

Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems:
Standards of Care, Practice Guidelines,
Workforce Competencies, and Training Curricula

Report
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Preface

This report is the result of the collective efforts of a national panel of dual diagnosis experts, during the period October 1996 to February 1998, to develop national standards, workforce competencies, and training curricula for the treatment of people with co-occurring psychiatric and substance disorders in managed care systems. The panel members were selected to represent consumers, family members, and providers, and to include individuals with geographic, cultural, and racial diversity as well as public and private sector, and psychiatric and substance disorder backgrounds. In order to accomplish their task, the panel members first performed an extensive review of published and unpublished literature concerning dual diagnosis treatment and managed care, in order to create an Annotated Bibliography, which was completed in July 1997.

Based on the material compiled in this bibliography, the panel then proceeded to develop this report. The Panel Report is divided into five parts:

- I. Consumer/Family Oriented Standards for Dual Diagnosis Treatment in Managed Care Systems
- II. Standards for Managed Care Systems Regarding Development of Comprehensive Dual Diagnosis Treatment
- III. Practice Guidelines for Dual Diagnosis Treatment in Managed Care Systems
- IV. Provider Competencies for Dual Diagnosis Treatment in Managed Care Systems
- V. Training Curricula

Each part builds on those that precede it. We begin in Part I emphasizing the primacy of the consumer/family perspective, by attempting to answer the following question:

As an individual with both psychiatric and substance problems, (or a family member of such an individual), how would I want the service delivery system to best meet my needs, and how can managed care help this to happen?

In Part II we then describe standards for designing a system to provide services that adhere to the consumer/family standards in Part I. Part III elaborates practice guidelines to be implemented by the system described in Part II. Part IV establishes competencies necessary for providing treatment in accordance with those guidelines, and Part V describes training curricula for developing those competencies among clinicians.

This report - and these standards - are based on the current state of knowledge in the field; background material is contained in the Annotated Bibliography referenced above. However, the field of dual diagnosis treatment is far from static; new concepts, new program models, and new research are emerging regularly. As these guidelines are used over time, they may require modification based on the evolving literature, particularly in the areas of gender-specific treatment, culturally relevant treatment, treatment of comorbid

cognitive impairments (e.g., head injury, attention deficit disorder), and treatment of comorbid post-traumatic stress disorder. Consequently, the readers of this report are encouraged to build upon the recommendations contained herein with newer material (both published material, and unpublished documents chronicling state and local initiatives) as it becomes available.

Finally, we would like to emphasize that our recommendations are deliberately idealistic. We acknowledge that "real" systems will have great difficulty meeting all of our recommendations. Nonetheless, we stand by these ideals. We believe it is our mission to define a standard for necessary treatment for individuals whose comorbid disorders result in poor outcomes, significant suffering for themselves and their families, and costly service utilization. We believe these individuals deserve a care system that meets the standards we have defined. We do not want to settle for less.

PART I

Consumer/Family Oriented Standards for Dual Diagnosis Treatment in Managed Care Systems

Introduction

Managed care entities can have considerable power to transform the service delivery systems in which they operate to improve efficiency of resource utilization and decrease cost, while improving system functioning and clinical outcome. Regardless of specific diagnosis or disability, consumers and their families should expect that managed care entities will use this power to approximate an ideal system of care from the consumer/family perspective to the fullest extent possible, and should continually advocate for standards of care that will bring this ideal system into reality. The following standards were written with this vision of an ideal system in mind, and are intended to answer the following question for dual diagnosis consumers and families:

As an individual with both psychiatric and substance problems, (or a family member of such an individual), how would I want the service delivery system to best meet my needs, and how can managed care help this to happen?

General Principles

1. CUSTOMER-FOCUSED/CONSUMER-FAMILY CENTERED

Managed care systems must create dual diagnosis service delivery that is customer-focussed and consumer/family centered through the development of a system of care that is welcoming, accessible, integrated, continuous, and comprehensive.

A. Welcoming

Objective

In traditional systems of care, people with co-occurring disorders often experience themselves as system misfits, unwelcome, unwanted, and blamed for the complexity of their difficulties. To correct this, managed care entities must do more than create dual diagnosis programs; they must create a system of care that welcomes dual diagnosis consumers and families at every level.

Guidelines

- All programs (including criminal justice and primary care settings) are required to develop culturally competent and linguistically appropriate intake and assessment procedures. Dual diagnosis is an expectation and all staff are appropriately trained to address the needs of individuals who have such diagnoses.
- All intake staff are trained to approach individuals with dual diagnosis comfortably and empathically.
- All relevant programs are required to welcome dual diagnosis consumers - explicitly, through program literature, policies and procedures, and payment methodology.
- Benefit design rewards programs that create and implement models for accommodating people with co-occurring disorders.

- System wide policy emphasizes that no program can discriminate against individuals who have a co-occurring disorder.
- System wide trainings define and reinforce an optimistic approach to people with dual diagnosis, with an emphasis on a hopeful dual recovery philosophy.
- Utilization management policies emphasize the value of ongoing engagement of seriously ill individuals with dual disorder, even without immediately discernible progress.
- People with co-occurring disorders - and their families - are empowered to make treatment decisions, but not abandoned for making the wrong choice; they are protected whenever possible from immediate harm to self or others, but not indefinitely restricted, controlled, or punished.

B. Accessibility

Objective

People with co-occurring disorders have difficulty gaining access to services that meet their needs. They experience time-consuming or burdensome procedures that are often intended to screen them out.

To correct this, the managed care system must develop, in conjunction with consumers and families, a system of access that can accommodate people with dual disorders no matter where or how they present.

Guidelines

- Psychiatric triage and emergency services demonstrate the capacity to initiate assessment and complete disposition on individuals with any combination of psychiatric and substance disorder.
- Assessments are initiated without regard to blood alcohol level, or other arbitrary measures.
- Inpatient programs demonstrate capacity for acute stabilization and accurate evaluation and referral of individuals with dual disorders.
- Benefit design and program procurement insure available and accessible services in each geographic region for both individuals with SPMI and substance abuse/dependence and individuals with serious substance dependence and other (non-SPMI) psychiatric symptoms or disorders, and for individuals in any phase of treatment readiness.
- For every region, and for the system as a whole, the managed care entity publishes an annotated listing of all available dual diagnosis programs, their specific focus (type of dual disorder, phase of readiness required), and means of access.
- Information about dual disorders in general is made readily accessible to consumers and families in all service delivery settings, both through educational literature and through psychoeducational interventions.
- Ease of access also includes use of screening instruments in non-treatment settings (e.g., educational, correctional, rehabilitation system settings) to detect individuals, especially children with seriously emotional disturbance, who may be suffering from - or at risk of developing - comorbid psychiatric and substance disorders.
- For consumers identified as dual diagnosis via such screening, there is a protocol that facilitates referral for appropriate treatment matching.
- Ease of access requires engagement of consumers in various stages of treatment readiness. "Lack of motivation" is not a barrier to access to phase-specific services. As a pre-requisite for developing trust and enhancing motivation, staff demonstrate empathy, acceptance, and

unconditional positive regard for consumers, regardless of stage of readiness.

C. Integration

Objective

Lack of integrated treatment places the historical burden of solving problems between addiction and mental health systems on the consumer and family. Consumers are deprived of access to appropriately combined interventions, and access to appropriate peer support. To correct this, managed care entities must implement program integration throughout the system of care.

Guidelines

- All programs within the system are required to provide integrated services to consumers, and to specify - accordingly to subtype of dual disorder and phase of treatment - the type(s) of integrated services that are offered.
- Managed care network development and benefit design identify, develop, and reimburse integrated program models as distinct from "single-diagnosis" programs, with higher rates as appropriate.
- Consumers (and families) are able to receive treatment for comorbid disorders in the settings in which they receive treatment for their most serious disorder. That is, people with SPMI have access to appropriate substance services in their mental health treatment settings; people with substance dependence and other psychiatric comorbidity have access to appropriate psychiatric treatment in their addiction setting.
- Consumers have access to "integrated" peer support groups.
- Dual diagnosis consumers receive from primary caregivers and case managers who are cross-trained and able to provide integrated treatment themselves.
- Managed care entities require programs to demonstrate that there are sufficient dual diagnosis clinicians with demonstrable dual competencies to serve their expected cohort of dual diagnosed clients.
- Psychoeducational and skill training for consumers and families integrates specific knowledge and skills relevant to living with dual disorders.
- Integration of treatment and services for psychiatric and substance disorders is also present in other agencies (e.g., social service and child welfare) and settings (e.g., correctional facilities, schools, vocational rehabilitation settings) with which consumers and families are frequently involved.
- Despite the desirability of integrated treatment, opportunity for consumers to exercise preference to participate in parallel or serial generic services is preserved.

D. Continuity

Objective

Clinical outcome is enhanced for consumers who can develop ongoing, caring therapeutic relationships with dual competency clinicians and/or integrated programs. Unfortunately, such relationships are difficult to initiate, and are frequently disrupted as a result of changes (by the consumer) in program affiliation. To correct this, managed care entities need to create system structures which promote the initiation and maintenance of continuity of clinical responsibility regardless of point of entry.

Guidelines

- As early in the therapeutic process as possible, dual diagnosed consumers are connected to a clinician or team of clinicians who will maintain a long-term continuous therapeutic relationship.
- Such a relationship does not depend on the consumer's continued abstinence or treatment compliance, on participation in any particular program, or ideally, on maintaining a particular residence.
- Such a relationship is initiated at the consumer's point of readiness, and permits progress at the consumer's pace through incremental increases in motivation and functioning, without imposition of arbitrary outcome criteria that may jeopardize the relationship (e.g., treatment benefits terminated if no abstinence within a certain time frame).
- Integrated continuous treatment teams with mobile outreach capacity are established for consumers with the most difficult and complex problems.
- Similar continuous relationships are established with significant family members, ideally by members of the consumer's primary integrated treatment team.
- Within acute episodes, continuity of clinical responsibility is maintained throughout the episode even if the consumer moves between levels of acute care (e.g., hospital - crisis bed - day hospital).
- Continuity principles extend to participation in peer recovery supports (clubhouses, dual diagnosis groups) and residential supports, so that consumers do not need to change supports or housing as a result of arbitrary time limits.

E. Comprehensiveness

Objective

Dual diagnosis treatment must be individualized to accommodate the specific needs of different subtypes of dually diagnosed consumers in various phases of treatment (and readiness for treatment) for either disease. Unfortunately, consumers often find that dual diagnosis programming is confined to only a few settings, and all consumers may be served with program models designed for only a subgroup. To correct this, it is necessary that dual diagnosis services are the responsibility of the entire system of care, and that gaps in services for specific consumers are identified and addressed.

Guidelines

- Screening/detection of children, especially those who may be experiencing emotional problems, to provide preventive interventions for stopping the occurrence or lessening the duration of using psychoactive substances.
- Each consumer requires dual diagnosis treatment services that are individually matched, based on the specific subtype of dual disorder, specific diagnoses, and the acuity, severity, disability, treatment readiness, and phase of treatment for each disorder.
- Within both acute and long-term care systems, consumers also have access to a comprehensive continuum of service intensities, so that the intensity of service provided is the least restrictive service that accommodates the consumer's needs and preferences.
- Managed care entities need to develop and procure a comprehensive continuum of programs

and services to meet consumers' needs as defined above. This includes requiring all programs to identify specific sub-populations of dual diagnosis patients. It also includes identifying program models that incorporate a range of service intensities.

- Consumers have access to flexible program models in which various service intensities are de-linked and available in a way that targets consumers' specific needs. The independent intensity dimensions include residential, biomedical, nursing, treatment programming, and case management.
- Within any particular program, services are comprehensive as well, including comprehensive assessment, and availability of multi-modality dual diagnosis treatment (individual, group, day activity, skill training, psychopharmacology, etc.).
- All services emphasize the continuing hope of recovery for individuals with comorbid disorders, and focus on helping each consumer to develop attitudes and skills to promote personal rehabilitation and recovery. Comprehensive services also include programs for families of the dually diagnosed, possibly utilizing multifamily groups. Content can include information, education, assistance with resources, skill training, and peer support.
- All services are designed to be sensitive to cultural and gender differences.

2. CONSUMER/FAMILY INVOLVEMENT

Dual diagnosis consumers need to be more than just passive recipients of care. Consumers and families need to be involved in the development and oversight of every aspect of the dual diagnosis delivery system, to ensure adherence to the standards of care described above.

A. Consumer/Family Involvement in Quality Management

Objective

To ensure meaningful consumer/family involvement in dual diagnosis systems development, managed care entities must create formal quality management structures which include dual diagnosis consumers and families in the design and oversight of an integrated continuous and comprehensive delivery system.

Guidelines

- Consumers and families have meaningful input into program design, standards, policies, practice guidelines, staff competencies, and utilization criteria for dual diagnosis.
- Consumers and families have involvement in the design and delivery of training and certification programs for staff treating dual diagnosis.
- Consumers and families are involved in a quality management process, specific for dual diagnosis services, through the design of indicators, the collection and review of data, identification of problems, review of the effectiveness of interventions, and participation on quality improvement teams.
- Consumers and families are involved in the design and implementation of outcome evaluation for dual diagnosis, including assessment of consumer/family satisfaction .

B. Consumer/Family Involvement in Service Delivery

Objective

Managed care entities must provide meaningful opportunities for consumers and families to provide services and support to their peers.

Guidelines

- The importance of peer support and peer recovery in the dual diagnosis continuum of services is supported by the policies and procedures of the managed care entity. All consumers and families have access to dual diagnosis peer support and recovery programs.
- Each dual diagnosis treatment continuum is required to implement accessible peer recovery programs (e.g., Dual Recovery Anonymous, MICAANON, Helpful People in Touch).
- Consumers have access to peer treaters, case managers, and counselors; there is a process for training, credentialing, and reimbursing peer counselors for dual diagnosis consumers and families.
- Consumer-run services may be particularly relevant for dual diagnosis consumers (crisis programs, recovery homes, etc.). Such programs are facilitated and encouraged by the managed care procurement process.

PART II
Standards For Managed Care Systems Regarding Development of a Comprehensive
Dual Diagnosis Continuum

Introduction

The previous section described standards for delivery of dual diagnosis treatment as viewed from the perspective of the recipients of care, consumers and families. This section views the dual diagnosis system from the "top down" perspective of the purchaser of care, usually the public payor system contracting with a managed care entity. The purpose of this section is to guide public purchasers - and systems level advocates (consumers, families, and providers) - in determining performance standards for managed care contractors regarding dual diagnosis services. These standards should answer the following question:

As a public purchaser of managed care services, what should I require from the managed care contractor in order to achieve the best and most cost-effective dual diagnosis treatment system?

