

Best Practices

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Implementing an Integrated System of Care Model in the State of Maine

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The State of Maine has had a long-standing concern for the needs of people with co-occurring disorders. Over 20 years ago, a Maine Reimbursement Task Force was formed for the purpose of addressing the needs of individuals with co-occurring disorders more effectively. This task force brought together a group of leaders representing providers, consumers, policy makers, and funders to think through changes in policy and treatment approaches. National experts were brought in to advise and provide education. Grants then were given to collaborative networks across the state to develop common language and integrated assessment tools for mental health and substance abuse. The state continued this initiative through funds from the Robert Wood Johnson Foundation to expand one of the networks and create the first Assertive Community Treatment (ACT) team in Maine, a co-occurring ACT team complete with vocational specialist and consumer team members. The Cumberland County Dual Diagnosis Collaborative was the successful recipient to head up this work. This collaborative evolved to become the Co-Occurring Collaborative Serving Maine (CCSME) and has worked steadily for 15 years to provide and engage the community in training and networking on co-occurring issues. *Psychiatric Services* credits CCSME with improving the local delivery of services and bringing change to the way that agencies work together (Ridgely, Lambert, Goodman, Chichester, & Ralph, 1998).

Despite many years of progress by CCSME in creating a local service network and providing training to improve practice, most of the work occurred

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through working around the existing public sector delivery system in Maine, and large-scale system changes did not happen. In the last 7 years, this situation has begun to change; however, these large-scale system changes have been met with skepticism from some of those who have been involved in the human services system in Maine for many years: "We've been talking about this issue for 20 years . . . what's going to be different now?" Large-scale system change in Maine at this point has made significant progress. It takes time and concerted effort and often is reflective of the political leadership, both elected and appointed, as much as the merits of the change itself. This article is written to tell the story of how the process has unfolded in the last 7 years.

In 2002, under the direction of Kimberly Johnson in the Maine Office of Substance Abuse, Maine formally began a large-scale statewide system initiative through a Substance Abuse Mental Health Service Administration (SAMHSA) Center for Mental Health Services Community Action Grant. With the support of a new Commissioner of Human Services, Ms. Johnson rallied key providers through a contract with CCSME to begin meeting monthly on a plan to address co-occurring disorders statewide. She invited Dr. Kenneth Minkoff to advise the state leadership on his Continuous, Comprehensive, Integrated System of Care model (CCISC) and to educate providers on systems change (Minkoff & Cline, 2004, 2005, 2006). The work of articulating what systems integration would look like began. Dr. Minkoff did presentations in different regions of the state and at a statewide meeting of agency and state leaders. The result was a Memorandum of Understanding (MOU) between the Department of Health and Human Services and more than 60 providers who agreed that they would begin the process of implementing co-occurring disorder services and policies in their agencies. Catherine S. Chichester, the Executive Director of the CCSME, applied for various grants, and, with funding from the Maine Health Access Foundation (MeHAF), established Centers of Excellence: agency forerunners that became the models of agency change and that were supported in their efforts to inform the other members of the system of the changes necessary to move toward integration. Dr. Minkoff and his partner, Dr. Christie A. Cline, continued to advise state leadership on the implementation of system-wide integrated services and provide training, consultation, and technical assistance to the Centers of Excellence in the MeHAF project. The project was very successful at the level of the pilot providers. The evaluation report indicated that with limited resources, the pilot agencies had made progress in improving welcoming, access, and the availability of integrated screening, assessment, and interventions in their agencies (Chichester, Hornby, Farr, Delaney, & Ferguson, 2006).

By the mid 2000s, there were very few providers in Maine who had not been exposed to the CCISC model or to the basic constructs of co-occurring disorder best practice. The pilot Centers of Excellence in the MeHAF project, although creating change in their agencies, had not influenced change at the

state level or created wide-scale change in the agencies that had signed the MOU. In a state where the Office of Mental Health and the Office of Substance Abuse led separate lives on separate tracks, services remained in fixed silos and providers, with few exceptions, continued to provide one service or the other, but rarely both in any integrated way. A lesson learned: *training alone does not change a system*. Systems are supported by their infrastructure, which can be both slow and difficult to change. A base of resources of pilot agencies, champions, and consensus documents, however, can be used to build the foundation for development of welcoming, recovery-oriented, and co-occurring disorder-capable services.

