# Region VI

## Memorandum of Agreement

## between

## Office for Addictive Disorders and Office of Mental Health

## implementing

## LOUISIANA INTEGRATED TREATMENT SERVICES (LITS)

LITS is based on the Comprehensive, Continuous, Integrated System of Care Model that outlines research-driven and consensus-driven principles (Ken Minkoff and Christi Cline). OMH and OAD agree to cooperate with each other and provide services with these principles in mind.

> *1. Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of co morbidity, along with clinical outcome data associating ICOPSD (individuals with co-occurring psychiatric and substance disorders) with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinical competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

The Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD) will always include a screen for substance abuse and mental health. For those clients accepted for treatment, OMH and OAD will evaluate each client for the presence of both substance abuse and mental illness.

> *2. All ICOPSD are not the same; the national consensus four-quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH-high CD (Quadrant III), high MH-low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

OMH and OAD agree to work with those individuals within their own caseloads according to the four-quadrant model. OMH will concentrate on Quadrant II and OAD will concentrate on Quadrant III. Quadrant I is outside the target population of OMH. Those individuals within Quadrant IV will be a joint effort of OMH and OAD working in collaborative fashion making decisions with the client as to the most advantageous treatment approach.

*3. Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize (a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice and (b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

OMH and OAD agree to integrate into the general operation of service delivery the expectation that clinicians will address both psychiatric disorders and substance disorders in keeping with the respective program focus; thus, providing integrated treatment. OMH and OAD agree to provide a welcoming attitude and environment and agree that all clients with co-occurring disorders, who otherwise meet admission criteria, will be accepted for treatment.

Note: #'s 4, 6, and 8 each address treatment philosophy, planning and expected outcomes, and treatment approaches; therefore, they will be combined for the purposes of this agreement.

*4. Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency-based learning strategies involving a variety of community-based reinforcers to make incremental progress within the context of continuing treatment.

*6. Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001).

*8. Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long-term goals, but short-term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

OMH and OAD administration agree to incorporate all nine principles in policy and procedure. OMH and OAD will take advantage of the training opportunities offered through the departments and will seek additional methods for continuing education and collaboration in order that clinicians may obtain and maintain competency in treating clients with co-occurring disorders.

> 5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting.

OMH and OAD will document both diagnoses when present and will consider both primary. OMH and OAD will provide services in an integrated manner in keeping with the respective program focus as described in Principle #2.

> 7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnoses services, thereby mobilizing treatment resources throughout the entire system.

OMH and OAD agree to individualize treatment. OMH and OAD will develop procedures for ensuring that clients are served at the agency where they would best be served (based on Quadrant model) and will develop procedures that support the client through that process.

> 9. *The system of care operates in partnership with consumers, family members and concerned significant others and a continuous effort is made to involve the individual and family at the system, program and individual levels.* Change is most likely to occur and be sustained if all major stakeholders in the treatment system are engaged in the process of change. All stakeholders (consumers, families, clinicians, supervisors, program leaders, and policy makers) should be involved in planning, implementing, and sustaining an integrated service system for people with co-occurring disorders.

OMH and OAD agree to support the development of and participation in Dual Recovery Anonymous programs. OMH and OAD agree to support the development of and participation in self-help programs for family members. OMH and OAD agree to consider the family as

significant support and link in the treatment process, involving family members in education and treatment aspects to the degree appropriate for each individual client.

This memorandum of agreement is enacted by Region VI Office for Addictive Disorders and Office of Mental Health with full regards to the compliance with all requirements of DHH/OAD/OMH/HIPPA regulations and guidelines relative to and governing client confidentiality, rights and freedom of choice.

| ______________________________ | ______________________________ |
|---|---|
| John McDaniel, LCSW | David Durbin, LCSW |
| Region VI Office of Mental Health | Region VI Office for Addictive Disorders |