General Principles

1. ESTABLISH STANDARDS FOR THE SYSTEM AS A WHOLE

Managed care systems must not view dual diagnosis service capacity merely as a matter of establishing a set of dual diagnosis programs. The high prevalence of comorbidity requires that the whole system of care must be designed to provide integrated, continuous, and comprehensive services to consumers with comorbid disorders (and, of course, single disorders) wherever they present. Consequently, the first set of standards must apply to the design of the system as a whole, and must encompass the system's mission, philosophy, governance, integration, comprehensiveness, and quality management with regard to dual diagnosis.

A. Mission

- The managed care system develops a clear mission statement regarding comorbid disorders.
- The mission statement should be inclusive and proactive in defining target populations, with specific emphasis on providing services to consumers who might otherwise fall through the cracks.
- The "dual diagnosis mission statement" emphasizes consumer-oriented standards of care: welcoming, accessible, integrated, continuous, and comprehensive.

- The mission statement encompasses dual diagnosis consumers of all ages who are served by systems other than mental health and substance abuse service systems: e.g., correctional system, social service system, educational system, medical system, rehabilitation system.

Sample Mission Statement

The mission of the system of care is to develop a welcoming, accessible, integrated, continuous, and comprehensive system of care for all dual diagnosis consumers, both those who are members of traditional priority populations, and those who might otherwise fall through the cracks, and to provide proactive outreach to engage the consumers who are most difficult - those who are homeless, medically ill and/or criminally involved.

The system of care will develop a continuum of services to address the priority needs of all types of consumers, including those with (a) psychiatric disorders and no substance disorder, (b) SPMI and substance abuse, (c) SPMI and substance dependence, (d) substance dependence and other psychiatric disorders/symptoms, (e) substance abuse and other psychiatric disorders/symptoms, and (f) substance disorder and no psychiatric disorder. The system will be accessible to persons at all levels of treatment readiness and motivation within these profiles.

B. Philosophy

The managed care system shall define a philosophic approach to the treatment of psychiatric and substance disorders that is consistent with the mission statement, the available literature, and the implementation of consumer/family oriented standards of care. Key elements of such a philosophy include:

- Comorbidity is an expectation not an exception. Consequently the whole system must be designed to be welcoming and accessible to all types of dual diagnosis. All programs in the system participate in and support this mission.
- Psychiatric and substance disorders are both regarded as primary disorders when they coexist, each requiring specific and appropriately intensive assessment, diagnosis, and treatment, in accordance with established practice guidelines.
- Serious psychiatric and substance disorders are both chronic, relapsing illnesses that can be conceptualized using a disease and recovery model, with parallel phases of treatment or recovery.
- Within each subtype (a-f) of the treatment population, consumers present in different phases of treatment/recovery and in different stages of motivation or readiness for change with regard to either illness. This requires a comprehensive array of interventions that are phase/stage-specific, according to one or more established schema (e.g., Prochaska & DiClemente: - Precontemplation, Contemplation, Preparation, Action, Maintenance; Osher & Kofoed: Engagement, Persuasion, Active Treatment, Relapse Prevention; Minkoff: Acute Stabilization, Engagement, Prolonged Stabilization; Rehabilitation and Recovery; Sciacca: Identification, Engagement, Assessment of Readiness, Treatment Phases 1,2&3, Relapse Prevention, etc.).
- Treatment of individuals with complex, comorbid disorders is provided by individuals, teams, and/or programs with mental health and substance abuse expertise whenever possible.

- The system promotes a longitudinal perspective for dual diagnosis treatment, which emphasizes the value of continuous relationships with integrated treatment providers, independent of specific program participation, phase of treatment, or level of functioning.
- Admission criteria are not designed to eliminate consumers from receiving service but rather promote acceptance of consumers at all levels of motivation and readiness. Specifically, no eligible consumer is excluded from mental health evaluation or treatment due to comorbid substance disorder; no eligible consumer is excluded from substance disorder treatment due to comorbid psychiatric disorder.
- The service system does not begin or end at the boundaries of formal treatment programs; rather, it includes interventions to engage the most detached individuals, (e.g., homeless dually diagnosed persons) who are alienated from all helping systems and/or are unable to recognize their disorders and ask for help effectively.
- The fiscal and administrative operation of the system supports the accomplishment of its mission and the implementation of its philosophy (see next section).

C. Structure and Governance

- 1) The structure and governance of the managed care system must be designed to support the accomplishment of its mission and the implementation of its philosophy.
 - Management of substance treatment funds and mental health treatment funds is fully integrated at every level of organization in the managed care system.
 - System oversight and accountability incorporates equal representation from both substance and mental health treatment systems, and includes representation from other systems with which service integration for dual diagnosis is necessary [see D. below].
 - The organizational structure for clinical operations integrates mental health and substance abuse oversight and expertise in each region, and at each operational level.
 - Centralized quality management structures focus separately and equally on the quality of primary mental health treatment and primary substance disorder treatment as delivered in each type of integrated treatment program model throughout the provider network continuum.
- 2) The fiscal and administrative operations of the managed care system support the implementation of integrated services.
 - Policy and procedure manuals reflect the expectation that all programs will be treating dually diagnosed consumers.
 - Utilization management, reimbursement, and MIS requirements acknowledge reporting of multiple primary diseases, and integrated service interventions.
 - The public payor and managed care entity define a common system of cost accounting for psychiatric and substance disorder services, and monitor data carefully to emphasize collaboration, not cost shifting.
 - The public payor and managed care entity establish a single point of billing for dual diagnosis providers, in order to facilitate provider ability to be reimbursed for dual diagnosis services, i.e., it is not necessary to submit two bills; one for mental health services and another for substance abuse services.

D. Integration

The complex needs of dual diagnosis consumers require proactive attention to integration across traditional service boundaries.

1) Integration of Addiction and Psychiatric Services

In addition to integration of structure, governance, and administrative operations, the managed care entity should promote the integration of clinical services and operations as well, through the following initiatives:

- Establishment of cross-training and dual competencies for its own clinical staff.
- Expectation that all network programs will provide integrated assessment and treatment for a defined cohort.
- Expectation that all network clinicians will develop integrated expertise relevant to their speciality functions.

2) Integration of Acute Care and Long-Term Support Services

In all systems, but especially those based on managed Medicaid, the interface between acute (Medicaid reimbursable) services and long-term care (mental health clubhouse, residential, addiction half-way house, care coordination) can be problematic. Dual diagnosis consumers require continuity, but are also more likely to fall through the cracks in transition.

- Consumers with comorbidity are identified as a priority for long-term care and continuity.
- Policies, procedures, and interdepartmental monitoring structures are in place to facilitate the transition from acute care to long-term care.
- Integrated care coordination by the system is maintained in both acute and long-term care settings.

3) Integration of Insured and Uninsured

Dual diagnosis consumers, especially those without SPMI, are more likely to be uninsured, and are highly represented in the uninsured population seeking acute treatment. The managed care system structure incorporates responsibility for all dual diagnosis consumers, independent of funding source, and develops innovative strategies for integrated provider reimbursement from the pool of public funds

(mental health, substance abuse, Medicaid, etc.). This integrated reimbursement can be accessed by the providers' submission of one bill for dual diagnosis services to one point of billing, rather than requiring both a bill for mental health services and a bill for substance abuse services.

4) Integration With External Systems

a) *Children, Adolescents, and Families:* The managed care entity will develop and describe a set of formal structures, plus create and reimburse program models for integrating medical (including pre-natal), social service, educational, and juvenile justice services to adolescents and families with active comorbid disorders.

b) *Adults in Correctional Facilities:* The managed care entity will develop and describe a set of formal structures, plus create and reimburse program models for implementing an integrated system of dual diagnosis services for prisoners, parolees, and probationers. This will include models for case management via the parole system, and using wrap-around mental health/substance abuse services in pre-release and post-release residential settings.

c) *Rehabilitation Services:* The managed care entity will collaborate with social and vocational rehabilitation programs to ensure accessibility of such programs to consumers with dual diagnosis, and provide appropriate staff training to work with such consumers to meet this goal. Policies and procedures governing rehabilitation services for dually diagnosed consumers should be developed with collaborative input from the managed care entity and the mental health and vocational rehabilitation agencies. In addition, program models should be developed to encourage integration of vocational/rehabilitation expertise into integrated dual diagnosis treatment and case management teams.

d) *Housing Services:* The managed care entity should foster a collaborative, ongoing process between mental health housing providers, addiction recovery housing providers, shelter providers, homeless outreach advocates/street workers, and mental health/substance abuse treatment providers to establish the elements of a comprehensive integrated housing continuum, and to create a plan for implementation of such a continuum with existing service dollars. The managed care entity might facilitate such implementation by considering financial incentives for development of innovative housing models to reduce acute care utilization.

E. Comprehensiveness

The managed care entity must provide a model for a comprehensive service system, based on existing established models in the literature (e.g. Minkoff), to accomplish the implementation of its mission and philosophy. This comprehensive model should include the following:

- A comprehensive array of acute, subacute, and outpatient dual diagnosis services within each geographic region, to accommodate major subtypes of dual diagnosis, at each level of service intensity, at each phase of treatment, and at all levels of treatment readiness and motivation.
- An array of tertiary or specialized services that are available to multiple regions (or even state-wide). Ex: dual diagnosis continua for hearing impaired persons, linguistic/cultural minorities, "triple diagnosis" (e.g., PTSD/dissociative disorder, eating disorder, substance disorder), developmentally disabled, etc.

- An array of "non-reimbursable" services provided in collaboration with other agencies (see Section D) - housing models, correctional services, family/child social services, rehabilitation services, etc.
- Outreach services to identify dual diagnosis consumers who are on the streets, or who are disengaged from traditional access to treatment.
- An array of integrated case management services, with varying intensities and specializations, to ensure continuity of care for all types of consumers.
- Availability of preventive services to target psychiatric populations at high risk of developing co-occurring substance disorder.

F. Quality Management

- The managed care system establishes a quality management system that incorporates oversight of treatment of both psychiatric and addictive disorders in integrated settings.
- The system includes both internal quality management personnel with psychiatric and addiction expertise, and an oversight body (e.g., Quality Council) which includes representation from dually diagnosed consumers, their families, and the various agencies which provide services to such individuals (see Section D).
- The quality management system includes identification of comorbidity as high risk, problem-prone event, and develops a series of indicators to monitor access, structure, process, and outcome for dual diagnosis services.
- Management and reimbursement information systems are designed to collect data specific for dual diagnosis and relevant to those indicators.
- Performance incentives and penalties for the managed care entity are related to these dual diagnosis quality measures.
- Outcome data are longitudinal, and utilize measures (e.g., Substance Abuse Treatment Scale (SATS), from McHugo, et al.) which assess progress in treatment participation and readiness as well as specific events or behaviors (e.g., abstinence, hospitalization).
- Progress can be measured by incremental amelioration of substance abuse and reduction in adverse consequences, not only by attainment of abstinence.
- Cost and effectiveness of integrated interventions are regularly assessed utilizing this outcome data.

2. ESTABLISH STANDARDS FOR THE CONTINUUM OF SERVICES

In addition to structuring the entire managed care operational system in such a way as to promote the accomplishment of the dual diagnosis mission, the managed care entity must also establish standards for the service system itself, to ensure that all clinical operations are also directed to the accomplishment of that same mission.

A. Practice Guidelines

The managed care entity adopts comprehensive dual diagnosis practice guidelines and promulgates them to all programs and providers in the network. (See Part III for practice guidelines).

- Practice guidelines include standards, policies, and peer review procedures for psychopharmacologic practice with dual diagnosis individuals.

B. Comprehensive Program and Service Manual

The comprehensive continuum model defined above is implemented in the form of a program manual which defines every program type in the continuum of care, and matches the service that each program provides to subtypes of dual diagnosis consumers and various levels of service intensity and treatment readiness.

This manual identifies the basic mandate for integrated services in traditional programs (inpatient, detoxification, outpatient), as well as defining new integrated program models that address system gaps.

The Patient Placement Criteria for the treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM), Second Edition, PPC-2, provides one recognized model of a comprehensive continuum of care, specifically for addictive disorders.; modification of ASAM PPC-2 represents one of several possible approaches to defining such a continuum for individuals with dual diagnosis. Other models, as yet unpublished, are referenced in the accompanying bibliography.

At minimum, a comprehensive continuum of care for dually diagnosed consumers will include the following components:

Acute or Intensive Services including:

- l24-hour integrated psychiatric and substance triage and assessment capacity
- lntegrated psychiatric and substance disorder crisis intervention and crisis counseling
- lcrisis stabilization beds which can accommodate substance involved individuals in mental health crisis
- lacute psychiatric inpatient beds, with dual diagnosis assessment and stabilization capacity
- lntegrated psychiatric and addiction or dual diagnosis specialized acute psychiatric units
- lintermediate or long-stay psychiatric inpatient beds for severely mentally ill consumers with coexisting substance disorders
- lacute detoxification programs, (ASAM Levels I-IV) which can accommodate individuals with stable comorbid psychiatric conditions
- lpsychiatrically-enhanced detoxification programs, which can accommodate more psychiatrically unstable addicted individuals
- lsubstance dependence residential rehabilitation programs, which can accommodate individuals with stable, comorbid psychiatric conditions
- lpsychiatrically-enhanced or dual diagnosis residential substance rehabilitation programs, for more unstable individuals
- lntegrated partial hospitalization programs, for acute stabilization of psychiatric and substance disorders
- laddiction day treatment and intensive outpatient programs, with capacity to accommodate consumers with stable psychiatric illness
- lpsychiatric day treatment/clubhouse/rehabilitation programs with dual diagnosis programming for SPMI individuals with comorbid substance disorders
- lntegrated intensive continuous case management services (individuals or teams) for all types of dual diagnosis consumers (not just SPMI)
- loutpatient services incorporating integrated mental health and substance abuse treatment capacity,

with authorized reimbursable services including:

- lmental health and substance disorder assessment
 - lindividual/family case management and case coordination
 - lindividual treatment (mental health, substance disorder, or both)
 - lpsychopharmacologic assessment and treatment
 - lgroup treatment (engagement/persuasion, active treatment, relapse prevention groups)
 - lfamily treatment, including individual and group psychoeducation, and peer support (MICAA-NON)
 - lrehabilitation counseling
 - lpeer counseling, and peer support groups (Dual Recovery Anonymous, Helpful People Touch)
- (Peer support services may not be reimbursable)

In

Residential Services including:

- laddiction halfway houses, therapeutic communities, and sober houses, with capacity to accommodate individuals with psychiatric illness (but not severe disability)
- lpsychiatric residential continuum for SPMI consumers (group homes, safe havens, and supported housing models) which incorporates “wet,” “damp,” and “dry” housing
- ldual diagnosis case-managed supported sober housing
- ldual diagnosis modified therapeutic communities
- ldual diagnosis sober psychiatric group home and recovery programs

Special Programming

Special programming in each area may be required for adolescents, trauma survivors (especially women), individuals in the criminal justice system, and individuals with special needs (linguistic/cultural minorities, developmentally disabled, head injured/cognitively impaired, sight/hearing impaired, etc.). These special programs must ensure a customer service approach that reflects sensitivity to the special needs of these populations. Organizational policy should state that to comply with this all staff members must receive additional training to emphasize an integration of clinical and non-clinical interventions. Generic care givers (child welfare workers, teachers, police or correctional officers, vocational counselors) as well as administrative, custodial, housekeeping, and security personnel are specifically educated in matters such as confidentiality, security, and appropriately sensitive behavioral management of difficult individuals and families. Generic care givers, as defined above, should become integral parts of the strategy planning of management interventions that will be sensitive and appropriate to the individuality of the consumers within the specific institutional or programmatic setting. On the other hand, the particular demands of these special settings (e.g., schools, jails) must be clearly communicated to consumers within a context of clear guidelines to address their special needs.

