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Changing the World: Inspiring Hope, Health & Recovery

Transforming systems at every level
to be about the needs, hopes and dreams
of the people and families with complex needs
who come to our door

Christie Cline, MD, MBA ccline@ziapartners.com, www.ziapartners.com
Kenneth Minkoff, MD kminkov@aol.com

The Complexity Challenge

- Individuals with complex multiple issues have the poorest outcomes in multiple domains.
  - Most likely to cost a lot of money, most likely to be homeless, most likely to die.
  - Often experienced as misfits rather than as priorities to serve.
- Is your system or organization designed to welcome people with complexity as a priority for care?

The Hope Challenge

- In order for our system to inspire people and families with serious challenges and multiple issues, we need to be in the hope business.
- Hope: Every person, including those with the greatest challenges, is inspired when they meet us with hope for achieving a happy, hopeful, productive, and meaningful life.

Is your system/organization designed to inspire hope for people with complex needs?

Principle-Driven Adult and Child Systems of Care

ALL services are:

- Hopeful
- Person- or family-centered
- Empowering and strength-based
- Designed to help people achieve their most important and meaningful goals.

Integrated Systems of Care

- Complexity is an expectation, not an exception.
- ALL services are designed to welcome, engage, and provide integrated services to individuals and families with multiple complex issues (MH, SUD, DD, BI, health, trauma, housing, legal, parenting, etc.)

What is a System?

Sets of nesting Russian dolls
that are not quite so nesting:

Systems
within systems
sitting next to other systems
within systems.

Transformation

- Involves EVERY system, subsystem, and sub-sub-system in a common process to achieve a common vision, with EVERY dollar spent and EVERY policy, procedure and practice.
- In a provider agency, that means the agency as a whole, every program in the agency, and every person delivering care is working toward a common vision.

Comprehensive, Continuous Integrated System of Care

CCISC

- All programs in the system become welcoming, hopeful, strength-based (recovery or resiliency-oriented), trauma-informed, and complexity-capable.
- All persons delivering care become welcoming, hopeful, strength-based, trauma-informed, and complexity-capable.
- 12-Step Program of Recovery for Systems

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Person- Centered, Resiliency/Recovery-Oriented

Complexity Capability

Each program organizes itself,
within its mission and resources,
to deliver integrated, matched,
hopeful, strength-based
best practice interventions for multiple issues
to individuals and families with complex needs
who are coming to the door.

Person- Centered, Resiliency/Recovery-Oriented

Complexity Competency

Each person providing clinical care is helped to develop core competency, within their job and level of training, licensure or certification, to become an inspiring and helpful partner with the people and families with complex needs that are likely to already be in their caseloads.

