the therapist and consumer through **contracting,** and opportunity for **contingent learning**. A comprehensive system of care will have a **range of programs** that provide this balance in different ways.

5. When people with developmental disabilities, physical health issues, mental illnesses and substance abuse have co-existing disorders, **each disorder should be considered primary**, and dual primary treatment is required through collaboration with internal and external providers.

6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a **disease and recovery model**. Each disorder has **parallel phases of recovery** (acute stabilization, engagement, and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and **stages of change**. Treatment must be matched not only to diagnosis, but also to phase of recovery and stage of change. Appropriately matched interventions may occur at almost any level of care.

7. Consequently, there is **no one correct dual diagnosis program** or intervention.

8. Desired outcomes must also be **individualized**, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.[1]

[1] Minkoff, K. Model for the desired array of services and clinical competencies for a comprehensive, continuous, integrated system of care. Center for Mental Health Services Research, University of Mass. Dept. of Psychiatry. Worcester, MA, 1999.

**By signing your name to this document, you are willing to ascribe and stand behind the Purpose, Commitment and Philosophy of the Community Mental Health Partnership of Southeastern Michigan in its initiative with Co-Occurring Disorders. It is encouraged that you share this document will all of your staff members.**

NAME: _____

ORGANIZATION: Livingston CMH

POSITION: Executive Director

DATE: 4/5/04

NAME: _____

ORGANIZATION: LENAWEE CMHA

POSITION: EXECUTIVE DIRECTOR

DATE: 4/5/04

NAME: Kathleen M. Reynolds

ORGANIZATION: WCHO

POSITION: Executive Director

DATE: 4/5/04

NAME: _____

ORGANIZATION: Monroe CMHA

POSITION: CEO

DATE: 4/5/04