C. Utilization Management Manual

This manual defines admission, continuing stay and discharge service intensity criteria for each program type listed in B. above, and defines utilization parameters (length, frequency, and number of sessions) for each reimbursable service type listed in B. above.

Acute utilization criteria do not define linear "levels of care," but rather address multiple independent dimensions of service intensity (psychiatric/medical, nursing, residential, treatment/program, and case management).

Outpatient utilization parameters do not assume a short-term, time-limited focus, but rather assume a need for time-efficient continuing case management and intervention.

All utilization criteria assume that comorbidity may be present, and define the impact of two interacting conditions on service intensity requirements (e.g., severe disabling chronic psychosis plus alcoholism needing detoxification and rehabilitation).

D. Service Intensity Assessment Methodology

Based on the Utilization Management Manual, the managed care entity implements a system-wide instrument for both psychiatric and substance disorder service intensity assessment (e.g., Level of Care Utilization System [LOCUS 1.5], developed by the American Association of Community Psychiatrists [AACCP]), to standardize methodology and data collection in this area.

E. Access Standards

The managed care entity defines system-wide access standards for all service types in the manual (B), to minimize the extent to which individuals are denied service due to comorbidity. Sample standards may include the following:

- Crisis services will not refuse to initiate assessment on consumers who are intoxicated, but rather endeavor to evaluate such consumers for appropriate dual diagnosis services.
- Psychiatric outpatient programs will not refuse services to clients who are actively using substances who otherwise meet entry criteria.
- Addiction services will not refuse access to clients who are taking psychotropic (non-addictive) medication, but who otherwise meet entry criteria.

F. Program Standards

Each program model listed in the manual (B) will be able to reference specific sets of program standards (e.g., licensure or certification requirements) that define staffing requirements, quality management/utilization management requirements, and so on. For established program types (e.g., inpatient), the managed care entity will define minimum standards for dual diagnosis services (e.g., mission

statement, philosophy, access, specific policies, training, staff competencies, program content). For new integrated models of services, the managed care entity elaborates program descriptions and standards in even greater detail.

Relevant program standards are compiled in a program standards manual.

G. Staff Competencies

The managed care entity uses established Practice Guidelines (see Part III) to define competencies for various types and levels of dual diagnosis clinicians, and to incorporate these defined competencies into staffing requirements for various program models. (See Part IV)

Competency-based training is sponsored - and mandated - by the managed care entity, to facilitate the ability of programs - and staff - to meet these requirements. Such trainings are derived from established dual diagnosis curricula. (See Part V)

H. Continuity Standards

The managed care entity identifies outpatient and case management programs which are required to assume primary clinical responsibility for and provide continuity of care to dual diagnosis consumers, and defines the extent of the continuity mandate for each program, based on the type of clients it serves, and the level of non-compliance it can be expected to accommodate.

The managed care entity also identifies program models and access standards for dual diagnosis consumers who require ongoing case management services but are not eligible for usual case management entitlements (e.g., not SPMI).

I. Formulary Standards

System-wide formulary standards acknowledge comorbidity as an indicator for utilization of more expensive "second-line" medication (e.g., clozapine, neurontin, naltrexone), in that more effective medical treatment for the primary psychiatric disorder might enhance outcome of the primary substance disorder, and vice versa.

J. Outcome Measurement Policies

Outcome instruments utilized by programs within the system (both satisfaction surveys and clinical outcome measures) are designed to report data for both psychiatric and substance disorders for each consumer.

Consequently, outcome evaluation begins at the onset of service for each consumer with assessment or measurement of the following three dimensions: level of readiness and motivation to engage in treatment, acuity and severity of symptomatology (e.g., substance abuse vs. substance dependence), and the level of functional disability associated with both psychiatric and substance disorders.

Clinical outcome is then best measured at intervals, by assessing incremental progress in each of the three dimensions.

Changes in level of readiness can be measured by:

- l increased ability to discuss or recognize symptoms
- l increased insight and acceptance of disorder and need for treatment
- l increased ability to identify and address relapse triggers
- l self-report of willingness to adhere to treatment recommendations
- l progress through stages of treatment participation

Changes in symptomatology can be measured by:

- l stages of remission per DSM-IV criteria (e.g., for substance disorder, early full remission, early partial remission, sustained full remission, sustained partial remission)
- l reduction or elimination of one or more psychiatric symptoms
- l reduction or elimination of use of one or more substances
- l decrease in use of hospital and crisis services, or other indication of "harm reduction"

Changes in disability can be measured by:

- l improved psychosocial functioning
- l increased housing stability
- l reduction of criminal/legal involvement

The quality and effectiveness of care delivered by programs within the system is determined through the use of clinical outcome measures. As a standard, the literature indicates that the most effective programs currently achieve sustained abstinence rates of 10-15% per year for dually diagnosed consumers who have SPMI (Drake, Mueser, et al. 1996), approximately the same rate as for addicted consumers without mental illness. However, sustained abstinence rates are relatively crude measures of outcome; abstinence as an outcome measure is always augmented by other measures of progress in treatment.

K. Cultural Competency

Integrated programs must adhere to the same standards for cultural, linguistic, and gender competency as apply to the system as a whole.

3. ESTABLISH STANDARDS FOR EACH PROGRAM WITHIN THE CONTINUUM

Managed care entities implementing integrated systematic dual diagnosis treatment must define standards and expectations for each program or component of the service system with regard to two elements:

1) The definition or purview of the program, with respect to both dual diagnosis clients, and, where applicable, clients in general.

AND

2) The criteria for staffing, policies/procedures and program content which define the program's competence to provide services to individuals with comorbid disorders.

These standards will be discussed with regard to each major program type within the continuum.

A. Emergency/Triage/Crisis Services

Definition/Purview

Emergency services with dual diagnosis capacity provide twenty-four hour availability to perform crisis assessment - on site or mobile - for patients with psychiatric and/or substance disorders with any type of clinical presentation.

Program Content

All clients receive an integrated crisis assessment of both substance disorder and psychiatric symptoms that have contributed to the presenting crisis. The assessment includes evaluation of client's detoxification needs (using formal withdrawal scales) and substance disorder treatment readiness, as well as evaluation of safety needs, mental status and mental health treatment willingness. The goal of the assessment is (a) to determine the most appropriate service intensities ("level of care") to address the patient's need for crisis stabilization, using approved utilization management criteria, AND (b) to identify the most appropriate means to engage the individual in ongoing beneficial treatment for either substance or psychiatric disorder or both.

All staff have basic competency to perform these integrated assessments, and are expected to convey positive, welcoming, attitudes to all clients indicating that the primary role of the crisis service is to help people enter treatment, not to screen them out.

Crisis services also offer the capacity to provide brief crisis intervention, including follow-up crisis visits, psychopharmacology assessment, and family crisis interventions, as well as referral to ongoing intensive outpatient services, including outpatient detoxification.

Program policies and procedures mandate that the assessment process begins at the point of initial contact. Clients should not wait until they are "sober", or until attainment of an arbitrary alcohol/drug level, for assessment to be initiated. Clients are also not required to have "medical clearance" unless there is a clear clinical indication.

B. Crisis Stabilization Beds

Definition/Purview

Crisis stabilization bed programs are short-term, non-hospital residential services that provide emergency intervention to clients in psychiatric crisis. Crisis stabilization must have dual diagnosis capacity, in order to accommodate clients in psychiatric crisis who are also intoxicated, and where substance use may exacerbate psychiatric symptomatology, but who do not require medically monitored detoxification.

Program Content

The program provides twenty-four hour staffing with available nursing and psychiatric consultation. All clients receive staff support and monitoring, crisis assessment and intervention, supervision of

medication and administration of PRNs, contact with collateral care givers/treaters/family members to assist in crisis resolution, education and engagement strategies regarding both psychiatric and substance difficulties, and development of an aftercare plan and follow-up linkage.

The goal of treatment for dual diagnosis consumers is both (a) to safely stabilize the acute crisis and (b) to encourage appropriate engagement in ongoing psychiatric and substance treatment. In this regard, all staff must have basic competency in discussing mental health and substance abuse issues, as well as positive, welcoming attitudes toward substance using consumers.

The program provides twenty-four access for admissions, without arbitrary requirements for prior medical clearance, threshold alcohol levels, and so on. The program provides daily access to psychopharmacology consultation and nursing supervision.

C. Detoxification Services

Definition/Purview

Detoxification programs with required dual diagnosis capacity provide supervised detoxification for substance dependent individuals at a variety of levels of treatment intensity as defined by ASAM criteria (Levels I, II, III, IV), including individuals with comorbid psychiatric disorders which are relatively stable or which are transiently exacerbated by substance dependence, but which are expected to return to baseline following detoxification. Required treatment intensity (Levels I-IV) is in part determined by scoring on the emotional/behavioral ASAM dimension of assessment (PPC-2), in addition to five other dimensions. The six assessment dimensions of the ASAM PPC-2 are as follows:

- 1) Acute Intoxification and/or Withdrawal Potential
- 2) Biomedical Conditions and Complications
- 3) Emotional/Behavioral Conditions or Complications
- 4) Treatment Acceptance/Resistance
- 5) Relapse/Continued Use Potential
- 6) Recovery Environment

Program Content

The goal of treatment is safe detoxification while maintaining psychiatric stabilization, and referral to appropriate ongoing treatment for both disorders. In addition to providing the standard elements of the various levels of detoxification services, detoxification programs have access to psychiatric consultation and regular psychiatric nursing monitoring. Nursing and counseling staff demonstrate welcoming and accepting attitudes to consumers with psychiatric symptoms and disorders, and are trained in assessment, treatment, and management of behavioral disorders. Patients are routinely maintained on pre-existing regimens of psychotropic medication during detoxification, and the program has the capacity to administer PRNs and make minor medication adjustments. Clients receive assessment of and coordination with their mental health treatment system, as well as intensive

education and engagement interventions regarding substance disorder. Appropriate aftercare plans and linkages are developed for both psychiatric and substance disorder.

Procedures and protocols are established for early identification of clients whose medical or psychiatric needs exceed the capacity of the program, and for having readily available barrier-free access to emergency services for assistance in triaging such clients and transferring them to more appropriately intensive services.

D. Psychiatric Inpatient Services

Definition/Purview

Psychiatric inpatient services provide hospital level of care to patients who require the most intensive services - daily psychiatric management, twenty-four hour skilled nursing, and capacity for secure holding (restraint, seclusion, involuntary commitment). Psychiatric inpatient services may provide dual diagnosis services at two levels - basic (required of all hospitals) and specialized (designated specialty or tertiary care providers only).

Program Content

Basic - The goal of basic dual diagnosis services is to provide accurate identification and diagnosis of comorbid psychiatric and substance disorders, stabilize both psychiatric and substance disorders (using established detoxification protocols when indicated), and to endeavor to engage such individuals to accept appropriate referral for ongoing psychiatric and substance disorder assessment.

In such settings, substance disorder assessment tools are used routinely to facilitate detection. All staff are trained in substance disorder assessment including determination of diagnosis and stage of treatment readiness; in addition, there are key staff with substance abuse treatment certification and/or expertise. Group programming is designed on the assumption that comorbidity is an expectation, so that substance related issues (in patients or families) are addressed on a daily basis through psychoeducational programming. Family system assessment routinely evaluates for the presence of substance disorder in the family, as well as gathering data on the patient's substance use and factors which may influence change. Substance disorders, when present, are identified clearly on problem lists in treatment planning, and specific goals, objectives, and interventions are documented. Discharge planning staff are familiar with substance disorder and dual diagnosis resources, in order to facilitate referrals.

Specialized - Specialized services are either dual diagnosis programs (treat only dual diagnosis) or integrated psychiatry and addiction programs (treat either disorder separately as well as together). In addition to the goals of the basic service, the goal of specialized inpatient services is to provide accurate assessment, diagnosis, and treatment recommendations for patients with comorbid disorders that are unusually complex or confusing, to provide simultaneous intensive recovery-based treatment for both substance abuse/dependence and acutely unstable psychiatric disorders or to provide intensive substance dependence treatment for patients with severely disabling chronic psychiatric disorders, and to engage patients with comorbid disorders to participate in an ongoing dual recovery program of treatment upon discharge.

In order to accomplish this goal, specialized programs provide all the basic services, plus the following:

- (a) integrated psychiatric and substance assessment methodology
- (b) predominantly cross-trained staff
- (c) psychiatry staff (especially medical director) with dual diagnosis experience and/or addiction certification
- (d) group program with a full schedule of substance disorder and/or dual diagnosis focused groups
- (e) active involvement of peer support and recovery programs (for patients and families)

E. Residential Rehabilitation

Definition/Purview

Psychiatrically-enhanced acute or subacute residential rehabilitation programs provide a safe, staffed, sober environment in which individuals with comorbid disorders who are at least partially stabilized can continue to receive education and training in the development and utilization of recovery skills for both disorders. Dual diagnosis residential rehabilitation services vary in the intensity of staffing, level of client functioning, availability of nursing and psychiatric monitoring, length of stay, and intensity of case management. Each program must define these parameters in relation to its specific target population within the continuum of care.