Person- Centered, Resiliency/Recovery-Oriented

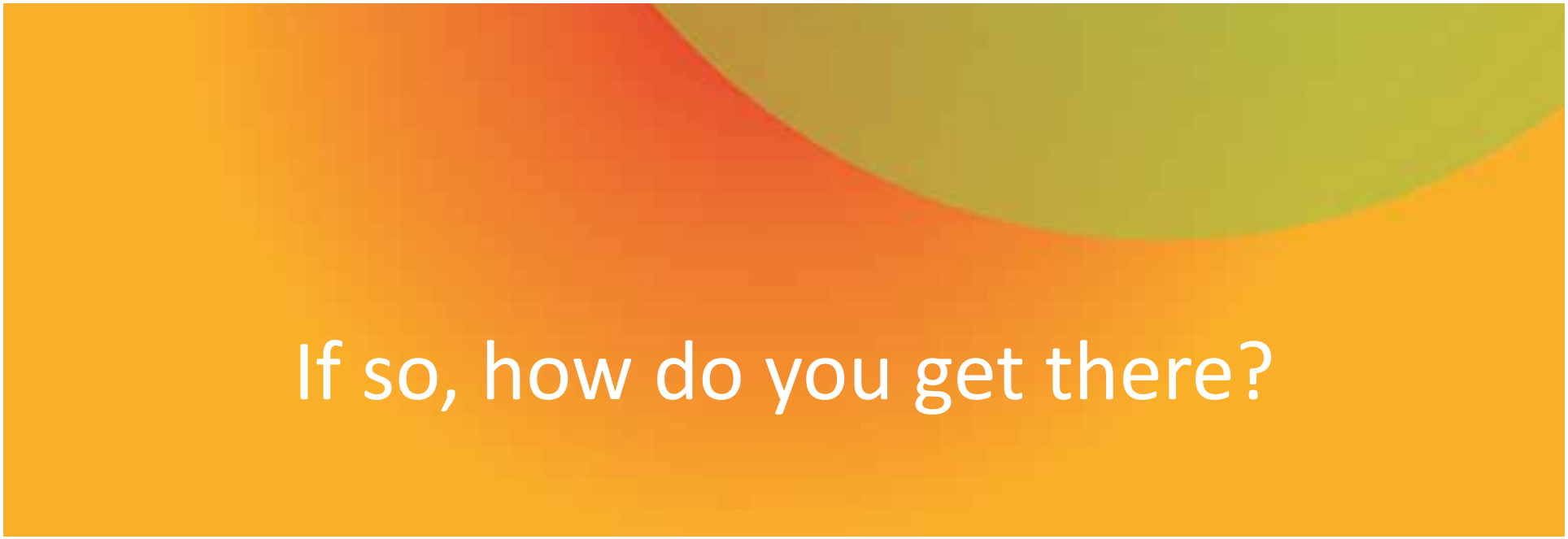
Complexity Capability

- CCISC Program Self-Assessment Tools: COMPASS-EZ™, COMPASS-ID™, COMPASS-PH/BH™, COMPASS-Prevention™
- 12 Steps for Programs Developing Complexity Capability

Person- Centered, Resiliency/Recovery-Oriented Complexity Competency

- CCISC Clinician Self-Assessment Tool: CODECAT-EZ™
- 12 Steps for Staff Developing Complexity Competency

Is this your vision?



How do we get there clinically?

Research-based principles

of successful intervention

that can be applied

to any population

in any program

by any person delivering care.

As a system or organization, how do we get there?

Quality Improvement

- Recovery process for systems
- Horizontal and vertical quality improvement partnership
- Empowered Change Agents
- Anchoring value-driven change into the "bureaucracy"
- Serenity Prayer of System Change

Vision-Driven Quality Improvement Challenge

- How well is your system, agency or program organized to empower staff as partners in vision-driven quality improvement?
- How well are you organized to build inspiration:
  - In the face of complex challenges in your program?
  - To provide services that effectively and efficiently match the complex challenges of your clients?

Principles Made Simple

Principle #1

Complexity is an expectation.

- Welcome people with complexity as priority customers.
- Remove access barriers that make it hard to be welcomed.
- See all the complex issues: integrated screening and documentation.

Principle #2

Service partnerships are empathic, hopeful, integrated, and strength-based.

- Hopeful goals for a happy life.
- Work with all your issues step by step over time to achieve success.
- Build on strengths used during periods of success.

Principle #3

All people with complex issues are not the same.

- Different programs have different jobs.
- All programs partner to help each other with their jobs, and their populations
- 4-Quadrant model (HI/HI, HI/LO, LO/HI, LO/LO) for MH/SA, MH-SA/PH or MH-SA/DD may help with service mapping and matching.

Principle #4

For people with complexity, all the co-occurring conditions are primary.

Integrated multiple primary condition-specific best practice interventions are needed.

Principle #5

Parallel process of hopeful progress for multiple conditions

- Recovery/resiliency/self-determination of the *person* with one or more conditions.
- Progress involves:
  - Addressing each condition over time.
  - Moving through stages of change for *each* condition.
- Integrated services involve stage-matched interventions for *each* condition.

Principle #5 (continued)

Stages of Change

Issue-specific, not person-specific.

