CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS INITIATIVE (Winnipeg Region)

CONSENSUS DOCUMENT

October, 2002

Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

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Overview

Individuals with co-occurring mental health and substance use are recognized as a population with unacceptable outcomes and higher costs in multiple clinical domains. They are often poorly served in both mental health and substance abuse settings, with resulting over-utilization of resources in criminal justice, primary health care, child protection, and women's and homeless shelter systems. In addition to having unacceptable outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all mental health and addiction service settings that they can be considered an expectation, rather than an exception.

In order to provide more welcoming, accessible, integrated, continuous, and comprehensive services to these individuals, the Winnipeg Regional Health Authority, the Addictions Foundation of Manitoba, and Manitoba Health, have adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model and will adapt it for designing systems change at the local level. This Consensus Document contains a description of the principles and characteristics of CCISC as well as an implementation action plan for participating programs.

Endorsement of this Consensus Document by the three principal partner organizations of the Co-occurring Disorders Initiative, or by other stakeholder organizations within the mental health and addiction service systems, will:

- ✓ Signify their support and participation as a partner in this initiative; and,
- ✓ Commit their organizations to adopt the CCISC model and to participate in a change process, consistent with the principles and philosophies set out here.

Best Practice Principles

This model is based on the following eight clinical consensus best practice principles (adapted from Minkoff, 1998, 2000) which espouse an integrated clinical service philosophy. These principles make sense from the perspective of both the mental health and the substance abuse service systems:

1. Co-occurring disorders are an expectation, not an exception. This expectation must be a consideration in every aspect of system planning, program design, clinical procedure, and clinician competency, and incorporated in a welcoming manner into every clinical contact.
2. The core of success in any setting is the availability of empathic, hopeful clinical relationships that provide integrated and coordinated service during each episode of care, and across multiple episodes.
3. The population of individuals with co-occurring disorders can be organized into four subgroups for service planning purposes, based on high and low severity of each type of disorder.
4. Within the context of any clinical or helping relationship, supportive case management needs to be balanced with empathic detachment at each point in time, based on each individual's specific needs, goals and strengths.

5. When mental health and substance use disorders co-exist, a comprehensive, continuous, integrated approach, which supports the provision of concurrent responses to both as primary disorders, is recommended.
6. Mental health and substance use disorders both tend to be persistent, biopsychosocial problems that can be addressed using a CCISC model. Each disorder has parallel phases of recovery and stages of change. Helping services for individuals with co-occurring disorders need to be matched across all levels of care.
7. There is no one correct program or intervention. Service responses or interventions must be individualized for clients/patients according to: assessment/diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care requirements. Programs must also be sensitive to age, culture and gender specific needs of its clients/patients. In a CCISC environment, all programs are co-occurring disorder programs that meet at least minimum criteria of "dual diagnosis capability", but each program has a different "job," that is matched to a specific cohort of patients/clients.
8. Similarly, outcomes for patients/clients need to be individualized. Outcome variables need to include not only abstinence, but also reduction in harm, movement through stages of change, changes in type, frequency, and magnitude of substance use or psychiatric symptoms, and improvements in specific problem management skills and program adherence.

Implementation Characteristics

Using these principles, implementation of the CCISC will be based on the following four core characteristics:

1. The CCISC requires participation from all components of the mental health and addiction service systems, with expectation of achieving, at minimum, Dual Diagnosis Capability standards[1] (and in some instances Dual Diagnosis Enhanced capacity[2]), and planning services to respond to the needs of appropriately matched clients/patients.
2. The CCISC will be implemented initially with no new funding, within the context of existing operational resources, by maximizing the capacity to provide integrated services proactively.
3. The CCISC incorporates utilization of the full range of evidence-based best practices and clinical consensus best practices for individuals with mental health and substance use disorders, and promotes integration of appropriately matched best practices for individuals with co-occurring disorders.
4. Using the eight principles listed above, the CCISC incorporates an integrated services philosophy, develops common clinical language, and develops specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the service system.