In 2004, Maine applied for and was invited to a SAMHSA Policy Academy on Co-occurring Disorders. Ms. Johnson attended, along with key agency leaders, representatives of the CCSME, and the person who eventually would become the new Commissioner of the Maine Department of Health and Human Services, Brenda Harvey. At this meeting, Maine developed a state action plan and, more importantly, gained the support of the commissioner to declare that "co-occurring disorders are an expectation, not an exception." This proclamation was a critical communication throughout the Department of Health and Human Services as CCSME and the other stakeholders continued their work. A second lesson learned: *leadership and communication from the top are necessary for change to occur*.

In 2005, SAMHSA awarded Maine a Co-occurring State Infrastructure Grant, one of 19 that have been awarded around the country to date. Under the leadership of the Governor's Office, the Office of Substance Abuse, and the Office of Mental Health, this grant stimulated more focused and intensive work across Maine on system-wide infrastructure development of integrated treatment. CCSME was given responsibility for grant management, as well as training and technical assistance. Claudia Bepko was brought on board to head up the initiative as project coordinator. The consulting firm of Hornby Zeller Associates was charged with evaluating all aspects of both the grant work and treatment outcomes. In November of 2005, the State of Maine set out to continue "changing the world" for its individuals and families with complex conditions.

INFRASTRUCTURE AND POLICY: THE REAL WORK OF CHANGE

SAMHSA Co-occurring State Infrastructure Grants were designed to help states change the structural elements within state policy: regulation and functioning that inhibit the provision of co-occurring disorder services. This is a tall order, since the barriers to co-occurring disorder care are embedded in the historical weight of medical, political, and professional divisions. They also are supported by the structure of federal funding systems and the other silos that fragment behavioral health treatment in our country. Maine's goals

for the grant work were to implement practice changes that included requirements for integrated screening assessment and treatment. At another, more ambitious level, however, the work of the grant was to change the whole state system so that all aspects of the system would be designed based on the expectation that complex conditions are the expectation—and there was much to be changed.

Maine in 2005 could not reliably count the number of people coming for help who had co-occurring conditions. We knew little, other than anecdotally, about prevalence in our state. In keeping with the separate lives led by the Offices of Mental Health and Substance Abuse, each office had its own data collection system, neither collected data on the services provided by the other, and the two data systems could not “talk” to each other. Furthermore, neither system routinely had mechanisms for identifying individuals with co-occurring issues within its own services. The Office of Substance Abuse had begun only recently to track people with substance use conditions who also had a mental health condition. In the Office of Mental Health, the only way to track this kind of data was to comb through MaineCare billing data in order to see whose names showed up under both diagnoses. Needless to say, there had not been much interest in undertaking this time-consuming and likely unrevealing project. Most people in substance abuse treatment in our state are not MaineCare (Medicaid) recipients; the data therefore would have been relatively limited. Finally, there was no capacity to recognize “co-occurring families” in the children’s mental health system, where children with emotional disturbances have caregivers with substance use issues.

Effective data collection was not the only barrier to change. Unlike some states, Maine *does* provide coverage for substance abuse treatment under its Medicaid funds, although the majority are covered by Federal Substance Abuse Block Grant funds. In 2005, reimbursement rates for mental health conditions were much higher than those for substance abuse treatment. There was no mechanism or instruction for billing for integrated treatment. On the regulatory side, substance abuse licensing regulations and requirements were completely different from those for mental health licensing. Often the two licensing regimes contradicted one another. Providers offering both services had to keep strictly separate records and follow strictly different documentation requirements. Before Co-occurring State Infrastructure Grants began, a visionary person in the licensing department had begun to encourage integrated care and created a “module” of regulations that permitted integrated practice if an agency had a mental health license and was serving individuals with mental illness who had co-occurring substance use disorders. When that person left the department, new licensing assessors, knowing little or nothing about this “module,” began punitively citing agencies for “integrated” practices that had previously been encouraged. Needless to say, most agencies went back to strict adherence to separate and distinct reg-

ulatory protocols, and for a significant time in the work of our grant this fear of reprisal from the licensing department was a major barrier to progress.