Program Content

All clients receive an integrated assessment which identifies recommendations for stabilizing treatment for each disorder, and defines specific recovery skills which must be attained in order for the client to “step down” to a less intensive setting. Clients receive psychopharmacologic monitoring and medication adjustment, individual and group counseling and education, occupational therapy (development of social, recreational, and independent living skills), family education and counseling, and program-based case management. All staff are cross-trained to demonstrate competency with both psychiatric and substance disorder rehabilitation. Involvement in mental health and addiction peer recovery programs is strongly emphasized and facilitated.

Program structure maintains baseline expectations for abstinence and treatment participation, but also demonstrates the ability to individualize expectations based on clinical need. Clients who are discharged or transferred due to substance use and/or non-compliance are encouraged to return, and provided with attainable readmission criteria. Program will often include recovering peer counselors, and may be consumer-operated.

Residential rehabilitation programs may be integrated with - and share staff and/or programming with - inpatient, detoxification, crisis stabilization, and/or day treatment/intensive outpatient programs.

F. Day Treatment/Intensive Outpatient

Definition/Purview

Dual diagnosis day treatment/intensive outpatient programs encompass a wide range of acute,

subacute, and long-term programs which provide structured outpatient dual recovery interventions. Day treatment programs (9-42 hours/week) may include:

- Acute dual diagnosis partial hospitalization, in which clients receive intensive short-term (1-4 weeks) stabilization of both psychiatric and substance disorder
- Psychiatrically-enhanced addiction day treatment, in which clients with comorbid psychiatric conditions (but who are not SPMI) receive intensive addiction rehabilitation
- Intermediate dual diagnosis rehabilitation, in which severely ill or disabled clients receive longer-term (1-3 months) structured abstinence orientation and psychiatric rehabilitation
- Long-term dual diagnosis day treatment, in which pre-motivational clients with SPMI receive intensive engagement programming and case management in a psychiatric rehabilitation setting.

Intensive outpatient programs (3-12 hours/week) - including evening treatment programs - may include:

- Acute intensive crisis stabilization, in which clients receive crisis intervention addressing both psychiatric and substance issues.
- Dual diagnosis outpatient detoxification - a variation of crisis stabilization, which incorporates a formal detoxification protocol for clients with mild-moderate substance dependence
- Psychiatrically-enhanced addiction treatment (see above)
- Intensive integrated case management, which engages pre-motivational clients over an extended time frame.

Program Content

Although there clearly is great variability in these programs, they all share certain characteristics:

- Cross-trained multi-disciplinary staff
- Integrated assessment, treatment planning, and case management
- Coordination with outside care givers, residential settings, and families
- Continuing psychopharmacologic monitoring
- Individual and group treatment
- Utilization of peer recovery programming
- Dual recovery philosophy with emphasis on strengths, skill development, and social/vocational rehabilitation

Some programs will include recovering peer counselors, and some may be consumer operated.

Day treatment and intensive outpatient programs may be integrated with and share staff and/or programming with inpatient, residential rehabilitation, detoxification, and/or crisis stabilization programs.

G. Intensive Integrated Case Management

Definition/Purview

Intensive integrated case management services are flexible client-centered interventions which engage clients at any stage of readiness, and wherever they present. Such services are characterized by mobility, outreach, continuity, and provision of non-traditional services. Services may be provided by individual clinicians, or by multi-disciplinary teams. Clients with more severe instability are usually better served with a team approach; team interventions can vary in intensity (e.g., staff/client ratio) based on level of severity.

This treatment model includes a number of specific interventions, described in the literature, which are targeted to people with SPMI (e.g., Continuous Treatment Teams; Assertive Community Treatment Teams; PACT model). However, this intervention can be targeted to individuals with psychiatrically-complicated substance disorders as well. Some programs define specific subpopulations (pregnant/parenting women; HIV positive, trauma survivors); others incorporate a broad range of clients.

Program Content

Individual clinicians must demonstrate dual competency. Case management teams develop shared competencies across multiple areas of expertise.

Programs provide integrated assessment, diagnosis, and treatment planning; crisis intervention; individual, group, and family counseling; individual and group pre-motivational interventions; comprehensive care coordination and resource brokering, social and vocational rehabilitation counseling; money management (payeeship); behavioral contracting; and continuous psychopharmacologic management. Most teams will include a psychiatrist and/or psychiatric nurse prescriber.

H. Outpatient

Definition/Purview

Dual diagnosis outpatient services provide integrated assessment, treatment planning, and ongoing treatment to a full range of dual diagnosis clients, including:

- SPMI clients with stabilized substance disorders (high-low, high-high) who require pre-motivational interventions
- Psychiatrically complicated substance dependent (low-high) clients (non-SPMI) who require stabilization, engagement, or relapse prevention for one or both disorders
- Clients with substance abuse and less serious psychiatric symptomatology (low-low) who require ongoing assessment and treatment

Dual diagnosis outpatient services may be a subcomponent of an existing outpatient service - or, the entire service may be integrated.

Program Content

The following components are required:

- A cadre of dual competency staff
- A system for client access to assessment by cross-trained staff without requiring categorization (as mental health or substance abuse)

- Inter-disciplinary treatment planning by dual competency staff
- Ongoing simultaneous individual assessment and treatment of both disorders, at any stage of readiness
- Family assessment, engagement, education, and intervention regarding both disorder
- Access to a full range of phase-specific substance groups for clients receiving individual psychotherapy and/or psychopharmacology services.
- Access to psychopharmacology evaluation and management, and to a full range of psychiatric group programming (e.g., trauma-survivor groups; dialectical behavioral therapy groups) for clients receiving individual substance disorder treatment
- Individualized continuing care coordination for both disorders by primary clinician.

I. Residential

Definition/Purview

Dual diagnosis residential services include a comprehensive continuum of residential models that address a wide range of needs. Although residential services are usually not reimbursed as a component of managed Medicaid, they are essential to treatment success and to reduction of utilization of more expensive acute services.

Residential services can be categorized according to level of psychiatric disability (SPMI - requiring continuing staff support to maintain basic living skills vs. non-SPMI - requiring little or no independent support) and level of substance use expectation (e.g., wet, damp, or dry). Dry housing requires abstinence; residents will be asked to leave after a finite number of lapses, damp housing encourages but does not require abstinence, but does require moderation, and will extrude residents who are out of control or disruptive. “Wet” housing is accessible to individuals who are actively using substances addictively. Models may include traditional staffed group homes, case managed supported housing (individual or group), modified therapeutic communities, and psychiatrically-supported shelters.

Program Content

Staff competency and intensity must match the level of disability of the residents. In addition, staff competency must match the program mandate: e.g., sober (dry) housing staff need competency in substance recovery and relapse prevention; “damp” housing staff in motivational enhancement and substance education; wet housing staff in pre-motivational outreach and crisis management.

Most programs will offer some phase-specific groups, as well as individualized counseling, case management, social and vocational rehabilitation, leisure skills training, living skills training, money management, and close monitoring.

PART III
Practice Guidelines for Dual Diagnosis Treatment in Managed Care Systems

In contrast to the previous two sections, focusing respectively on the recipients of care and the system of care, this section focuses on the provision of treatment and the providers of care. The purpose of this section is to outline a set of specific practice guidelines, based on the available literature, for treating individuals with co-occurring disorders. These practice guidelines should answer the following question:

As a clinical provider of services to people with dual disorders in a managed care system, what services should I (or my program) be prepared to offer in order to deliver the best and most cost-effective dual diagnosis treatment?

1. General Principles

Regardless of programmatic setting or type of service, there are general clinical principles which are necessary for successful treatment of people with co-occurring disorders. (This section is based on Drake RE, Bartels SJ, et al.: Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disorders 1993;181:606-611).

A. Empathy

Empathy is the cornerstone of all treatment, particularly for individuals who are perceived as “non-

compliant” or “system misfits.” Clinicians must communicate understanding and acceptance of the consumer’s struggle with adherence vs. resistance to treatment/treaters.

B. Optimism/Hope

Clinicians must convey meaningful hope to individuals who often have profound despair, hope based in the recognition that dual recovery can restore dignity, pride, self-worth, and mastery to individuals who may believe these are no longer possible.

C. Integration

Regardless of treatment setting, clinicians must be prepared to assess and address both psychiatric and substance disorder issues throughout the treatment process.

D. Individualization

There is no one type of dual diagnosis intervention; clinicians must be prepared to match treatment to the acuity, severity, disability, motivation, stage or phase of treatment, and specific diagnoses of each individual.

E. Assertiveness

Dual diagnosis treatment requires clinicians to be active in continually structuring (and restructuring) treatment interventions to engage the consumer in the treatment process.

F. Flexibility

People with co-occurring disorders have constantly changing needs in a treatment that has few rules; clinicians must go with the flow.

G. Longitudinal Perspective

Regardless of treatment setting, or the length of a particular episode, clinicians must maintain a focus on the importance of continuity, and on the relationship of any particular intervention to the long-term process of dual recovery.

2. Assessment Guidelines

(a) The assessment process begins at the point of initial clinical contact, regardless of the consumer’s clinical presentation.

(b) Initiation of assessment should not be made conditional on arbitrary criteria such as length of abstinence, non-intoxicated alcohol level, negative drug screen, and so on. At times, disposition may be made conditional on these factors, but this is done on a case-by-case basis only.

(c) Assessment requires establishing an empathic, detached, and accepting stance, to facilitate

honesty and minimize denial.

(d) Assessment is integrated and longitudinal, gathering a chronological history of the symptoms, treatment, treatment response, and attitudes about treatment for both disorders over time, emphasizing factors that have contributed to - or inhibited - previous recovery efforts.

(e) Assessment addresses biological, psychological, familial, and social/environmental dimensions, and identifies problems in each area. Assessment includes four components: detection, diagnosis, description, and determination of treatment requirements.

(f) Detection: In many mental health or substance abuse treatment settings, structured instruments are helpful to insure early detection. and appropriate data gathering, as well as to permit outcome monitoring. Instruments for assessing substance use disorders in people with psychiatric disorders include: CAGE, Michigan Alcohol Screening Test (MAST)/DAST, Addiction Severity Index (ASI), Alcohol/ Drug Use Scale, Substance Abuse Treatment Scale (SATS); instruments for assessing psychiatric disorders in people with substance disorders include: SCID, Brief Symptom Inventory (BSI), Beck Depression Inventory, Hamilton Scales, Dissociative Experiences Scale.

(g) Diagnosis: In people with comorbid disorders, establishing an accurate diagnosis of one disorder often requires that the other disorder is at baseline. However, treatment must usually be initiated when neither disorder is at baseline. Consequently, initial diagnoses are often presumptive, and are subject to continual reassessment and revision as treatment progresses.

(h) Description: Accurate treatment matching goes beyond diagnosis. Each disorder must be described in detail according to the following dimensions:

Acuity

Severity

Disability

Functionality

(e.g., cognitive abilities/disabilities, physical limitations, medical problems)

Symptomatology

(e.g., specific drugs used, patterns of use, consequences, dependence/withdrawal, positive vs. negative symptoms)

Recovery Factors

(e.g., factors which support or inhibit recovery or support symptoms)

continued

(i) Determination of Treatment Needs: Treatment requirements are determined by more than specific diagnosis and description of each disorder. Other determinants include:

Dual Diagnosis Subtype

(e.g., low-low, low-high; high-low; high-high - & Miller, 1993)

Ries

Stage of Change/Motivation(pre-contemplation, contemplation, preparation,

action, maintenance - Prochaska & DiClemente, 1992)

Phase of Treatment

(acute stabilization, engagement, active treatment/

Minkoff,		maintenance, rehabilitation and recovery - 1989) (engagement, persuasion, active treatment, relapse prevention - Osher & Kofoed, 1989)
	Current Treatment and Support Systems Resources	(case manager, therapist, psychopharmacologist, family, peer support, housing, day structure)
used	Quality of Treatment	(extent to which available resources are being
	Participation	appropriately)
	Utilization Management Criteria	(matching illness severity determination to service intensity criteria for available dual diagnosis programming, both inpatient and outpatient - e.g., ASAM PPC-2 criteria, LOCUS 1.5)
system,	Involvement of Collaborative Treatment Systems	(correctional system, vocational rehabilitation child protective system)

3. Treatment and Rehabilitation Guidelines

(a) Treatment is integrated and longitudinal. Regardless of point of entry into the service system, the consumer with dual diagnosis is connected as quickly as possible to an individual or multi-disciplinary team of individuals who have integrated mental health and substance abuse disorder expertise. The multi-disciplinary team may include expertise in mental health case management, substance abuse counseling, family systems, psychopharmacology, and rehabilitation.

(b) This individual (or multi-disciplinary team) serves as the consumer's primary clinician/case manager, and maintains a therapeutic relationship that provides care coordination independently of participation in any particular type of treatment.

The primary clinical relationship is expected to continue to be available even if the consumer is treatment non-compliant, failing to make progress, or relapsing.

(c) At any point in time, treatment interventions are prescribed based on the assessment process, and individualized according to specific diagnosis, subtype of dual disorder, phase of treatment/stage of change, and acuity/severity/disability for each disorder.

(d) At any point in time, treatment intensity (level of care) is prescribed based on the factors listed above (in (b)), plus a multidimensional assessment of service intensity requirements, addressing dimension of intensity of residential support/safety; biomedical (nursing,

psychiatric) intensity; treatment program intensity; and case management intensity, and utilizing established dual diagnosis utilization criteria developed in the context of an integrated dual diagnosis continuum of care. This assessment can be facilitated using the six ASAM assessment dimensions listed below and, if available, an established rating system (ASAM PPC-2; LOCUS 1.5, etc.).

