

ONEIDA COUNTY CHARTER AND CONSENSUS DOCUMENT

Co-Occurring Psychiatric And Substance Disorders

Overview

In Oneida County, we believe that individuals with co-occurring psychiatric and substance disorders, though often difficult to treat, can become valued, productive members of our community. They are recognized as a population with whom we need to improve clinical outcomes to decrease costs in multiple clinical domains. They are commonly poorly served in both mental health and substance abuse treatment settings, with resulting over utilization of resources in the criminal justice system, the primary health care system, the homeless shelter system, and the child protective system. In addition to having poor outcomes and high costs, individuals with co-occurring disorders are sufficiently prevalent in all behavioral health settings that they can be considered an expectation, rather than an exception.

The treatment and service providers in Oneida County believe that individuals with co-occurring psychiatric and substance disorders are deserving of and entitled to, treatment and services that promote and facilitate recovery.

In order to provide more welcoming, accessible, integrated, continuous, and comprehensive services to these individuals, the following entities in Oneida County:

Catholic Charities of Roman Catholic Diocese of Syracuse, Inc.

Center for Addiction Recovery

Central New York Services, Inc.

D.A. Mancuso Counseling Services

Family Services

Faxton Hospital/St. Luke's Hospital

House of the Good Shepherd

Human Technologies Corporation

Insight House Chemical Dependency Services

Kids Oneida

McPike Addiction Treatment Center

Mohawk Valley Council on Alcoholism and Addictions

Mohawk Valley Psychiatric Center

Neighborhood Center

New York State Division for Parole

Office for the Aging / Continuing Care

Oneida County Department of Mental Health

Oneida County Department of Probation

Oneida County Department of Social Services

Rescue Mission of Utica, Inc.

Resource Center for Independent Living

Rome Memorial Hospital

Safe Schools Healthy Children, Utica School District

St. Elizabeth's Medical Center

United Cerebral Palsy and Handicapped Persons of the Utica Area, Inc.
Utica Drug Court

(Additional agencies may be invited to participate as community needs arise, i.e. various school districts, the Health Department)

have agreed to participate in a Dual Recovery Coordinating Council (DRCC), organized and empowered under county leadership, for the purpose of implementing the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change to improve outcomes within the context of existing resources. This model is based on the following eight clinical consensus best practice principles (Minkoff, 1998, 2000) which espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system:

VALUE STATEMENT

1. Dual diagnosis is an expectation, not an exception. This expectation has to be included 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 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.
4. Within the context of any treatment relationship, case management and care, based on the client's impairment or disability, must be balanced with empathic detachment, confrontation, contracting, and opportunity for contingent learning, based on the client's goals and strengths, and availability of appropriate contingencies. 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 dual primary treatment is required.
6. Mental illness and substance dependence are both examples of chronic, biopsychosocial disorders that can be understood using a disease and recovery model. Each disorder has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) 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 dual diagnosis program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, all programs are dual diagnosis programs that at least meet minimum criteria of dual diagnosis capability,

but each program has a different “job”, that is matched, using the above model, to a specific cohort of patients.

8. Similarly, outcomes must be also individualized, including reduction in harm, movement through stages of change, changes in type, frequency, and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

Using these principles, we have agreed to implement a CCISC in Oneida County, with the following four core characteristics:

1. The CCISC requires participation from all components of the behavioral health system, with expectation of achieving, at minimum, Dual Diagnosis Capability standards (and in some instances Dual Diagnosis Enhanced capacity), and planning services to respond to the needs of an appropriately matched cohort of dual diagnosis patients.
2. The CCISC will be implemented initially with no new funding, within the context of existing treatment operational resources, by maximizing the capacity to provide integrated treatment proactively within each single funding stream, contract, and service code.
3. The CCISC will incorporate utilization of the full range of evidence-based 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. The CCISC will incorporate an integrated treatment philosophy and common language using the eight principles listed above, and develop specific strategies to implement clinical programs, procedures, and practices in accordance with the principles throughout the system of care.

Action Plan

To acknowledge their agencies role in operationalizing the CCISC Model, agency executives agreeing to participate in the Dual Recovery Coordinating Council (DRCC) are asked to signify their commitment by completing the following statement and signing in the appropriate block at the end of this document.