At the same time, there were the changes occurring at the state level: integration of two major departments (Behavioral and Developmental Services with Health and Human Services); in the interests of streamlining services and reducing costs, the introduction of managed care; mounting budget deficits requiring realignment of services; and mental health consent decrees (related to state hospital populations) legally requiring time, attention, and fixed fiscal and service focus on a specific population of people. Although "co-occurring [disorders were] certainly an expectation," these multiple other priorities within the department rendered the Co-occurring State Infrastructure Grants process (which tended to be viewed as "just a grant") low on the list of things requiring attention.

We addressed the need for practice changes through 30 agency pilot sites that were to implement screening, assessment, and treatment practices. Working with pilot sites was, for the most part, fun; it was easy, had visible positive outcomes, and capitalized on the enthusiasm and energy of providers who knew the need for integration because people with co-occurring conditions were the ones most frequently walking through their doors. We dispatched the former treatment team manager for the Office of Substance Abuse to the field to lead pilot sites through the process of internal change. She used tools designed for agency co-occurring disorder capability assessment. Pilot programs performed an initial COMPASS (Minkoff & Cline, 2001) to assess baseline co-occurring disorder capability, developed continuous quality improvement processes, groomed an empowered group of organizational champions, and worked from action plans that they developed (Minkoff & Cline, 2001). They also administered pre- and post-versions of the DDCAT in order to make it possible to track their progress by the end of their 18-month work with the project (McGovern et al., 2007). Both the Maine DDCAT, which Maine altered to measure co-occurring disorder capability in *both* mental health and substance abuse services, and the COMPASS helped agencies focus on the specific domains they needed to change, be it agency policy, organizational structure, treatment practices, or clinical training.

While working with provider agencies on service integration (co-occurring capability) at the program level, our project also was structured to focus on state-level infrastructure issues through working committees. We set up groups to steer, advise, and address data issues, clinical practice issues, licensing concerns, and workforce concerns. Each committee comprised members of the department, with mental health, children's, and substance abuse representatives, stakeholders from the community, both providers and professional advocacy or other community groups and, as much as possible, consumers. As the work of the grant changed and goals were accomplished, groups were disbanded or reengineered. Some new ones were added. We

wanted to be flexible and to orient the structure of the grant to the work that needed to be done. The groups were meant to help develop consensus on the major change initiatives and to involve the community as much as possible in the work and philosophy of integration.

Of the two aspects of grant work and systems change, work on infrastructure by far has been the more challenging and difficult. But Dr. Minkoff warned us of this. As one of our two consultants, he and Dr. Cline began to gently lead us through the minefields of systems change.

Dr. Minkoff and Dr. Cline insisted that our initial focus had to be on getting the buy-in of department leadership. We also had to convince the department that this work had to become part of a quality improvement initiative that encompassed all offices in the department. The commissioner had to make a statement that integration was now the business of everyone. Much of the work of the first 2 to 3 years of the grant was taken up with this piece of the process. The resistance we encountered was not so much about disagreement with the principle of integration; rather, it was about a lack of understanding of what it actually meant and what each person was actually supposed to do about it. It also was about access, getting the attention of very busy people with multiple other priorities. Getting attention became the full-time job of the project coordinator. She got so good at it that she was nicknamed the "pit bull."

Once the department leadership was aligned with promotion of the initiative, change flowed as if a dam had been opened. The commissioner issued a policy statement. A committee began work on integrated licensing regulations. We were able to have co-occurring disorder treatment recognized in sections of MaineCare rule. Co-occurring disorder requirements were inserted into every contract the department has with providers. The requirements for attention to co-occurrence and integration were embedded in new substance abuse licensing regulations. While the work of the pilot sites flowed along easily with our providing extensive training and technical assistance, this infrastructure work was accomplished only through continual pushing and pulling at various levels of the department. Dr. Minkoff and Dr. Cline led numerous "consultation" meetings with department leadership. The project coordinator camped out in the offices of various deputy commissioners. We whined, wheedled, coaxed, and communicated. The system slowly began to change. Having the commissioner's support was invaluable.