- 1) Acute Intoxification and/or Withdrawal Potential
- 2) Biomedical Conditions and Complications
- 3) Emotional/Behavioral Conditions or Complications
- 4) Treatment Acceptance/Resistance
- 5) Relapse/Continued Use Potential
- 6) Recovery Environment

- (e) Co-occurring disorders are treated as dual primary disorders, in which each disorder receives specific and appropriately intensive treatment simultaneously.
- (f) Treatment for previously diagnosed mental illness continues at appropriate intensity even when consumers are actively using substances.
- (g) Treatment for substance disorders continues at appropriate intensity even when consumers have psychiatric symptoms, and/or are receiving psychiatric interventions.
- (h) The presence of comorbidity is an indication for enhanced treatment of each primary disorder. People with serious mental illness and substance dependence will require more substance dependence treatment to attain sobriety than people with comparable substance dependence and no mental illness.
- (i) Whenever possible, dual primary treatment is integrated into a single setting and/or set of interventions. Ideally, individuals can receive treatment for both disorders in the setting in which they are treated for their most serious disorder.
 - 1) Individuals with SPMI can receive a full range of substance treatment in mental health settings.
 - 2) Individuals with substance dependence and other psychiatric disorders can receive psychotherapy and psychopharmacology in substance settings.
- (j) Assessment and treatment incorporates families as much as possible. Ongoing family intervention is provided by primary care givers or team members, and includes: individual/group/family psychoeducation, peer family support groups, individual family therapy, and behavioral contracting.
- (k) Assessment and treatment incorporates collateral care givers and agencies. Multi-agency treatment planning coordinated by the primary care giver(s) occurs at least quarterly. Multi-agency problems are included in treatment plans.

- (l) Phase-specific interventions for each set of disorders are described in **Appendix A**.
- (m) Involuntary/coercive interventions such as payeeships, guardianships, contingencies on access to family resources, and outpatient or inpatient commitment to treatment are commonly used by clinicians treating severely ill consumers with dual diagnoses (O'Keefe, Potenza, et al., 1997)

These involuntary measures may be helpful to ensure safety and assist with initial stabilization and engagement. This may give the consumer an opportunity to experience a period of relative freedom from mental illness symptoms and abstinence, providing a contrast that may facilitate motivational development. However, there is no evidence to support the utility of involuntary treatment measures as a primary long-term treatment strategy and they may lead to feelings of resentment, rebellion, and impaired treatment alliance. Moving into active treatment will require motivational development which involves transfer of responsibility for illness management to the consumer. Therefore, the risks and benefits of involuntary/coercive treatments should be re-evaluated frequently over time and regular attempts made to gradually transfer responsibility back to the consumer. The managed care entity should recognize that the presence of an involuntary measure may create an obligation for closer monitoring.

- (n) Treatment interventions are re-evaluated at least quarterly in relation to consumer progress and family needs. Provision is made for consumers to move in both directions through phase-specific programming.

- (o) Housing is an important component of dual disorder treatment. Housing must be phase-specific and appropriate to consumer preferences and functional capacity.

1) “Wet” housing is appropriate for difficult to engage individuals who are homeless and/or seriously impaired, yet unable to acknowledge willingness to change substance use behavior.

“Wet” housing, including psychiatrically supported shelters, provides a setting in which pre-motivational engagement, and possibly initial psychiatric stabilization, can begin.

- 2) “Damp” housing is appropriate for consumers with psychiatric disabilities who require significant staff support, and are willing to limit substance use in order to promote a manageable environment, but are not committed to abstinence.

“Damp” housing can facilitate engagement/persuasion interventions for consumers who are more psychiatrically engaged. Behavioral contracting can be used to help substance dependent consumers recognize the need for more specific addiction intervention.

- 3) “Dry” or “sober” housing is necessary for many individuals to maintain initial abstinence and to continue to develop recovery support.

homes for support is Sober housing can range from modified therapeutic communities to staffed group SPMI consumers to relatively independent sober apartments. Case management variable.

(ideally management also in the back) By definition, sober housing programs must be able to extrude people who relapse after more than one episode - e.g., 2 or 3 slips). Consequently, outside case by primary care giver must be actively involved, both to facilitate success, but event of discharge.

back) Ideally, in a housing continuum, consumers can move from wet to damp to dry (and as their needs and motivations change.

(p) Pharmacology is an important and often controversial component of dual disorder treatment. Psychopharmacology practice guidelines are detailed in a separate section.

APPENDIX A
PHASE SPECIFIC INTERVENTIONS FOR INDIVIDUALS
WITH COMORBID DISORDERS
(Based on Minkoff & Rossi, 1997)

1. Acute Stabilization

Acute stabilization needs vary according to subtype of dual disorder, and acuity/severity of each diagnosis.

Individuals with SPMI and substance dependence, where both disorders are fully decompensated, will usually require hospitalization in an inpatient unit with dual diagnosis capacity. If the patient only requires detoxification, the patient may be managed in a psychiatrically-enhanced detoxification program. If the patient has only lapsed, but does not require detoxification, stabilization may occur in a substance-capable crisis bed. In all of the above cases, appropriate medication for each disorder must be provided simultaneously in adequate dosages.

Individuals with SPMI and substance abuse who have psychiatric decompensation will require dual diagnosis capable inpatient or crisis beds, depending on severity. Detoxification should not be required. Psychotropic medication is maintained.

Individuals with substance dependence and other psychiatric disorders, where both diagnoses are decompensated, require an integrated inpatient program with full addiction treatment capacity. If the psychiatric condition is more stable, but substance exacerbated, a psychiatrically-enhanced detoxification program is recommended. Less severe decompensations may be managed at lower levels of care.

2. Engagement/Persuasion

Engagement techniques are similar across all dual disorder subtypes.

Pre-Motivational: Outreach, relationship building, collateral contacts, practical support, consideration of legal/coercive constraints and use when necessary.

Motivational: Motivational interviewing, motivational enhancement therapy, engagement groups (individuals and families), harm reduction strategies, behavioral contracting, empathic confrontation with consequences, education regarding disease and recovery, social network intervention.

Confrontation is empathic, caring, respectful, carefully planned and consistent with program policies and procedures that balance program requirements with sensitivity to consumer rights and needs.

3. Active Treatment/Relapse Prevention

Treatment is specific to each diagnosis.

A. Substance Disorder

- 1) *Substance Abuse*: Individual, group, and family interventions; behavioral contracting; cognitive/behavioral relapse prevention; social skills training, day treatment, residential support.
- 2) *Substance Dependence*: All substance abuse interventions, plus intensive daily participation in a recovery program (AA, NA, Dual Recovery Anonymous, or other structured intervention), residential and/or day program focused on sobriety.

For both abuse and dependence, interventions are made more concrete for clients with more severe psychiatric and/or functional/cognitive disabilities. Gender-specific groups may be helpful.

Psychopharmacology and other psychiatric treatment is maintained throughout.

SPMI individuals can often be successful in 12 Step programs, when appropriately intensive

training, preparation, and rehearsal is provided.

B. Psychiatric Disorder

- 1) *Major Mental Illness (Schizophrenia, Bipolar, OCD, etc.):* Pharmacologic treatment of specific disorder with best possible medication regime, plus individual, family, group, or residential treatment as indicated, with continuing case management. Diagnosis-specific dual diagnosis groups may be helpful.
- 2) *Post-Traumatic Stress Disorder (PTSD):* As above, plus specific individual and group work on trauma recovery and associated cognitive reframing and behavioral skills (Evans & Sullivan, 1995)
- 3) *Attention Deficit Hyperactivity Disorder (ADHD)/Head-Injury:* As above, plus specific cognitive interventions based on neuropsychological or functional assessment to promote learning and skill acquisition.
- 4) *Borderline Personality Disorder:* As above, plus specific individual and group work incorporating dialectic behavioral therapy or similar cognitive strategies.
- 5) *Antisocial Personality Disorder/Impulsive, Aggressive Disorders:* As above, with specific cognitive behavioral interventions in the context of correctional system oversight, or in a highly intensive residential setting (e.g., therapeutic community).

4. Recovery/Rehabilitation

Recovery/rehabilitation strategies are similar for all subtypes:

- (a) continued maintenance
- (b) individual/group strategies to enhance empowerment and choice
- (c) emphasis on strengths, and involvement in social/vocational rehabilitation
- (d) step work/psychotherapy
- (e) club houses
- (f) supported housing models, sober houses
- (g) peer advocacy/peer counseling
- (h) dual recovery self-help programs
- (i) taper back any involuntary/coercive measure, increasingly empowering the consumer to take full responsibility for the recovery process

4. Psychopharmacology Guidelines

(a) Assessment

- Initial psychopharmacologic evaluation in mental health settings should not require consumers

to be abstinent.

- Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medication during detoxification and early recovery.
- Assessment and diagnosis of individuals with comorbid disorders is based ideally on careful chronological description of both disorders, including emphasis on onset, interactions, effects of treatment, and contributions to stability and relapse of either disorder. Obtaining information from family members and collateral care givers can be extremely helpful.
- Diagnostic and treatment decisions regarding psychiatric illness are best made when the comorbid substance disorder is stabilized. Nonetheless, thorough assessment (as described above) can provide reliable indications for diagnosis and psychopharmacologic treatment, even for individuals who are actively using. This is particularly true for individuals with SPMI.
- Diagnostic and treatment decisions regarding substance disorder are best made when the comorbid psychiatric disorder is at baseline. Nonetheless, thorough assessment can provide reliable information about the course and severity of substance disorder, even for individuals whose mental illness is destabilized.

(b) General Principles

- Psychopharmacology with people with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic clinical relationship, which emphasizes continuous re-evaluation of diagnosis and medication and artful utilization of medication strategies to promote outcome of both disorders.
- Psychopharmacologic providers need to have ready access to peer review and/or consultation regarding difficult patients.
- Some evidence for improvements in addictive disorders has been associated with several classes of psychiatric medications (e.g., SSRIs, bupropion, atypical antipsychotics, and others). The prescriber may want to consider the substance use disorder when choosing a medication for the psychiatric disorder.
- In general, psychopharmacologic interventions are designed to maximize outcome of two primary disorders, as follows:

IFor diagnosed psychiatric illness, the individual receives the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder.

IFor diagnosed substance disorder, appropriate psychopharmacologic strategies (e.g., disulfiram, naltrexone, methadone maintenance) are used as ancillary treatments to support a comprehensive program of recovery, regardless of the status of the comorbid psychiatric disorder (although taking into account the individual's cognitive capacity and disability).

IFor patients with known substance dependence (active or remitted), continuing prescription of benzodiazepines, addictive pain medications, or non-specific sedative/hypnotics is not recommended, with or without comorbid psychiatric disorder. If such medications are being prescribed, this is an indication for consultation or peer review. (See p.39)

- In general, psychopharmacologic providers will prioritize the following tasks, in order:
 - I. Establish medical and psychiatric safety
 - II. Maintain stabilization of severe and/or established psychiatric illness
 - III. Establish sobriety
 - IV. Diagnose and treat more subtle psychiatric disorders

I. Establish medical and psychiatric safety

- In acutely dangerous behavioral situations, utilize antipsychotics and other sedatives as necessary to establish behavioral control.
- In acute withdrawal situations requiring medical detoxification, use detoxification medications for addicted psychiatric patients no differently than for patients with addiction only.

II. Maintain stabilization of severe and/or established psychiatric illness

- Provision of necessary medication for treatment of psychotic illness and other known serious mental illness must be initiated or be maintained regardless of continuing substance use.
- Ongoing substance use is not a contraindication to use of clozapine, olanzapine, risperidone, quetiapine, or other atypical neuroleptics. Improving psychotic or negative symptoms may promote substance recovery.
- In patients with active substance dependence or substance dependent patients in early recovery, non-addictive medication for non-psychotic disorders may be maintained, provided reasonable historical evidence for the value of the medication is present. Continuation of the medicine over time may be made contingent on working toward establishing/maintaining abstinence.

III. Establish sobriety

- It is preferable to treat addiction without medication in order to focus the patient on the importance of his/her own work in recovery.
- Utilizing medication (e.g. disulfiram, naltrexone) to help treat addiction should always be presented as an ancillary tool to a full recovery program.
- Psychotropic medications should be clearly directed to the treatment of known or probable psychiatric disorders - not to medicate feelings.
- Addicts in early recovery have great difficulty regulating medication; fixed dose regimes, not PRN's, are recommended, except for regulation of psychotic symptoms.
- In clinical situations where the psychiatric diagnosis and/or severity of substance

disorder are unclear, psychotropic medications may be used as part of a strategy to facilitate engagement in treatment and the creation of contingency contracts to promote abstinence.

IV. Diagnose and treat less serious psychiatric disorders (e.g., affective disorders, anxiety disorders, PTSD, ADHD, personality disorders, which are not serious or disabling)

- Psychotropic medications should be clearly directed to the treatment of known or probable psychiatric disorders - not to medicate feelings.
- In patients with active substance dependence or substance dependent patients in early recovery, non-addictive medication for non-psychotic disorders may be maintained, provided reasonable historical evidence for the value of the medication is present. Continuation of the medicine over time may be made contingent on working toward establishing/maintaining abstinence.
- In patients with known active substance dependence, it is not recommended to initiate medication for treatment of primary, non-psychotic disorders which are not serious or disabling while patients are actively using; it is usually impossible to make an accurate diagnosis and effectively monitor treatment.
- For patients with substance dependence in early recovery, non-addictive medication for treatment of primary non-psychotic disorders which are not serious or disabling may be initiated, if there is reasonable indication of a non-substance induced disorder.
- It is not recommended to establish arbitrary time periods for initiation of medication. At times, it may be appropriate to initiate psychotropic medication for non-psychotic disorders in the latter stages of detoxification; at other times, it may be appropriate to wait a few weeks, or even longer. With the emergence of newer medications (e.g., SSRIs) with more benign side effect profiles, there is little evidence that prescription of these medications inhibits recovery from substance dependence, and some evidence that such medication may in fact promote successful abstinence.
- Prescribers need to carefully consider the risks of prescribing potentially addictive medications (Schedule II-IV substances) beyond the detoxification period. Continuing prescription of these medications should generally be avoided for patients with known substance dependence (active or remitted). On the other hand, they should not be withheld for selected patients with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for consumers with diagnosed substance dependence, is an indication for both (a) careful discussion of risks and benefits with the patient (and, where indicated, the family) and (b) documentation of expert consultation or peer review.

PART IV
Provider Competencies for Dual Diagnosis Treatment in Managed Care Systems

Introduction

Implementation of high quality assessment and treatment services for individuals with co-occurring disorders in accordance with the previously described standards of care (Part I) and practice guidelines (Part III) requires the development of a wide range of competencies in treating dual diagnosis among providers throughout the service system. This section is intended to delineate those competencies, by answering the following question.

As a managed care entity responsible for development of a high quality integrated service system for individuals and families with co-occurring disorders, what attitudes, values, knowledge, and skills are required for providers to participate successfully in the implementation of such a system?