- **Pre-contemplation:** You may think this is an issue, but I don't—and even if I do, I don't want to deal with it, so don't bug me.
- **Contemplation:** I'm willing to think with you and consider if I want to change, but have no interest in changing, at least not now.

Principle #5 (continued)

Stages of Change

- **Preparation:** I'm ready to start changing but I haven't started, and I need some help to know how to begin.
- **Early Action:** I've begun to make some changes, and need some help to continue, but I'm not committed to maintenance or to following all your recommendations.

Principle #5 (continued)

Stages of Change

- **Late Action:** I'm working toward maintenance, but I haven't gotten there, and I need some help to get there.
- **Maintenance:** I'm stable and trying to stay that way as life continues to throw challenges in my path.

Principles Made Simple

Stage-matched (for substance use) options for supportive housing

- Individuals have a choice of housing options that include
  - Abstinence-expected (dry)
  - Abstinence-encouraged (damp)
  - Full consumer choice of substance use (wet)

Principle #6

Adequately supported, adequately rewarded, skill-based learning for each condition.

- Small steps of practical learning
- Self-management skills and “asking for help” skills
- Rounds of applause for each small step of progress

Principle #7

There is no one correct intervention or program.

In CCISC,
every program, policy, practice, etc.,
is organized to match interventions
based on the principles.

Principles Made Simple

Summary

- Welcoming, empathic, hopeful, continuous, integrated recovery and support partnerships
  - Addressing multiple primary issues
  - Providing adequately supported, adequately rewarded, strength-based, skill-based, stage-matched, community-based learning for each issue
  - Moving toward the goal of a happy, meaningful life

For Systems, Agencies and Programs

12 Steps of Recovery: Step 1

- Welcome all staff into an empowered partnership.
- Define a vision for all programs and all staff.
- Define the vision as related to core values:
  - Welcoming, hope, resiliency, autonomy, and recovery
  - Matching services to the needs and dreams of the people and families with complexity.

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For Systems, Agencies and Programs

12 Steps of Recovery: Steps 2, 3, 4

- **Step 2:** Define your CQI "Recovery Team" for the agency.
- **Step 3:** Identify Change Agents from each program to represent the voice of front-line staff and consumers.
- **Step 4:** Engage all staff as partners in improving their own competency.

For Systems, Agencies and Programs

12 Steps of Recovery: Step 5

- Perform a system/agency/program baseline self-assessment.
  - Engage staff in a “democratic” conversation.
  - Evaluate program policy, procedure, practice (not people).
  - Use a structured tool to guide the conversation.
  - Rounds of applause for finding improvement opportunities.

For Systems, Agencies and Programs

12 Steps of Recovery: Step 5 Tools

- **COMPASS-EZ™** for MH/SA in BH programs
- **COMPASS-PH/BH** for primary health and BH integration
- **COMPASS-ID™** for BH in intellectual disability service
- **COMPASS-Prevention™** for prevention and early intervention programs

For Systems, Agencies and Programs

12 Steps of Recovery: Step 6

- Achievable Quality Improvement Plan for each program
  - Small measurable steps in the direction of the vision.
  - Progress not perfection.
  - Rounds of applause for each step of progress.
  - Share success in the QI team; identify and remove barriers.
  - Anchor changes in policy, procedure, and paperwork.

For Systems, Agencies and Programs

12 Steps of Recovery: Steps 7, 8, 9

- **Step 7:** Welcoming individuals and families with complex needs.
- **Step 8:** Seeing the complexity in the people we serve: integrated screening and counting.
- **Step 9:** Establishing hopeful goals for a happy life. Identify periods of strength and success.

For Systems, Agencies and Programs

12 Steps of Recovery: Steps 10, 11, 12

- **Step 10:** Integrated hopeful, person- or family-centered strength-based assessment for multi-occurring primary issues.
- **Step 11:** Stage-matched interventions, skills training , and celebrating small steps of success with big rounds of applause.
- **Step 12:** Integrated stage-matched person-centered “recovery” planning.