As of this writing, Maine is moving toward an integrated system of care with an additional focus on integration of physical health care. It no longer is the case that the project coordinator is the only person who ever mentions the word "co-occurring" in a meeting. The awareness of the need for integration extends to the work of other major departments, including Child Welfare and Criminal Justice. Providers are implementing a standard co-occurring disorder screening tool, the AC-OK, and learning how to do integrated assessments and treatment (Cherry, 2007). Committees are focus-

ing on workforce issues and on creating clinical guidelines for co-occurring disorder care. While a great deal remains to be done and sustainability issues need to be address in a time of declining state resources, co-occurring disorder treatment integration is now the way the department does business. Co-occurring disorder treatment integration no longer is "just a grant."

PILOT SITES AND LESSONS LEARNED

Our pilot sites implementing similar changes at the agency level have had experiences isomorphic to ours at the state level. The agencies needed a "change" architecture with champions on all levels in their agencies to create change. A structure of oversight and assistance from pilot coordinator helped the agencies stay focused and on task. Communication needed to be clear and overt, and the whole agency needed to be involved. Two of the agencies that provided examples of their change process reflect the "lessons learned."

Crossroads for Women is located in southern Maine but draws clients from throughout Maine and provides a continuum of care, including short- and long-term residential programs and intensive outpatient and outpatient treatment for females with substance use and co-occurring conditions. After the grant was awarded, agency executives conveyed the message to all staff by written notice and attendance at program staff meetings that improving co-occurring disorder treatment would be a key focus of the agency at all levels during the term of the grant. While this introduction seemed a bit heavy-handed, in retrospect it was important to convey the significance of the work and to set expectations. Again, that communication from the top stating that this is important work is critical to its success.

An agency action plan was used as the structure to organize the work, a decision that proved invaluable. Each time Crossroads' team of champions met, the action plan was updated; that process provided focus, direction, and motivation as it started to become more complete. Had we not used the action plan in this manner, our work might not have been as broadly based as it was, reaching many facets of the organization (e.g., policies, marketing materials, customer satisfaction survey, forms for treatment plans and assessments)—even the mission statement is under review.

The team of champions consisted of clinical representatives from each of the programs. On a positive note, using this approach improved the consistency of Crossroads' treatment across the continuum of care. The programs now seem less separate from one another. However, Crossroads did not incorporate front-line staff at the beginning as much as they feel they should have, and the bulk of Crossroads' work became focused on treatment. The Co-occurring State Infrastructure Grant work has been timely. The AC-OK data showed that 98.5% of the clients who came in for an evaluation had positive findings for a mental health diagnosis; 81.5% had a positive

screen for trauma. In terms of success, Crossroads' assessments, treatment plans, and treatment goals now include a co-occurring disorder focus. The message to Crossroads' clients is clearer that a co-occurring diagnosis is not unusual. Crossroads has started a medication management program that provides more consistent assessment and treatment for psychiatric conditions at all levels of care. Crossroads has begun to use Basis 24 to look at aggregate data that could inform treatment planning.

In terms of challenges, there were several hurdles to address:

- **Resources:** It has been a constant challenge to find time to do the performance improvement work. As a result, much of the work of the management team has been to handle staff expectations of what can realistically be accomplished, and yet sponsor the push forward.
- **Regulations:** The state's regulations and licensing requirements have been a barrier to moving quickly and efficiently.
- **Staff flexibility:** All agency staff continue to learn that improvement requires flexibility. Flexibility/adaptability is a theme that must be stressed continually. Change is the only constant.

Community Counseling Center (CCC) is a multiprogram mental health center in Portland, Maine, that provides adult and youth outpatient services, as well as case management for families and children. Participation in the Co-occurring State Infrastructure Grant project over the last 15 months has taught CCC how much it was still functioning in a segregated manner. Few staff in the agency had training, experience, or a desire to treat clients with substance abuse issues. Initially, there was a quiet or passive resistance to change by line staff (intake and clinical), with all adult clients with co-occurring disorders being funneled to two or three dually trained clinicians. Staff would openly express "Oh, I don't do that [Co-occurring State Infrastructure Grant] stuff" at the beginning of the process, and agency trainings were poorly attended.