ATTITUDES

Regardless of level of training, clinical background, or service setting (mental health or substance disorder), clinicians' goal to develop attitudes about individuals with comorbid disorders must facilitate the implementation of a welcoming service system, and foster the initiation and continuation of empathic, hopeful, and empowering clinical relationships to promote dual recovery.

Specific attitudes include:

- Compassion and empathy for the difficulty of consumers' lives, and for the loss and disability associated with both psychiatric and substance disorders.
- Belief that all consumers deserve to be treated with respect and dignity, even when - especially when - non-compliant, decompensated, and/or intoxicated.
- Genuine interest in and strong desire to understand the consumer's point of view.
- Substance use and/or psychiatric treatment non-compliance are not to be viewed as moral issues (good vs. bad behavior).
- Consistent hopefulness and optimism that consumers can improve, and can assume increasing responsibility for themselves and their decisions.
- Consistent acceptance of the consumer's own values, attitudes, and behavior.
- Consistent acceptance of variations in culture, and continual desire to understand the consumer's culture in greater depth.
- Acceptance and comfort with lack of ability to control consumers or fully protect them from the consequences of their own choices.
- Belief that all consumers have the ability to learn and grow.
- Acceptance of consumers' need to be dishonest with treaters.
- Belief that families and friends are valuable collaborators in treatment and must be approached with the same welcoming attitudes with which one approaches consumers.
- Patience with slow pace of progress, and comfort with lapses, without discouragement or anger.
- Recognition that small gains are important, and that maintaining stability alone is valuable, difficult work.
- Belief that addictive and other psychiatric disorders are equal in validity and significance, and that treatment of both disorders over time is equally important.
- Accepting, non-judgmental, and objective stance regarding symptoms and treatments for both disorders.
- Belief that mental illness and substance disorders are both chronic relapsing disorders in which relapses are not failures but opportunities for learning.
- Belief that sustained remission and recovery cannot be attained by external control, only by sustained motivation of the consumer.
- Comfort with maintaining a treatment relationship when the consumer is not following recommendations; abstinence and compliance can be goals, not preconditions.
- Belief that the consumer and family deserve to feel proud of themselves, even when they have

not yet attained success, simply for their daily courage and determination to survive the ravages of both disorders.

FOR PSYCHOPHARMACOLOGY PRESCRIBERS:

- Acceptance of the necessity to discover the best treatment regime through exploration and experimentation in the context of an ongoing treatment relationship.
- Comfort with maintaining necessary medication for consumers who are actively using substances.
- Willingness to exercise great caution in prescribing benzodiazepines to people with substance dependence.
- Willingness to seek consultation when indicated.

VALUES

Attitudes and values are frequently intertwined. Providers will have great difficulty meeting the challenge of treating individuals with comorbid disorders without a strong ethical foundation to guide their work. Where attitudes reflect the way in which the clinician views the clients or the treatment, values reflect the standards by which clinicians evaluate their own behavior. Specific values for dual diagnosis treaters include:

- Consumers and families should always be treated with empathy, compassion, dignity, and respect.
- Consumers and families are valuable human beings, regardless of the severity of their diseases, and regardless of their out-of-control behavior.
- Consumers and families benefit from patience, persistence, and consistent optimism.
- Consumers should always be made to feel welcome in any treatment encounter.
- Consumers and families should be fully involved as collaborators in the recovery process.
- All members of the treatment team should be treated by each other with respect, dignity, and compassion.
- Consumers and families should be treated with integrity and honesty at all times, and encouraged to respond in kind.
- Confrontation or coercion, when necessary, should always be applied with compassion and love.
- All clinical and non-clinical personnel servicing consumers and their families should be sensitive to the specific biological, psychological, and social challenges faced by their clients in addition to the already difficult condition of dual diagnosis.
- Interventions should never be punitive; consequences should be applied consistently and caringly, with an effort to help consumers learn from their mistakes.
- Addiction and mental illness should be viewed as no-fault diseases. Neither consumers nor families should be blamed for comorbidity.
- Objectivity and non-judgmental acceptance are very important; clinicians should exercise care to prevent their own needs/issues from affecting the treatment process.
- Orthodoxy and rigidity should be avoided; and flexibility valued. There is rarely one “right

way” to recover.

- All clinicians and programs should be capable of providing integrated treatment: that is, comfortably treating comorbid psychiatric and substance disorders in their caseload or clientele. Developing expertise in both psychiatric and substance disorders is both necessary and possible.
- Consumers should be treated with the level of service intensity that best matches their needs with utmost respect to their uniqueness and individualities.
- Creative programming should be developed to effectively address the consumers' needs as identified through individual assessments of the consumers' biological, psychological, and social functioning. Such programming should have an all inclusive approach, providing consumer centered services that appeal to the widest range of diversity among the populations served.
- Maintaining a treatment relationship is crucial for progress to occur; disruptions in treatment continuity should be minimized.
- Treatment of substance disorders and other psychiatric disorders should be equally valued; and recognized treatment approaches from either field equally valued and validated.
- All treaters and treatment programs should play a valuable role in a dual disorder system of care.
- Consumers should exercise self-determination as a pathway to growth whenever possible, and must be allowed to take risks and fail, while always having access to help if desired.
- Recovery from both disorders is an attainable and valuable goal that can be reached by anyone, and is worth the pain and work involved to reach it.

FOR PSYCHOPHARMACOLOGY PROVIDERS:

- Initiating and maintaining a treatment relationship is the most important step in attaining good long-term outcomes.
- Needed psychopharmacologic treatment for severe psychiatric disorders should never be withheld.
- Arbitrary barriers to access for evaluation and prescription should be avoided.
- It is more important to convey caring and concern than to avoid being manipulated or conned.

KNOWLEDGE

In addition to the generic knowledge base specific to each discipline, clinicians of any level of training working with individuals with dual disorders must have a specific knowledge base concerning comorbidity. This knowledge (and accompanying skills) can be organized into several broad categories.

A. Conceptual Overview

- History of emergence of comorbidity in the service system, and historical barriers to service integration.
- Epidemiologic data supporting high prevalence of comorbidity.
- Literature demonstrating poor outcomes of individuals with comorbid disorders.
- Literature demonstrating effectiveness of integrated, continuous treatment approaches.
- Familiarity with integrated conceptual framework, with parallel phases of treatment, and application of disease and recovery model to both psychiatric and substance disorders.
- Familiarity with models for defining stages of change and phases of treatment.
- Identification of significant population subtypes of dual disorder.
- Knowledge of the principles of public sector managed care, and its implications for horizontal and vertical service integration and flexibility.
- Knowledge of basic utilization management guidelines for mental health, substance abuse, and comorbid disorders (e.g., ASAM PPC-2).

B. Belief System

- Knowledge of required attitudes and values for successful treatment.
- Awareness of own biases, and how they may interfere with treatment.
- Knowledge of the risks of enabling, overprotection, confrontation, manipulation, rigidity and sensitivity to and awareness of boundary violation and cultural diversity and its impact on comorbidity.

C. Systems Overview

- Knowledge of consumer/family-oriented dual diagnosis standards of care.
- Familiarity with practice guidelines.
- Awareness of system-wide mission for dual diagnosis treatment, and system structures that support/inhibit service integration.
- Knowledge of comprehensive array of dual diagnosis services, plus admission criteria and utilization management criteria.
- Knowledge of mechanisms for interface with collaborative treatment systems, (rehabilitation, corrections, child/family services, medical).
- Knowledge of legal requirements governing treatment of each disorder, including criteria for involuntary treatment, consumer/family rights and protections, and significant regulations in each service system relevant to comorbidity.
- Knowledge of system-wide quality management processes regarding dual diagnosis, including consumer/family oversight, satisfaction monitoring, and outcome evaluation.

D. Basic Knowledge of Psychiatric and Substance Disorder, and Their Interactions

- Familiarity with DSM-IV diagnostic criteria, including distinction between substance use, abuse, and dependence.
- Knowledge regarding diagnosis, duration, functionality, and disability associated with psychiatric and substance disorders, separately and together.

Familiarity

with multi-factorial (bio-psycho-social-spiritual) etiology of both disorders, and how each can contribute to the cause and exacerbate the symptoms of the other.

- Identification of substance-induced psychiatric syndromes and disorders.
- Identification of typical patterns of substance use among individuals with various psychiatric disorders, effects of substances on psychiatric symptoms, and benefits/consequences of use.
- Knowledge regarding process of recovery for each disorder, and familiarity with self-report and research literature on dual recovery.

E. Assessment

- Familiarity with the components of a comprehensive, bio-psycho-social-spiritual, integrated, longitudinal assessment, emphasizing identification of onset of each disorder, characteristics of each disorder and treatment response, factors facilitating/inhibiting treatment entry and continuation, and status of each disorder when the other is stabilized.
- Understanding of strengths/limitations of drug screening for detection.
- Familiarity with standardized mental health and substance abuse screening tools (CAGE, MAST, BSI, BDI).
- Familiarity with instruments for assessing level of acuity: CIWA/CINA withdrawal scales; LOCUS, ASAM PPC-2 or similar tool for assessing service intensity needs.
- Recognition of the importance of involving family and collaterals in the assessment.
- Familiarity with methodology for assessing phase of treatment and treatment readiness (SATS).
- Understanding of relevance of cultural, gender, age, and sexual orientation issues to assessment.
- Familiarity with special needs of pregnant, HIV infected, and other medically involved individuals.
- Familiarity with special needs of individuals involved with the correctional system.
- Knowledge of application of assessment data to diagnostic criteria in the presence of active comorbidity.
- Familiarity with family systems impact of comorbidity.

F. Crisis Intervention

- Knowledge regarding high risk of suicide and violence in individuals with comorbidity.
- Awareness of indications for medical referral.
- Familiarity with access to crisis stabilization services at various levels of intensity for individuals with active comorbidity.

G. Treatment Planning

- Knowledge regarding systematized treatment matching for individuals with various subtypes of dual disorder in various phases of treatment.
- Understanding of the elements of an integrated treatment plan which addresses both disorders simultaneously.
- Familiarity with full range of available treatment resources required, and how to access them.

H. Pharmacologic Stabilization

- Knowledge of signs, symptoms, and interventions for detoxification from common substances in presence of comorbidity.
- Knowledge of basic psychopharmacology for stabilization of psychiatric disorders.
- Knowledge regarding continuation of necessary psychotropic medication for serious mental illness in patient with active substance abuse/dependence.
- Familiarity with psychopharmacology practice guidelines for treating less serious psychiatric disorders in early recovery. Awareness of interactions between medications, substance use, and symptoms.
- Knowledge of risk of iatrogenic addiction, and guidelines regarding avoidance of use of ongoing benzodiazepines (or other addictive medications) in patients with known substance dependence.
- Awareness of the guidelines for utilization of pharmacologic strategies in addiction treatment, including methadone maintenance, disulfiram, and naltrexone.

I. Treatment, Rehabilitation, and Recovery

- Familiarity with the principles and practices of integrated, continuous case management and assertive community treatment.
- Understanding of the application of a range of interventions for treating psychiatric disorders (both SPMI and non-SPMI) and substance disorders (both abuse and dependence).
- Familiarity with integration of phase-specific interventions for one disorder into the treatment program for the other.
- Familiarity with application of motivational enhancement interventions (motivational interviewing, harm reduction) to both psychiatric and substance disorders.
- Knowledge regarding peer recovery programs for both addiction (e.g., 12 Step) and mental

illness, as well as dual recovery programs (Dual Recovery Anonymous, STEMSS).

- Familiarity with treatment modification for individuals with cognitive impairments and/or learning disabilities.
- Understanding of principles and practice of trauma (PTSD) treatment and recovery in individuals with co-occurring disorders.
- Knowledge of models for family engagement, intervention, and peer support (MICAA-non).
- Knowledge of characteristics of various types of group interventions (engagement, persuasion, active treatment, relapse prevention).
- Understanding of cognitive-behavioral relapse prevention and social skills training interventions.
- Familiarity with psychodynamic principles (e.g., resistance, transference).

- Knowledge regarding application of behavioral contracting, empathic confrontation, payeeship, and other coercive strategies.
- Familiarity with continuum of dual diagnosis housing models (wet, damp, dry; group homes, supported housing).
- Awareness of available resources and how to access them.
- Understanding of the role of current treatment interventions and/or treatment program in the overall course of dual recovery.
- Familiarity with the value of limited, focused goals/objectives for each phase or episode of treatment.
- Familiarity with coordination of services from multiple systems, including corrections, rehabilitation, child/family, and medical.

J. Quality Monitoring

- Familiarity with indicators and monitors for quality monitoring.
- Understanding of the utilization of satisfaction surveys for consumers/families.
- Familiarity with at least one clinical outcome monitoring instrument.

SKILLS

Required **dual diagnosis** skills conform to the knowledge base described above.

A. Conceptual Foundation

- Consistently demonstrates familiarity with integrated disease and recovery model; can correctly identify subtypes of dual disorder, and phases of treatment.
- Consistently matches utilization criteria to program levels of care.

B. Beliefs/Attitudes

- Consistently demonstrates ability to convey empathy, respect, flexibility, and hope, even to

individuals who are doing poorly.

- Maintains objectivity and empathic detachment.
- Provides continuity of care and responsibility while allowing consumers to make decisions and experience the consequences of their choices.
- Demonstrates ability to maintain patience, persistence, and optimism in the face of clinical adversity.
- Consistently displays sensitivity to individuals with diverse disorders, characteristics, and cultural backgrounds.

C. Systems Skills

- Demonstrates ability to assess and diagnose individuals with substance disorder only, to recommend and implement phase-specific individual, group, or family intervention, and to enhance appropriate referrals for other treatment components (day treatment, residential, peer recovery).
- Demonstrates ability to assess and diagnose individuals with common psychiatric disorders; to recommend and implement phase-specific individual, group, and family interventions; and to arrange appropriate referrals for other treatment components (e.g., psychopharmacology, day treatment, residential, peer recovery).
- Demonstrates ability to educate consumers and families regarding psychiatric or addictive disorders and their treatment.
- Demonstrates ability to consumers and families to convey hope through describing the process and promise of recovery for either psychiatric or substance disorder.