What will be your next small step of success as a system, agency or program?

And let’s give each other a round of applause!!!


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Thank You

June 18, 2001

AACP POSITION STATEMENT ON HOUSING OPTIONS FOR INDIVIDUALS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)

The problem of providing both housing and housing supports to individuals with serious and persistent mental illness presents significant challenges and controversies to mental health system planners and clinicians. These challenges result from several key issues:

1. Access to affordable housing is severely limited in most communities, so that consumer choice is even more severely limited. Furthermore, consumers may consequently experience housing negotiations with the mental health system as coercive, in the sense that provider imposed requirements become conditions for obtaining any housing at all.
2. There is substantial conflict between the preference of many consumers to live in independent, normative housing, integrated into the community, and the desire of mental health clinicians, family members, and the community at large to maximize safety and reduce risk of relapse and dangerous behavior by providing residential settings that are closely supervised, highly structured group living arrangements
3. There is conflict between the view that housing in the least restrictive setting is a fundamental right for individuals with disabilities, even if those individuals refuse treatment recommendations, and the view that providing housing without requiring treatment participation is at best enabling and at worst medico-legally irresponsible.
4. Finally, the problem of homelessness among individuals with serious and persistent mental illness continues to increase, most prominently among individuals with co-occurring substance use disorders. However, there is considerable controversy regarding what types of housing programs and supports should be made available to meet the needs of these difficult individuals, particularly with regard to the question of whether such supports should be offered to individuals (with SPMI) who continue active substance use.

This position statement is intended to address these controversies by identifying key philosophic principles for planning and providing housing supports to persons with SPMI, and then establishing general guidelines for the types of housing options that should be available in any system of care, and suggested methodology for planning these options to meet client needs.

Fourteen Principles

1. **Provision of safe, adequate, and appropriately supported housing for individuals with serious and persistent mental illness is a priority.** AACP believes that provision of housing and prevention of homelessness must remain a priority of all treatment systems addressing the needs of individuals with SPMI. Consequently, the range of housing options, particularly for individuals with co-occurring substance use disorders, must be developed with that priority in mind.
2. **Individuals with psychiatric disabilities should not be institutionalized because of lack of housing options.** The Olmstead decision creates a clear imperative to develop a range of housing supports to permit individuals with SPMI access to community-based housing in lieu of remaining in restrictive institutional settings in the public mental health system. AACP believes that there should be the same imperative to provide housing in lieu of inappropriate institutionalization in correctional facilities or nursing homes.
3. **Housing for individuals with SPMI is an issue for the whole community, not just for the behavioral health system.** Treatment systems must take initiative to establish relationships with public and private housing "providers" in the community (such as local housing authorities) in order to develop collaborative strategies for enhancing access to a wider range of housing options.
4. **Housing options should be designed to promote empowerment and recovery, through creating options that support *consumers' preferences for adequate assistance to achieve normative housing and full community integration.*** Housing choices should not be restricted to segregated mental health "ghettos", and consumers should neither be expected to remain indefinitely in supervised group homes or other artificial housing environments, *nor to move prematurely to more independent settings to satisfy arbitrary program requirements*.
5. **Housing options should be prioritized to be responsive to consumer choice and preference wherever possible.** Consumers are presumed to be competent to make housing choices, even if those choices are in conflict with the recommendations of their caregivers, and are entitled to access to supports in the settings of their choosing. In addition, choices regarding participation in treatment, substance use, and living companions should be respected as much as possible.
6. **Housing support options should maximize opportunities for individualization and flexibility in matching housing to consumer needs and preferences.** Housing services need to move away from attempting to fit consumers into pre-existing "slots" in pre-designed models of care, and move toward flexible wrap-around supports that can be more individually designed. In addition, housing services should be designed to maximize the consumer's ability to maintain continuous treatment relationships in the context of housing transitions.