[1] Capacity for providing services to individuals with co-occurring disorders within the usual service mix of the program through modification of program infrastructure within the context of the existing program design

[2] More extensive modification to provide services to individuals with more severe conditions (e.g., modified addictions program), or to provide services that are more specialized or integrated (e.g., intensive addiction rehabilitation within a psychiatric inpatient program)

Implementation Action Plan

In the first year of implementation, all participating programs will agree to the following action steps:

1. Adopt the Consensus Document as a commitment to improving services for people with co-occurring mental health and substance use disorders.
2. Circulate the document to all staff, and provide training to relevant staff regarding the principles and the CCISC model.
3. Assign appropriately empowered staff to participate in integrated system planning and program development activities.
4. Adopt the goal of achieving Dual Diagnosis Capability as part of the agency's short and long range strategic planning and quality improvement processes.
5. Participate in an agency self-survey using the COMPASS at regular intervals to evaluate the status of Dual Diagnosis Capability.
6. Develop an agency specific action plan outlining measurable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward Dual Diagnosis Capability. Monitor the progress of the action plan at regular intervals. Participate in system-wide training and technical assistance with regard to implementation of the action plan.
7. Participate in system-wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating agency specific improvements in screening and data capture in the action planning process.
8. Participate in system-wide efforts to improve welcoming and reduce barriers to access for individuals with co-occurring disorders by:
    a) Adopting agency specific welcoming policies, materials, and expected staff competencies; and,
    b) Identifying specific plans to expand access and capability to provide integrated continuous services.
9. Assign staff to participate in system-wide efforts to develop Dual Diagnosis Capability standards, and systemic policies and procedures to support welcoming access in both emergency and routine situations.
10. Assign appropriate clinical leadership to participate in interagency coordination meetings as they are developed and organized.
11. Participate in system-wide efforts to identify required attitudes, values, knowledge, and skills for all clinicians regarding co-occurring disorders, and adopt the goal of Dual Diagnosis Competency for all clinicians as part of the agency's long range plan.
12. Participate in clinician competency self survey using the CODECAT at six-month intervals, and use the findings to develop an agency specific training plan.
13. Identify appropriate clinical and administrative staff to participate as trainers in the system-wide train-the-trainer initiative, and to assume responsibility for implementation of the agency's training plan.

The forgoing Consensus Document is endorsed by the three partner agencies of the Co-occurring Mental Health and Substance Use Disorders Initiative.

Sharon Macdonald
Vice President, Community Care,
Winnipeg Regional Health Authority

John Borody
Chief Executive Officer,
Addictions Foundation of Manitoba

Bev Ann Murray
Executive Director, Strategic Initiatives
Manitoba Health

Marcia Thomson
Assistant Deputy Minister,
Manitoba Health

DATE: **October 30, 2002**

Original Signed

Participating Programs Included by Virtue of the Sponsor Organization Representative Signatures:

Winnipeg Regional Health Authority

Hospital-Based Mental Health Programs
(Inpatient and Outpatient units included in each)

- **Health Sciences Centre, Mental Health Program**
- **St. Boniface General Hospital, Mental Health Program**
- **Seven Oaks General Hospital, Mental Health Program**
- **Grace General Hospital, Mental Health Program**
- **Victoria General Hospital, Mental Health Program**

Community-Based Mental Health Programs

- **Geographic-based Community Mental Health Services (CMHW)**
- **Intensive Case Management (ICM)**
- **Program for Assertive Community Treatment (PACT)**
- **Community Forensic Program and Cross-cultural Mental Health Specialist**

Addictions Foundation of Manitoba, Winnipeg Region

Adult Rehabilitation Services
- **Residential**
- **Community**
- **Methadone**

Youth Services
- **Community-Based**
- **Residential**

Family Services

Gambling Services

Impaired Drivers Program

The forgoing Consensus Document has been endorsed by the following additional stakeholder agencies of the Co-occurring Mental Health and Substance Use Disorders Initiative.

Agency / Program	*Representative*	*Signature*	*Date*
Manitoba Adolescent Treatment Centre	Marg Synyshyn, Program Director		December 4, 2002
Behavioural Health Foundation of Manitoba	Lorne Weir, Executive Director		December 4, 2002
Canadian Mental Health Association, Winnipeg Region	Nancy Testar, Executive Director		December 4, 2002
Manitoba Schizophrenia Society	Chris Summerville, Executive Director		December 4, 2002
Main Street Project	Joan Dawkins, Executive Director		December 4, 2002
The Laurel Centre Inc.	Suhad Bisharat, Executive Director		December 4, 2002
Klinic Community Health Centre	Karen Ingebrigtsen, Executive Director		December 4, 2002
The Salvation Army Anchorage	Major David Oldford, Executive Director		December 18, 2002
Sara Riel Inc. Community Rehabilitation Program, Crisis Stabilization Unit	Rosemary Hrydowy, Executive Director		June 3, 2003
Anxiety Disorders Association of Manitoba	Herb Thompson, Executive Director		September 25, 2003
Serenity House	Isabelle Fiola Program Coordinator		October 7, 2003
Mood Disorders Association of Manitoba	Bev Trachuk Executive Director		September 9, 2004

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