D. Assessment

- Performs and documents comprehensive, integrated, longitudinal assessment of both psychiatric and substance disorder using a bio-psycho-social-spiritual approach.
- Demonstrates ability to utilize at least one diagnostic screening tool for psychiatric and substance disorder.
- Demonstrates ability to involve family and collaterals in assessment process, and incorporate this information into integrated assessment.
- Demonstrates ability to apply DSM-IV diagnostic criteria to assessment data to develop initial diagnosis and differential diagnosis.
- Addresses acuity, severity, disability, and duration in the assessment process to assess both immediate and long-term service intensity (level of care) requirements.
- Able to assess withdrawal severity and possible need for medical detoxification, and arrange for appropriate intervention.
- Demonstrates ability to apply ASAM Patient Placement Criteria and at least one tool (e.g., LOCUS) for assessing service intensity requirements to develop service intensity recommendations.

- Demonstrates ability to apply at least one methodology for identifying phase of treatment for each disorder, and incorporates phase of treatment in the diagnostic process.
- Describes and documents the status of each disorder when the other is at baseline, and the extent to which each disorder affects the presentation or manifestation of the other, including identification of possible substance-induced syndromes which require ongoing monitoring and assessment.
- Demonstrates ability to incorporate age, gender, and cultural sensitivity into the assessment and diagnostic formulation.
- Demonstrates ability to identify and assess special needs of pregnant/parenting, HIV infected, and other medically involved individuals.
- Demonstrates ability to assess legal status and correctional system involvement, and their impact on recommendations for treatment.

E. Crisis Intervention:

- Demonstrates ability to assess acute level of dangerousness - risk of harm to self or others - and arranging appropriate interventions to establish safety.
- Demonstrates ability to recognize indication of possible medical risk, including detoxification, and arrange appropriate interventions.
- Applies crisis intervention techniques regarding both psychiatric and substance disorder contributions to and manifestations of crisis in an integrated manner.

F. Treatment Planning

- Demonstrates ability to develop an integrated treatment plan for simultaneous phase-specific treatment of both psychiatric and substance disorder, consistent with the acuity, severity, and disability of each disorder.
- Demonstrates ability to identify and recommend phase-specific interventions, and describes how to incorporate interventions for one disorder into the setting for treatment of the other (usually more serious) disorder.
- Consistently identifies and accesses available resources to provide recommended interventions.
- Consistently involves consumers and families in treatment planning process.

G. Pharmacologic Stabilization

For non-prescribers:

- Demonstrates ability to describe and discuss substance withdrawal symptoms and treatments, and process of detoxification, with consumers and families.
- Demonstrates ability to identify common psychotropic medications, describe common effects and side effects, and discuss their role in the treatment of common psychiatric disorders.

- Demonstrates ability to discuss positive/negative indications for use of pharmacologic agents in addiction treatment (e.g. methadone maintenance, disulfiram, naltrexone).
- Demonstrates ability to monitor and encourage compliance with prescribed medication regime, and to communicate directly with prescribers regarding concerns or questions.
- Demonstrates ability to assist consumers and families to communicate directly with prescribers regarding effects, side effects, concerns, and questions around specific medications.
- Demonstrates consistent support of practice guidelines for psychopharmacologic practice, including maintaining necessary medication for serious mental illness for consumers who are actively using substances.

For prescribers:

Demonstrates ability to consistently apply practice guidelines to ongoing treatment of individuals with co-occurring disorders, including (but not limited to) the following:

- Develops an ongoing relationship, and continually re-evaluates diagnosis and treatment.
- Maintains needed psychotropic medication for known serious primary psychiatric disorders, even when patient is actively using, and seeks best pharmacologic interventions for each disorder.
- Avoids use of benzodiazepines in ongoing treatment of people with known substance dependence, and seeks consultation when indicated.
- Demonstrates ability to utilize pharmacologic strategies for addiction treatment, when indicated, as an ancillary tool to a full recovery program.
- Demonstrates ability to negotiate medication changes with consumers in a collaborative manner which promotes recovery from both disorders.
- Communicates effectively with consumers and families regarding psychopharmacology interventions and interaction with substance disorders.
- Collaborates effectively with other members of the treatment team, and with providers in other agencies and settings, including substance abuse counselors.

H. Treatment, Rehabilitation, and Recovery

- Demonstrates ability to provide simultaneous integrated treatment of both psychiatric and substance disorders, via individual interventions, and/or as part of a case management team.
- Applies a range of interventions (consistent with level of professional training) for both psychiatric and substance disorders, including individual, group, family therapy, skills training, peer recovery programs, and pharmacology.
- Integrates phase-specific interventions for both disorders.
- Demonstrates competency in motivational enhancement techniques.
- Assists consumers in utilizing peer recovery programs for either or both disorders.
- Modifies treatment approach for individuals with cognitive and/or learning disabilities.
- Applies principles of trauma recovery to individuals with significant PTSD and/or abuse history.
- Successfully modifies treatment approaches for individuals with severe personality disorders.
- Demonstrates ability to utilize cognitive-behavioral relapse prevention.

- Demonstrates ability to engage families and provide dual diagnosis education and support in a collaborative manner.
- Can design empathic confrontations, and successful (win-win) behavioral contracts.
- Demonstrates ability to maintain appropriate balance of detachment/empowerment and case management responsibility, and allows consumers more self-determination as recovery proceeds.
- Accurately identifies next-step goals/objectives, and can maintain focus.
- Can identify treatment and housing program requirements, make appropriate referrals, and collaborate effectively.
- Demonstrates ability to participate in multi-system care coordination appropriate to caseload (corrections, rehabilitation, medical and/or child/family, as well as addiction and psychiatric) quality monitoring and outcome.
- Can perform quality audits on relevant monitors.
- Can utilize satisfaction surveys with both consumers and families.
- Demonstrates ability to complete dual diagnosis outcome evaluation tool.

PART V Training Curricula

Introduction

Expectation of integrated competency among providers requires availability of suitable training programs or curricula. This section is intended to describe suitable curricula which answer the following question:

As a managed care entity wishing to require providers to demonstrate dual diagnosis competency, what curricula can be made available to guide the training process?

Overview

The consensus of the panel is that there can be no single version of a model curriculum. Rather, curriculum design can be quite variable, as long as four elements are included:

- 1) *Attitudes and values* must be a specific focus of training interventions; development of knowledge and skills alone is not sufficient for establishment of appropriate attitudes. Overt and covert biases about all aspects of individuals with co-occurring disorders must be systematically addressed.
- 2) *Consumer and family involvement* in the training process is essential to establishing sensitivity to consumer/family perspectives, understanding the importance of empathic detachment, and experiencing the process and promise of recovery.

3) *Systems standards, practice guidelines, and relevant literature regarding co-occurring disorders*, as defined in this document and elsewhere must be formal parts of the curriculum.

4) *Specific dual diagnosis competencies* (attitudes, values, knowledge, and skills), as outlined herein, should be identified as specific measurable outcomes of each curriculum module.

Methodology for Curriculum Development

We recommend that specific training curricula are developed within each system of care, based on the needs and resources of that system. The methodology for curriculum development is to define the attainment of the competencies outlined above as the specific learning objectives of the curriculum, and then, for each learning objective, utilize the following format for development of a training module or lesson plan:

Topic/Competency
Learning Goal(s)
Objectives
Activities
Evaluation
Resources

We have illustrated the application of this technique to two specific competencies, one for Attitudes and the other for Values.

Illustration 1

Topic/Competency:	Attitudes: Developing Positive Attitudes Toward People with Dual Diagnosis
Learning Goal(s): and consumers, compliant.	At the conclusion of this training, the participant will be able to: 1) demonstrate empathic listening with dual diagnosis consumers families. 2) convey a caring, hopeful attitude to all dually diagnosed including those who are treatment resistant and non-compliant.
Objectives: identify attitudes. can	1) The participant will explore his/her own attitudes regarding individuals with mental illness and/or substance disorder, and both productive and counter-productive attitudes. 2) The participant will recognize and describe the impact of his/her attitudes on clinical behavior. 3) The participant will indicate a willingness to change negative attitudes. 4) The participant will describe alternative cognitive strategies that facilitate attitude change. 5) The participant will demonstrate ability to describe positive,

empathic situations.	attitudes verbally. 6) The participant will demonstrate these attitudes in clinical situations.
Activities:	1) Didactic presentation re: empathic formulation of comorbidity 2) Experiential group process and discussion 3) Role playing in different situations 4) Video-taped interviews, with individual and group commentary
Evaluation:	1) Pre- and post-testing: attitude measurement 2) Self-assessment 3) Peer assessment 4) Consumer assessment
Resources:	1) <i>Dual Recovery Book</i> (Hazelden, 1993) 2) The Information Exchange, Inc. Counselor Training Manual 3) MICAA-NON 4) <i>Celebrating Small Victories</i> (Montrose & Daley, 1995) 5) Motivational Interviewing (Miller & Rollnick, 1991)

Illustration 2

Topic/Competency:	Values: Maintaining Necessary Medication
Learning Goal(s):	At the conclusion of this training, the participant will be able to: 1) Recognize the value of continuing to prescribe necessary psychopharmacologic interventions, even when the consumer is actively using substances.
Objectives: and situation.	1) Verbally espouse value of dual primary treatment. 2) Identify three situations in which medication might be withheld, explain why it <u>should not</u> be. 3) Describe how such an action would be punitive and dangerous. 4) State that the continuation of medication is safe in such a situation.
Activities:	1) Didactic on psychopharmacologic principles and background literature. 2) Case vignettes, including group discussion. 3) Consumer/family input.
Evaluation:	1) Pre- and post-assessment of case situations

- Resources:
- 1) *Double Jeopardy* (Lehman & Dixon, 1995)
 - 2) *Dual Diagnosis of Serious Mental Illness and Substance Disorder, Part II. New Directions for Mental Health Services.* (Drake & Mueser, 1996)
 - 3) NIMH/Demonstration Projects

Model Curricula

The following model curricula, already developed, are available in **Appendix C** as guides for curriculum development in specific systems, and illustrate the variability of curriculum design. Each curriculum incorporates these principles to varying degrees, and can serve as templates upon which more specific curricula can be designed to meet local needs:

Mehr J: Professional Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997

Mehr J: Case Manager Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997

MICA Case Management Curriculum Model. Final Report. Eastern Washington University Alcohol/Drug Studies Program, July 1993

Ridgely MS, Osher FC, Johnson J: Integrating Clinical Care for People with Co-occurring Mental Health and Substance Abuse Disorders. Baltimore, MD: The University of Maryland and Baltimore and State of Maryland, Mental Hygiene Administration, 1995

Sciacca Comprehensive Service Development for MIDAA: Curriculum for MICAA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism, MIDAA. Training, Cross-Training and Program Development. Developed for Managed Care Initiative Panel on Co-Occurring Disorders,

1997. Developed by Kathleen Sciacca, MA, New York, NY

The Information Exchange, Inc.: Substance Abuse and Mental/Emotional Disorders: Counselor Training Manual and Trainer's Guide. Developed by Jackie Massaro, CSW. New York, 1995

Dual Diagnosis Certification

Certification as a "dual diagnosis clinical specialist" is a natural incentive for clinicians who successfully complete training in an organized curriculum, and demonstrate attainment of recommended competencies. In addition, dual diagnosis certification creates a standard for demonstrating that staff in programs serving dually diagnosed consumers have attained the necessary level of competency to provide quality care.

Consequently, we recommend establishing "dual diagnosis certification" for all levels of professionals, case managers, and addiction counselors. We have included in **Appendix B** one model for designing standards for such certification, based on acquisition of defined competencies and participation in specific training and supervised clinical experience. This model is included as an example only, not as a recommendation; it is intended merely to serve as a guideline for designing similar certification standards in other states. No data exists as yet which would permit the recommendation of a national standard for the development of such certification standards, other than demonstration of attainment of competencies defined herein.

In addition, we want to caution strongly against managed care entities, states, or other entities establishing, prematurely, requirements for dual diagnosis certification of staff in dual diagnosis programs. Until formal dual diagnosis training - and certification - are more widely available, establishing such standards would only serve to limit dual diagnosis services and restrict access to care. Governmental payors and managed care entities must first ensure that an adequate supply exists of both certified clinicians and training programs before imposing such requirements.

A more constructive strategy is to require staff to develop competencies, as defined herein, by a specified target date (e.g., within six months of hiring), and to provide training to achieve that outcome. Once staff have attained competency, they should be encouraged to seek dual diagnosis certification to the extent such certification is available.

APPENDIX B

Program Standards for MICA TREATMENT FACILITIES in Arkansas

V. STAFFING REQUIREMENTS

MICA TRAINING CERTIFICATION STANDARDS

- MICA (A) Mental Health Professional
- MICA (B) Substance Abuse Counselor/Mental Health Paraprofessional
- MICA (C) Mental Health Paraprofessional

TRAINING REQUIREMENTS

80 Hours of training approved by DMHS

- a. Training must pass a written exam given by DMHS at end of 80 hours.
- b. Training cost: \$500.00 per person
(1) If trainee does not pass written exam, there will be a \$50.00 retesting fee.

240 Hours of on-site training:

- a. MICA consultants will periodically conduct on-site reviews.
- b. During the 240 hours of training, MICA (A) will sign off on MICA (B), and MICA (A) or (B) will sign off on MICA (C).
- c. Upon completion of 240 hours, trainees must pass an oral exam given by

DMHS.

After passing oral exam, MICA (A) and MICA (B) will no longer have to sign off

on each other.

SPECIAL TRAINING

Administrative Assistant will be required to have 20 hours of training on treatment outcomes and pass a written test.

A MICA (A) must meet training standards for MICA Certification. See MICA Certification Procedure Standards.

A MICA (A) shall be a mental health professional who meets all professional requirements as defined in the licensing and certification laws relating to their respective professions. MICA (A) shall include the following:

1. Psychiatrist (licensed physician in the State of Arkansas and having completed an acceptable residency in psychiatry).
2. Psychologist (licensed in the State of Arkansas)
3. Psychological Examiner (licensed in the State of Arkansas)
4. Master of Social Work (licensed in the State of Arkansas)
5. Registered Nurse (licensed in the State of Arkansas with one year of supervised experience in a mental health setting).
6. Physician (licensed in the State of Arkansas)
7. Licensed Professional Counselor (licensed in the State of Arkansas)
8. Persons in related professions (licensed in the State of Arkansas and practicing within the bounds permitted by their licensing authority with a master's degree and appropriate experience in mental health setting, including documented, supervised training and experience in diagnosis and therapy of a broad range of mental disorders).