7. **Housing support options should be designed in a culturally competent manner, and promote integration into community environments that support consumers' cultural and linguistic preferences.** This follows directly from the prior two principles. Cultural flexibility in housing services is enhanced by emphasizing individual and small group arrangements in scattered site apartments with flexible supports, in comparison to more traditional group home models.
8. **Individuals who are transitioning from the child and adolescent system to the adult system are a particular priority population for housing services.** Specific supports are needed to promote the development of independent living skills within a safe context. Other age-based transitions (e.g., those which result from an aging and potentially medically infirm SPMI population) also require specific planning and attention.
9. **For individuals who are NOT competent to make the full range of independent choices, caregivers must proactively establish the need for protective services and provide appropriate safety and supervision in the least restrictive possible manner.** This can range from payeeships for those whose areas of lack of competence are primarily in the area of money management, to fully supervised environments for individuals with significant cognitive compromise or demonstrable likelihood of dangerous behavior in unsupervised settings.
10. **Individuals should have access to a full range of treatment options in association with housing, and treatment requirements (if any) should be individualized based upon client need and preference as much as possible.** Housing options should not routinely require arbitrary participation in pre-arranged treatment. Treatment options should include participation in stage-specific substance disorder treatment, and access to a range of options for medical care.
11. **Within the context of consumer choice, providers should proactively offer assistance to promote safety, prevent relapse, and build recovery.** Simply because consumers are not required to participate in treatment does not mean that assistance should be withheld, or offered only passively. Housing support staff can work actively to encourage consumers to make the best possible choices without rejecting them for making the wrong ones.
12. **Within the context of consumer choice, abstinence from alcohol and drugs is consistently encouraged, but housing options should not be denied because a consumer continues to use substances and/or is unwilling to accept abstinence as a goal.** For this reason, housing options should include abstinence-expected housing, abstinence-encouraged housing, and consumer choice housing. These options will be described further below.
13. ***Public sector systems should develop mechanisms to encourage providers to provide the full range of housing options to consumers who continue to engage in risky behavior.*** *The premise of consumer choice housing is that risk of harm will be reduced for these individuals if basic needs are met and opportunity to engage with treaters is provided. Nonetheless, providers may be exposed to significant risk of liability for individual instances of harm that*

may occur. Consequently, AACP recommends that public systems facilitate initiatives for shifting liability for such programs from individual agencies to broader risk pools.

14. **Clinical decisions regarding housing recommendations should be based on evidence based best practice whenever possible.** More research is clearly needed to identify which housing models are most appropriately matched to consumers with particular needs or characteristics. Housing programs should therefore incorporate program evaluation efforts into program design whenever possible.

Dimensions of Housing Variability

Housing supports and housing programs can vary along multiple dimensions. **AACP recommends maximizing choices and flexibility along as many of these dimensions as possible.**

1. **Independent vs. group living**
2. **Wrap-around flexible support (supported housing) vs. staff model support (e.g., group home).**
3. **Consumer lease vs. program owned**
4. **Scatter site vs. congregate living**
5. **Programming optional vs. required/integrated**
6. **Loosely structured vs. highly supervised**
7. **Medical care off site vs. VNA vs. on-site nursing care**
8. **Self-medication vs. medication monitoring vs. med administration**
9. **Consumer choice re: substances vs. abstinence encouraged or expected**
10. **Permanent housing vs. transitional vs. temporary (shelter).**

Comprehensive Housing Array

The AACP position statement is as follows: In any service area or catchment area, there must be provided a full range of housing options for individuals with SPMI, including those with active co-occurring disorders.

First, a significant body of literature has established that individuals with SPMI predominantly prefer to live independently in normative, scattered site housing, with few requirements, and access to flexible supports as needed. When such supports are made available with sufficient intensity, these supported housing models produce significantly better outcomes at lower costs than more rigid group home models.

Consequently, AACP recommends maximizing availability of supported housing. Assessment of supported housing requirements begins with assessment of consumer preferences and their perceived needs for support.