I _____, of _____ (agency) agree to the following action steps (These will be incorporated into County contracting agreements in the year 2004). It is understood that as a participant my agency will have priority access to training and staff development, consultation (clinical and administrative), and interagency coordinating activities related to co-occurring disorders, as planned and implemented by the Dual Recovery Coordinating Council.

Steps

1. Adopt this agreement as an official policy statement of the agency or participating organization, and assign appropriately empowered staff to participate in the DRCC, as the official Oneida County integrated system planning and program development activity. Increase staff competency and organizational capability to serve persons with dual diagnoses as part of the agencies strategic planning and quality improvement processes.
2. Participate in agency self-survey using an OMH/OASAS approved instrument to evaluate the current status of dual diagnosis capability
 - i. 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. Participate in system wide training and technical assistance, coordinated by the Dual Recovery Coordinating Council, with regard to implementation of the action plan.
 - ii. Develop a process for assessing stage of change for each individual, and implementing stage specific interventions, including motivational enhancement, in treatment planning, for programs that provide continuing treatment.
3. Assign appropriate clinical leadership to participate in an official interagency care coordination meeting, coordinated under DRCC, which will include senior clinical consultation to resolve clinical disputes, and establish recommendations for clinical standards of care. The role of this group will be defined to minimize overlap and maximize coordination with the activities of other interagency meetings, including implementation of state mandates regarding A-SPOA/A and AOT.
4. Participate in designing an infrastructure for the operation of the DRCC, incorporating a leadership role for the Dual Recovery coordinator, and adapting a dispute resolution process. The DRCC will also develop a mechanism for consumer and family involvement. The structure for the DRCC will initially be developed by County leadership, and then revised with input from DRCC members.

5. The DRCC will identify selected outcomes from an OMH/OASAS approved instrument to monitor the progress of this project, and to report to all stakeholders on an annual basis.
6. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by developing procedures for maximizing identification of individuals with Co-occurring Disorders, and reporting them into the C-INFO database, in a manner consistent with confidentiality and HIPAA requirements.
7. Participate in system wide efforts to improve ‘welcoming’, access and continuity for individuals with co-occurring disorders by adopting agency specific welcoming policies, materials, and expected staff competencies, and implementing these via the action planning process. This will include:
 - a. Access to 24/7 emergency psychiatric evaluations in any setting for individuals who have been using substances.
 - b. Access to psychiatric assessment for individuals who may have serious mental illness and who are actively using substances, with no initial arbitrary length of sobriety required before initiating the evaluation.
 - c. Elimination of arbitrary treatment exclusion and discontinuation for individuals who fail to meet treatment requirements.
 - d. Agree to require all prescribers to review national practice guidelines concerning prescribing necessary non-addictive medication for individuals with Severe and Persistent Mental Illness who may be actively using substances, and to attend on-going trainings on this issue. Participate in the development and implementation of a countywide standard for discharge (seamless continuum of care, medications to match the required length of time before an outpatient psycho-pharmacology appointment is provided, counseling, detoxification). Develop a mechanism for rapidly reopening the case of any client who has been administratively discharged. Create a QI mechanism for tracking adherence to this standard.
8. Participate in county organized activities to prioritize regulatory relief to facilitate co-located assessments or groups, and to facilitate psychiatric assessment prior to discharge from substance treatment.

APPENDIX:

- I. To Describe the CCISC model
- II. National Consensus (NY State Model) Service Coordination Model for Co-occurring disorders

Signature pages:

Kathy Eichenlaub, Executive Director Catholic Charities of Roman Catholic Diocese of Syracuse, Inc.	Date
Ole Pettersen, Executive Director Center for Addiction Recovery	Date
John Warren, Executive Director Central New York Services, Inc.	Date
David Mancuso, Executive Director D.A. Mancuso Counseling Services	Date
Herb Freeman, Executive Director Family Services	Date
Faxton Hospital/St. Luke's Hospital	Date
Zygmunt Malowicki, Executive Director House of the Good Shepherd	Date
Patrice Modell, Executive Director Human Technologies Corporation	Date
Donna Vitagliano, President and CEO Insight House Chemical Dependency Services	Date
Michael Daly, Executive Director Kids Oneida	Date
John F. Crowley, McPike Addiction Treatment Center	Date
Rochelle Cardillo, Executive Director Mohawk Valley Council on Alcoholism and Addictions	Date

