City of Portsmouth, Virginia
Behavioral Healthcare Services
Charter for Systems Change to Services for Individuals With Co-Occurring Disorders

BHS Charter Overview:

The staff of Behavioral Healthcare Services (BHS) has recognized that individuals with co-occurring disorders, mental health/substance abuse/mental health/intellectual disabilities have lower outcomes due to the multiple clinical domains of improper treatment and continual hospitalizations, which results in the financial cost to the agency being higher. Traditional services do not meet the needs of individuals with co-occurring disorders and there is an over utilization of resources. It is apparent that there are a very large number of our consumers that fall into this category. Recent research has proven that with the proper assessment and services to meet their specific needs, these individuals will be on the road to recovery, healing, empowerment and self-determination.

BHS will come together and while utilizing the principals of Recovery, we will design and implement a process that will improve the outcomes of our co-occurring population.

The Management staff along with staff, the Advisory Board of Directors, Recovery Champions, Recovery Advisory Board and concerned citizens will address the challenges, barriers to developing the Recovery Process. BHS management is committed to developing the clinical and administrative initiatives to meet the challenges of this new, innovative path of hope.

The Comprehensive, Continuous, Integrated System of Care Model (CCISC) (Dr. Kenneth Minkoff 1998)

In order to provide more welcoming, recovery-based, accessible, integrated, continuous and comprehensive services to these individuals, Behavioral Healthcare Services will work toward the integration of services to improve outcomes within the context of existing resources. There is a CCISC Model, which is based on the eight clinical consensus best practice principles, which espouse an integrated clinical treatment philosophy that makes sense from the perspective of a mental health, substance abuse, and mental retardation treatment system. It is as follows:

1. Dual Diagnosis is an expectation, not an exception. This expectation has to be included in every aspect of systems planning, program design, clinical procedures, and clinician competency, and incorporated in a welcoming and recovery-based manner into every clinical contact.

2. The core of treatment success in any setting is the availability of empathic, hopeful treatment relationships that provide integrated treatment 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 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 or mental retardation.

4. Within the context of any treatment relationship, case management and care (based on the client's goals, strengths, and level of impairment) must be balanced with empathic detachment/confrontation (based on strengths and availability of contingencies) at each point in time. A comprehensive system of care will have a range of programs that provide this balance in different ways.

5. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and integrated co-occurring primary treatment is required.

6. Mental illness and substance dependence are both examples of primary, chronic, biological disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery) 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 co-occurring disorder program or intervention. For each person, the proper treatment must be individualized according to quadrant, diagnosis, disability, strengths/supports, goals problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are co-occurring disorder programs that at least meet minimum criteria of co-occurring disorder capability, but each program has a different "job" that is matched to a specific cohort of patients, using the above model.

8. Similarly, outcomes must be also individualized and based on the person's goals for recovery. The outcomes/goals may include reduction in harm, gaining or maintaining housing and/or employment, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills, or reduction in service utilization.

BHS Commitment:

Using these principles and other recovery models and resources, all BHS staff has to be totally committed to the Recovery Process in order to increase outcomes.

1. The Recovery Process requires participation from all components of BHS with expectation of the needs of appropriately matched cohort of co-occurring disorder consumers and appropriately assessing and meeting the appropriate needs of the consumers.

2. The CCISC state project has ended but the state and BHS is committed to the education and building the KSA's of therapists and case managers regarding co-occurring and working with a diverse population.

3. BHS will incorporate utilization of the full range of evidence based on best practices and clinical consensus best practices for individuals with psychiatric and substance disorders, and promote integration of appropriately matched best practice treatments for individuals with co-occurring disorders.

4. BHS will incorporate an integrated treatment philosophy and common languages using the eight principles listed above, and develop specific strategies to implement clinical programs, intense family and group therapy, case management in accordance with the Recovery Model.

Scope of Charter:

Includes person with multiple, complex needs, i.e., persons with MH/MR, MH/SA, as well as individuals with underlying medical conditions.

Action Plan:

Phase One (Planning)

1. Adopt this charter as an official policy statement of the agency with approval of the Advisory Board of Directors. Circulate the approved charter and document to all staff, consumers, families and stakeholders and provide training to all staff regarding the principles of The Recovery Process and is on the city's website.

2. Administrators and Supervisors will go through a strategic planning process and collect the responses to identify agency needs. Planning stages to specifically address the infrastructure—Central Intake, Reimbursement, Management Information Systems (MIS) and clinical systems change.

3. Assign staff, consumers, families and Board Members to participate in Behavioral Healthcare Services implementation team for integrated system planning and program development activities through focus groups and developing a co-occurring committee of empowered staff.

4. Adopt the goal of achieving co-occurring disorder capability as part of the agency's short and long-term strategic planning and quality improvement processes.

5. The priorities for implementation of the model are:

    a. Inform Stakeholders of our direction and welcome feedback,
    b. Improved identification of co-occurring disorders,
    c. Improved welcoming, recovery-based access for individuals, Family members, and other agencies,
    d. Remove unnecessary barriers to appropriate billing, (Reimbursement and (MIS),
    e. Realign standards, processes, policies and procedures that would support the model,
    f. Improve coordination of care with best practices,
    g. Improve relationships of clinical and case management staff across disabilities for a common goal of improved outcomes,
    h. Develop a system to measure specific outcomes.
    i. Send out newsletters to stakeholders of our challenges and successes.
    j. Continue to work with the city of Portsmouth for a new building for services.
    k. Train case managers through a certified case management module provided by the state.

Phase Two: BHS Staff Participates In Team Efforts:

6. To identify required recovery based attitudes, values, knowledge, and skills for all clinicians regarding co-occurring disorders and adopt the goal of dual diagnosis competency for all staff as part of the agency's long-range plan.

7. To improve identification and treatment planning of individuals, with co-occurring disorders by incorporating agency specific improvements in screening, assessment, case management efforts, person centered planning and motivational interviewing.

8. To improve customer relations with individuals with co-occurring disorders by adopting welcoming, at entry, recovery-based policies, processes, materials and increased staff competencies in the identified clinical areas.

9. Improve Recovery based access for collaborative community agency referrals of individuals with co-occurring disorders utilizing a single point of entry, this establishes clear policies for fee payment that accommodates individuals with either or both types of disorders at all levels of ability to pay (including court referrals).

10. Participate in system-wide efforts to remove unnecessary barriers to appropriate billing and appropriate MIS data collection.

11. Assess progress and continual improvement through Executive and Management teams and all staff meeting.

12. Work in a Culturally Competent agency.

16. Work on Recovery based services and solicit input from peers.

PHASE III:

- **We have accomplished goals from phase one and two.**
- **We have the recovery champions and recovery advisory board.**
- **We update our cultural diversity plan yearly**
- **Most are trained in person centered, motivational interviewing and CAMS**
- **We have administered COMPASS three times and used information for our improvement plan.**
- **Established a Family and Friends group, SARRA, NAMI and a HIV/AIDS Support group.**
- **We have best practice through the use of ASAM and the levels of care and through the use of best and evidenced based curriculum in our groups.**
- **We have Recovery based groups and programs**.

Future Goals will continue to be based on Surveys, Outcomes, Feedback, Strategic Planning and Virginia Department of Behavioral Health and Developmental Services Guidelines.