Second, despite the aforementioned literature, there remains a significant minority of individuals with SPMI who **prefer** a group home, or whose level of impairment leaves them unable to care for themselves in an independent setting.

Consequently, AACP recommends that group home models remain available to the extent that the aforementioned needs assessment establishes a cadre of individuals who prefer such settings or who require such settings.

Third, psychiatric housing programs (which provide or support a place to live for individuals with psychiatric disability, in order to prevent homelessness) must be distinguished from addiction (or psychiatric) residential treatment programs (which provide episodes of treatment in a residential setting, usually with defined expectations or requirements). Both are important components of a comprehensive system of care.

In most service areas, the addiction treatment system provides a range of addiction residential treatment programs and sober housing programs (e.g., Oxford House model programs), all of which need to be abstinence-expected programs, in order to protect the integrity of the addiction recovery support provided. Individuals who enter these settings are seeking a sober recovery environment, not merely housing, and expect these requirements to be enforced. Ideally, all such individuals have a plan for housing in the event that they fail to meet program requirements and are prematurely discharged.

The mental health system, by contrast, provides mainly housing support programs for individuals with SPMI. Many of these individuals have co-occurring substance use disorders, but vary in their willingness to define substance use as a problem and/or identify sobriety as a goal, even though they may desire assistance to maintain stable housing. Some of these individuals are simply unable or unwilling to limit substance use, even when all housing supports available require such limits; these individuals frequently become homeless as a result.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to psychiatric disability, and who are at risk of homelessness, MUST include the following choices:

a. **Abstinence-expected ("dry") housing**: This model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than "one strike and you're out".

b. Abstinence-encouraged ("damp") housing. This model is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than

substance use per se. Motivational enhancement interventions are usually built in to program design.

c. **Consumer-choice ("wet") housing**. This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (cf. Tsemberis & Eisenberg, "Pathways to Housing Program" in Psychiatric Services, April, 2000). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

In many systems, the latter option is unavailable, despite its potential value for preventing or ending homelessness.
Consequently, AACP specifically endorses the consumer choice housing model as a valuable component of the system of care. Consumers with psychiatric disabilities who need housing support, including those who have "failed" sober group living, should not be left homeless simply because of inability or unwillingness to maintain abstinence.

Assessment of Housing Requirements

In any system of care, a systematic process of assessment is required to determine the needed housing array.

AACP recommends utilization of a formal tool, like the LOCUS , for assessing housing "needs", in combination with assessment of consumer competence, consumer choice, and family/caregiver choice, in order to determine the best housing option for each consumer. When the choice of a competent consumer conflicts with provider recommendations, consumer choice should be given priority, assuming necessary wraparound supports are available.

Conclusion

The AACP is hopeful that this document will prove valuable to any system attempting to design a comprehensive array of housing supports for individuals with SPMI. We welcome feedback regarding how this document can be improved or amended to more adequately accomplish its purpose.

CCISC Description and Principles of Complexity Capability

***C**omprehensive **C**ontinuous **I**ntegrated **S**ystem of **C**are*

CCISC is both a framework for person- and family-driven system design and a process of getting there in partnership across the whole system.

The overall vision is to design the system at every level to be about the needs, hopes, and dreams of the people and families that are needing help with all types of co-occurring complex issues—including health, mental health, trauma, substance use, and cognitive conditions, as well as housing, legal, vocational, social and parenting issues.

The core of the vision is that ALL programs and ALL persons delivering care and support become welcoming, person-centered, resiliency-/recovery-oriented, hopeful, strength-based, trauma-informed, culturally fluent, and complexity-capable. In any community, all programs work in partnership to help achieve this vision, so that people with complex needs receive more integrated care within any door.

Making the vision a reality is based on implementing a set of evidence-based principles of service, each of which is associated with interventions and strategies that can be used in any setting, with any population, by any person providing care.

Making the vision a reality is also based on organizing a system-wide quality improvement partnership, in which all types of programs and providers are welcome to come together to move toward the common vision, and all levels of the system—state and county leaders, agency CEOs, program managers, front-line service and support staff, and people and families who are service recipients—come together in an empowered partnership for change.