Sarah Rudes, Executive Director Mohawk Valley Psychiatric Center	Date
Virginia Barney, Executive Director Neighborhood Center	Date
Janet Reeves New York State Division for Parole	Date
Kenneth Abramczyk, Director Office for the Aging / Continuing Care	Date
Philip R. Endress, Commissioner Oneida County Department of Mental Health	Date
Theodore Mohr, Commissioner Oneida County Department of Social Services	Date
Allen J. Belmont, Director Probation	Date
Rev. David Sanders, Executive Director Rescue Mission of Utica, Inc.	Date
Burt Danovitz, Executive Director Resource Center for Independent Living	Date
Darlene Burns, CEO Rome Memorial Hospital	Date
Nancy Kelly, Executive Director Safe Schools Healthy Students, Utica School District	Date
St. Elizabeth's Medical Center	Date
Louis Tehan, Executive Director United Cerebral Palsy and Handicapped Persons of the Utica Area, Inc.	Date
Honorable John S. Balzano Utica Drug Court	Date

APPENDIX I

CCISC MODEL - COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

Kenneth Minkoff, M.D.

Description

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

1. **System Level Change:** The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.
2. **Efficient Use of Existing Resources:** The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to ICOPSD within the context of each funding stream, program contract, or service code, rather than requiring blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training.
3. **Incorporation of Best Practices:** The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.
4. **Integrated Treatment Philosophy:** The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder treaters.

Principles

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating ICOPSD 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 clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

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.

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.

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.

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.

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 stage wise treatment (Drake et al, 2001.)

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 diagnosis services, thereby mobilizing treatment resources throughout the entire system.

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.

Implementation

Implementation of the CCISC requires utilization of system change strategies (e.g., continuous quality improvement), in the context of an organized process of strategic planning, to develop the specific elements of the CCISC. Minkoff (2001) has described a “12 Step Program for Implementation of a CCISC” that defines this process sequentially, and, in collaboration with Cline, has organized a CCISC implementation toolkit that promotes the successful accomplishment of many of the specific steps. Implementation of the CCISC occurs incrementally in complex systems, over a period of years, and is characterized by establishment of the following elements, which reflect fidelity to the model.

1. **Integrated system planning process:** Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families.

2. Formal consensus on CCISC model: The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

3. Formal consensus on funding the CCISC model: CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services

provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

4. Identification of priority populations, and locus of responsibility for each: Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations (commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

5. Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stagewise implementation. Program competency assessment tools (e.g., COMPASS (Minkoff & Cline, 2001)) can be helpful in both development and implementation of DDC standards.

6. Structures for intersystem and interprogram care coordination: CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

7. Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (Minkoff, 1998; Arizona DHS, 2001) are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).

8. Facilitation of identification, welcoming, and accessibility: This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize identification, reporting, and tracking of ICOPSD. 2. development of “no wrong door” policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

9. Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected “scope of practice” for singly licensed clinicians regarding co-occurring disorder, and incorporated into standards of practice for reimbursable clinical interventions - in both mental health and substance settings - for individuals who have co-occurring disorders

10. Development of basic dual diagnosis capable competencies for all clinicians: Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT, Minkoff& Cline, 2001) can be utilized to facilitate this process.

11. Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train-the-trainer curricula have been developed, or are being developed, in a variety of states, including Connecticut, New York, New Mexico, and Arizona.

12. Development of a plan for a comprehensive program array: The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

a. **Evidence based best practice:** There needs to be a specific plan for initiating at least one Continuous Treatment Team (or similar service) for the most seriously impaired individuals with SPMI and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.

b. **Peer dual recovery supports:** The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.

c. **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:

1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs).

2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.

3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities

4. Consumer - choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness

d. **Continuum of levels of care:** All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization.

CCISC implementation requires a plan, which includes attention to each of these areas in a comprehensive service array.