Lessons Learned:

- *Buy-in and communication from the top and at each programmatic level are critical.* CCC learned how very important it is to sustain and maintain a visible presence and promotion by senior management throughout the course of the project. Attendance and participation at trainings seemed to pick up when there was promotion from that level of management, resulting in 31 staff now being dually trained. It's important to have the Co-occurring State Infrastructure Grant project director be someone in the upper circles of management to ensure culture change is not impeded by staff feeling that the agency is only halfheartedly behind such change.
- *It is important to establish a baseline concerning staff's "comfort level" regarding engagement and effective treatment of clientele with co-occurring*

disorders. When CCC completed a pre-Co-occurring State Infrastructure Grant survey it learned that one-third of the agency staff had little to no training or experience in working with substance-abusing/-dependent clients and did not know how to complete an appropriate substance abuse screening. This helped CCC to shape training programs that it initially limited to basic training on substance abuse assessment and differential diagnosis of psychiatric and substance-induced disorders; then CCC moved on to offer training on the ASAM Clinical Pathway, harm reduction strategies, and a whole series on motivational interviewing.

- *Organize a study group of supervisory staff trained in motivational interviewing and co-occurring issues.* Line staff would frequently ask for case consultation on an informal basis. Offering a study group weekly would help support clinicians to become more comfortable with seeing clients with co-occurring disorders.
- *Senior management needs to create an expectation that all staff gain co-occurring disorder competence and treat people with co-occurring disorders.* Over time, mental health agencies tend to develop specialty programs and specialty-trained staff. At CCC, intake staff would funnel clients to clinicians "by specialty" (e.g., DBT, CBT, EMDR, trauma focused CBT) and by programs, such as SAT (child sexual assault trauma team). It therefore was important for senior management to articulate a generalized paradigm shift requiring that all clinical and case management staff become not only trauma-informed, but also co-occurring disorder competent. All staff now are expected to treat clients with co-occurring disorders, as opposed to this being seen as yet another subspecialty where clients are funneled to a handful of dually licensed or trained staff members.

DATA AND EVALUATION

Data collected by Hornby Zeller Associates as part of the project's evaluation point to positive client- and agency-based outcomes. Data show, for instance, that clients with co-occurring disorders who remain engaged in treatment have positive outcomes across multiple domains, including reduced criminal justice involvement and increased employment. Analysis of pre- and post-Maine DDCAT implementation at pilot agencies indicate that, in aggregate, agencies began their Co-occurring State Infrastructure Grant participation at a less than integrated level and, 18 months later, achieved an integrated level of care. Moreover, after their Co-occurring State Infrastructure Grant participation, over a third of pilot agencies had achieved an advanced level of integrated care.

NEXT STEPS

Systems change of this magnitude takes many years. With the Co-occurring State Infrastructure Grant, the allotted 5 years could comfortably have been 10, to be certain that change impregnates all the systems, to continue to develop the workforce, to further identify and develop best practices, and to embed more fully the necessary structural changes. While we have made enormous progress, sustaining it will be crucial. Systems always tend to revert to their default styles and behaviors, and the state system will be no exception.

The critical issues to sustain the efforts as the grant winds down and co-occurring disorder-capable services become the expectation are the following:

- The process of change has to be “owned” within the state mental health and substance abuse infrastructure. Key boundary spanner(s) or functions close to the commissioner will need to be identified to continue to carry the torch at the state level.
- Although the grant process has led to significant progress in 30 pilots, the effort to extend this process to all agencies in the state must continue in earnest. Pilot agencies need to continue to be empowered to expand their efforts and to mentor and share their experiences to guide other agencies. A structure for these activities is evolving with the creation of an Institute for Co-Occurring Studies through the CCSME.
- The development of recommended policies and standards from the various grant-related workgroups has not yet been connected to the routine processes of policy development that occur within the state agencies themselves. Those policies and standards are soon to be reviewed by executive management at the Department of Health and Human Services, and no doubt there will be plenty of discussion. The process of creating and editing future policies need to be identified.
- As the structure of the grant ends, it needs to be replaced by a structure and process that represents all the components of the system in the continuation of the change process: state leaders, agency executives, and front-line champions. That structure and process has yet to be figured out, but discussions are under way.

Maine has taken significant steps toward a welcoming and “no wrong door” approach to people with complex needs, and the awards have certainly been commensurate with the effort. We have turned the corner in the sense that the commitment to building integrated and co-occurring disorder-capable services is now an “expectation.” We have a lot of work to do as we transition out of the grant process into continuing the change process as part of “business as usual.” Twenty years later, the seed that was

planted by the Cumberland County Dual Diagnosis Collaborative has borne fruit, and the tree of change continues to flourish and grow.

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