CCISC change agent teams represent the empowered collective front-line voice of both staff and service recipients throughout the system who are engaged formally as partners in this process, representing their organizations, communities, and other constituencies.

The CCISC principles are:

- Complexity is an expectation, not an exception. This expectation must be incorporated in a welcoming manner into everything we do.
- Recovery partnerships or service partnerships are empowered, empathic, hopeful, integrated, and strength-based, working with individuals and families step by step over time, building on their periods of strength and success, to address ALL their issues in order to achieve their vision of a happy, meaningful life.
- All people with co-occurring and complex issues are not the same. Different programs and different systems have responsibility for serving different sub-populations, but all programs are complexity-capable. Each program provides complexity-capable services to its own population, and helps other programs with their populations.
- All the co-occurring issues are primary, and integrated best-practice interventions for each issue at the same time are needed.
- Progress for any issue involves moving through stages of change; integrated interventions and outcomes should be stage-matched for each issue.
- Active change for each issue involves adequately supported, adequately rewarded skill-based learning, so that individuals and families develop and practice the skills they need to succeed for each issue, with big rounds of applause for each small step of progress.
- There is no one correct program or intervention for individuals or families with complex and co-occurring issues. For each person or family, the correct match is based on these principles.
- In CCISC, the principles inform every program, practice, policy, procedure, and person providing service, with every available dollar and resource, to design the system to be about the people who need us the most.

TWELVE STEPS FOR CLINICIANS
DEVELOPING CO-OCCURRING DISORDER COMPETENCY

These steps are based on the Principles of CCISC, and can be practiced by any clinician within the scope of his or her existing job or caseload.

1. **WELCOMING: Welcome individuals who have co-occurring disorders, thank them for coming, and let them know you are glad to get to know them as they are.**
2. **HOPE: Ask every one about their goals for a happy life, and inspire a belief that you will work with them to help them to achieve that vision.**
3. **INTEGRATED: Screen for problems in multiple life domains (mh, sa, trauma, court, etc.) in the course of conversation, and practice using one tool.**
4. **EMPATHY: Ask clients to describe in detail their experience with the issues in the "other" domain, and empathize fully with what it feels like.**
5. **STRENGTHS: Ask clients to identify a period of recent success in relation to their problem, and describe in detail how they were successful, and what they were experiencing: e.g., mental health issues during a period of sobriety, what were they and how were they managed.**
6. **QUADRANT: Review each case in the case load, and determine: are they cod (yes, no, maybe). What quadrant are they in? (abuse vs. dependence; SPMI vs less serious mental health issues).**
7. **INTEGRATED PRIMARY PROBLEM SPECIFIC TREATMENT. For any client, list each problem, and list a specific day at a time set of recommendations to help that person succeed. Discuss with the client how they attempt to follow each set of recommendation on any given day. Include recommendations in other areas, like medical issues, probation, etc.**
8. **STAGE OF CHANGE: For each identified problem that may affect the person's goals for happiness, identify stage of change. Write down a stage matched goal for each problem in the client's own words. Practice establishing empathy with clients in earlier stages of change.**
9. **SKILLS AND SUPPORTS: For any identified problem during a period of success, identify in detail with the client the specific skills that the client used to be successful, including skills asking for help or using supports**
10. **SKILL-BASED LEARNING: Use one manual for teaching co-occurring skills, and practice one exercise with a client that is connected to their life. For example, work with the client in an addiction setting on managing mental health symptoms on any day; or work with a mental health client on refusing drugs from a friend.**
11. **POSITIVE REWARDS: Identify small steps of progress for any problem in any client, and provide strong positive reward for those small steps, as a "round of applause for one day of sobriety"**
12. **RECOVERY SUPPORT: Identify a place where the client can receive recovery support for each problem, whether from peers, family, or others, and discuss in detail how the client can improve asking for help.**

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