A MICA (B) is a :

1. Substance Abuse Counselor who is certified by State of Arkansas Substance Abuse Certification Board
2. Meets certification standards of a mental health paraprofessional for the State of Arkansas.
3. Meets MICA Certification Standards for State of Arkansas. (See certification procedures standards)

A MICA (C) must meet training standards for MICA Certification. (See MICA Certification Procedure Standards). A MICA (C) paraprofessional is defined as a person with a Bachelor's Degree or a person licensed by the Arkansas State Board of Nursing who does not meet the definition of mental health professional, but who is licensed and certified by the State of Arkansas in a related profession and is practicing within the bounds as permitted by his/her licensing authority, or a person employed by a certified Community Mental Health Center or Clinic with a high school diploma and documented training in the area of mental health. A MICA (C) may provide certain rehabilitative services for persons with mental illness and substance abuse problems under supervision of a mental health professional.

APPENDIX C
MODEL CURRICULA

***SCIACCA COMPREHENSIVE SERVICE DEVELOPMENT FOR
MENTAL ILLNESS, DRUG ADDICTION & ALCOHOLISM *MIDAA(R)***

***CURRICULUM for MICAA and CAMI DIRECT CARE PROVIDERS:
MENTAL ILLNESS, DRUG ADDICTION and ALCOHOLISM
MIDAA(R).and HIV: Training, Cross-Training, and Program Development.***

***Curriculum Developed for Managed Care Initiative Report on Co-Occurring Disorders,1997.SAMHSA,CMHS.
SMHSA/CMHS Best Practice Guidelines for Co-occurring Psychiatric and Substance Disorders.
Clinical Standards of Care, Practice Guidelines, Workforce Competencies and Training Curriculum,
1997-1998.**

DEVELOPED and WRITTEN BY:

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SCIACCA COMPREHENSIVE SERVICE DEVELOPMENT FOR MENTAL ILLNESS, DRUG ADDICTION AND ALCOHOLISM, *MIDAA(R).

Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism, MIDAA and HIV was founded in 1990 by Kathleen Sciacca, M.A., Executive Director to provide Consulting, Training, Cross Training, Education and Materials that foster Program Development and Comprehensive Services for Persons who have dual/multiple disorders including Severe and Persistent Mental Illness, Drug Addiction and/or Alcoholism, MIDAA.

Ms. Sciacca has developed Treatment Interventions, Treatment Programs, Consumer self-help programs, Family Programs, Curriculum and Training Programs and Program Materials since 1984. Her services and programs have been implemented state-wide, community-wide and agency specific in the mental health and substance abuse systems, HIV services, homeless services, nationally and internationally. Ms. Sciacca is formerly Director of the New York State Office of Mental Health MICA Training Site for Program and Staff Development New York State-wide. Ms. Sciacca has a certificate as trainer of Motivational Interviewing.

For information call: 212-866-5935,

Or write: 299 Riverside Drive, NYC, 10025.

E-mail: ksciacca@pobox.com

Dual Diagnosis Website: <<http://pobox.com/~dualdiagnosis>>

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REFERENCES:

Miller, WR., & Rollnick, S., "Motivational Interviewing: Preparing People to Change Addictive Behavior" The Guilford Press, 1991.

Sciacca, K., "MIDAA SERVICE MANUAL: A Step by Step Guide to Program Implementation and Comprehensive Services for Dual/Multiple Disorders. Sciacca Comprehensive Service Development for MIDAA, publisher, NYC, 1990, revised 1995, 2001, & 2002.

Sciacca, K., "An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders" New Directions for Mental Health Services, Dual Diagnosis of Major Mental Illness and Substance Disorders, Eds, Minkoff, K.& Drake, R., Jossey-Bass, publishers, summer 1991, #50.

Sciacca, K., Hatfield, A.B., "The Family and the Dually Diagnosed Patient" Double Jeopardy, Eds.

Lehman, A.F., and Dixon, L.B., Harwood Academic Publishers, 1995, Chapter 12, pp.193-209.

Sciacca, K., and Thompson, C. M., "Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction and Alcoholism, MIDAA," The Journal of Mental Health Admin. Vol.23, No.3, Summer 1996, pp.288-297.

Sciacca, K. "Peer Support for People Challenged by Dual Diagnosis: Helpful People In Touch," Consumers as Providers in Psychosocial Rehabilitation, Eds. Mowbray, C.T., Moxley, D.P., Jasper, C.A., Howell, L.L., IAPSRS publisher, 1997. Chapter 6, pp. 82-94.

Sciacca, K. "Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing" Professional Counselor, Volume 12, No.1, February 1997, pp. 41-46.

Sciacca, K., Video: "Integrated Treatment for Mental Illness Drug Addiction & Alcoholism..." Sciacca Comprehensive Service Development for MIDAA, NYC, 1994.

Sciacca, K., "On Co-occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment & Program Development" American Journal of Orthopsychiatry (66)3, July 1996.

CURRICULUM for MICA and CAMI DIRECT CARE PROVIDERS: MENTAL ILLNESS, DRUG ADDICTION AND ALCOHOLISM MIDAA® and HIV: Training, Cross-Training and Program Development.

Developed by: Kathleen Sciacca, M.A.

The goals of staff development and program development for dual/multiple disorders of co-occurring mental illness and substance disorders are directed toward the following accomplishments:

- 1. Each program in both the mental health and substance abuse service systems should include a screening instrument to detect persons who have dual disorders at the time of intake. The screening forms used within mental health and substance abuse programs should be sensitive to, and identify dual disorders in both populations (Sciacca, 1990).**
- 2. Once identified there should be a protocol of communication that will direct the consumer to a component of treatment services that addresses dual disorders within or outside of the agency.**
- 3. Program models should be available that engage consumers into treatment and/or services at various stages of treatment readiness and motivation. Programs should include and engage consumers along the continuum from denial to recovery.**
- 4. Attitudes and values of staff should include acceptance of all symptoms, empathy and the desire to promote self efficacy and instill hope for recovery.**
- 5. Non-judgmental, non-confrontational approaches are essential. Staff should be patient and convey genuine concern for the consumer's well being as a necessary pre-requisite to the development of trust. Treatment environments must be conducive to the relationship between level of consumer trust and positive treatment outcomes.**
- 6. The attainment of the provision of dual diagnosis services within each program model from both systems within a given community is a formidable goal. This should include continuity of care across program models, i.e., inpatient, clinic, clubhouse, detoxification, substance abuse counseling, residential, etc., and across systems, mental health and substance abuse. (Sciacca, Thompson 1996).
Curriculum, page 2, K. Sciacca.**
- 7. Consumers should have ready access to detoxification units, rehabilitation programs and other more intense models of treatment. Continuity across service models yields available dual diagnosis programs for consumers at various degrees of symptom severity and various levels of treatment and recovery.**
- 8. All direct care providers including case managers must be sensitive to, and understand both mental health and substance disorders. They should be trained in providing non-judgmental, basic interventions that assist consumers to become aware of their symptoms. They should support and encourage participation in dual diagnosis treatment whenever possible, and work cooperatively with dual diagnosis service providers.**
- 9. All consumers in both substance abuse and mental health programs should be provided with education about the etiology, symptoms, process and recovery from both substance disorders and mental health disorders. Substance abuse consumers do not initially have to own labels of mental disorders, and mental health consumers need not own labels of substance disorders. Information should be presented from the perspective of each symptom, i.e., depression, anxiety,**

delusions, addiction, etc. and interaction effects. Information should reduce stigma, blame and moral perspectives regarding any symptom of either the substance abuse or mental health disorder and related behaviors.

10. Engaging each consumer to comfortably discuss experiences around individual symptoms should permit an on-going assessment of the consumer's potential need for more formal or intense treatment. It should also include the opportunity to assist in motivating the consumer to recognize the effects these symptoms may have upon their well being, substance disorders and mental health.

11. Staff should be comfortable and supportive of various rates of consumer progress. Staff should be trained in skills that enhance consumer engagement and in motivational interviewing skills (Sciacca,1997).

12. Dual disorder group treatment for those consumers identified as having mental health and substance disorder symptoms should be integrated into each substance abuse and mental health program in every model of care regardless of duration. (Sciacca, Thompson, 1996).

13. Services should include a comprehensive dual diagnosis assessment (Sciacca, 1990). This should be administered by a trained professional at a time when the consumer is comfortable to discuss his/her symptoms about the disorder that is not

Curriculum, page 3, K. Sciacca.

the primary focus of the agency. The professional should be trained to interpret the assessment and integrate the information into treatment goals and planning.

14. Comprehensive treatment models should address dual/multiple disorders within a single treatment paradigm. Group treatment is optimal for this purpose. Small groups are often essential for engagement and sustained participation. Staff should receive training in group leading skills. They should be educated about each disorder and knowledgeable about interaction effects. They should be able to provide pertinent education to consumers.

15. Comprehensive services may also include programs for families of the dually diagnosed. Family programs may include multiple family groups. Content in these programs include education; assistance with resources; attention to the well being of family members including safety. Leaders should be trained to conduct these programs and to include on-going assessment of family issues (Sciacca, Hatfield, 1995). Families do not have to be in need of "treatment" to attend these programs. Dual diagnosis family programs can be based upon education, support and assistance with resources. Family members should be permitted to participate at their own pace and disclose information when comfortable to do so. One goal is to strengthen the family's ability to cope with the dually diagnosed relative and thereby prevent further loss of supports. Staff should respect families and learn from their experiences with the consumer. Families should be viewed as consumer supports and not as intruders.

16. Comprehensive services may also include consumer led self help programs as an adjunct to formal treatment (Sciacca, 1997). This alternative model provides additional support outside of program hours and provides new roles and responsibilities

for dually diagnosed consumers. In programs developed thus far consumers have met the challenges of this program model.

ADMINISTRATION:

- 1. Systems level administrators must make clear decisions to yield services and systems that are comprehensive in scope. The inclusion of dual diagnosis services across all levels of care and within each program in each system (mental health and substance abuse) is a formative goal. (Sciacca, Thompson, 1996).**
- 2. Decisions to yield a given community of care comprehensive must be clearly articulated to managers, supervisors and staff within every program in each system. This should include a Curriculum, page 4, K. Sciacca.**

written declaration of intent and goals.

- 3. A needs assessment may be conducted within and across systems and within each program. Managers and providers should be included in a survey that summarizes observations, suggestions, and potential solutions.**
- 4. A model of dual diagnosis treatment and services should be agreed upon. The model should be consistent in philosophy, methodology and attitudes and values.**
- 6. A plan of implementation should include integration of systems and accessible continuity of care across all program models.**
- 7. Implementation should begin with training overviews that include systems issues; historical divisions in philosophy and methodology across disciplines and systems; differentiating client profiles and corresponding treatment needs; etiology and physiology of discrete disorders of mental illness and substance disorders and an overview of interaction effects; the treatment model(s) and philosophy(s) intended for implementation; the attitudes, values and skills expected of staff to be identified for additional training as dual diagnosis resource persons; a review of program materials, screening, assessment, engagement, progress outcome, data collection, etc. (Sciacca, 1990, Sciacca, Thompson, 1996), and an overview of the training process and curriculum that staff will participate in to be able to implement programs and become resource persons.**
- 8. Follow up meetings with administrators, managers/supervisors of discrete programs should be included along with on-going staff development and training.**
- 9. Staff competencies should be reviewed as necessary to each program model. Staff disciplines should be considered for specific program models as optimal prerequisites for dual diagnosis training.**
- 10. The treatment model and outcome measures should be adapted to each specific service program. Adaptations account for length of stay; frequency of treatment; intensity of program; over-all goals and objectives of program. Dual diagnosis program guidelines and outcome goals and objectives should realistically reflect the level of motivation and readiness of the consumer and the duration and intensity of the interventions.**

11. Materials should be developed or revised in adaptation to each program model and its objectives. Implementation and refinement of these processes and materials should result in standards for each program model along Curriculum, page 5, K. Sciacca.

the continuum of care. This should address program development and implementation, and staff development curriculum and training.

12. Staff development should ensue with training groups that integrate disciplines and providers from both systems. Staff are cross-trained within the same training group. Optimal experiential training includes each staff member providing group treatment services within her/his own system and the alternative system with a co-leader who is from/familiar with the alternative system. Experiential training should occur under the supervision of the consultant/trainer as a part of the education, training and program implementation. (Sciacca, Thompson, 1996).

CURRICULUM Outline for MICAA and CAMI DIRECT CARE PROVIDERS: MENTAL ILLNESS, DRUG ADDICTION AND ALCOHOLISM, MIDAA (r). Training, Cross-Training and Program Development.

Developed by: Kathleen Sciacca, M.A.

MODULE ONE: Education regarding Systemic Issues. Training in Identification, and Initial Assessment:

1. Systemic Issues:

a. Education regarding in the Systemic issues in the delivery of services for dual/multiple disorders. Bureaucratic splits; The etiology of contrasting treatment methods and philosophies for discrete disorders, Mental Illness, Drug Addiction and Alcoholism (MIDAA), the need for new interventions and departures from traditional models; Statistical prevalence of dual disorders.

2. Identification and Initial Assessment:

a.) Training to administer screening instruments that identify consumers entering into or within the mental health system who may have substance disorders and consumers entering or within the substance abuse system who may have mental health symptoms.

b.) Guidelines to differentiate the various profiles of consumers, MICAA: Severe mental illness and substance disorders; CAMI: substance dependence with mental health symptoms; etc.; Sub-categories within profiles. (Sciacca, 1991, Sciacca, Thompson, 1996). Curriculum, page 6, K. Sciacca

- c.) Implement scales and guidelines to evaluate each consumer's level of readiness and motivation to participate in treatment for mental illness and/or substance disorders. (Sciacca, 1990, 1991, Sciacca, Thompson, 1996).
- d.) Training to determine and chart treatment goals and increments of progress that flow from each readiness level and to utilize forms and treatment plans to integrate this information (Sciacca, 1990, Sciacca, 1991, Sciacca 1994, Sciacca, Thompson, 1996).
- e.) Training in the diagnosis (DSM IV) of substance abuse and substance dependence. Training to utilize DSM IV remission criteria for each substance disorder.
- f. Education and training in the symptoms and physiological aspects of MIDAA in contrast to moral judgmental beliefs and stigma. To include: physiological considerations for each disorder, genetic theories, chemical changes with the use of various substances, i.e., crack/cocaine and resulting symptoms and interaction effects; etiological theories of mental illness i.e. schizophrenia and the roll of dopamine and other neurochemistry in mental illness. Interaction effects between mental illness and substance disorders. Some psychopharmacology.

COMPETENCIES:

1. Clinicians and direct care providers of all disciplines will learn to:

- a.) understand the systemic issues that impede services for dual disorders.
- b.) understand the differences between traditional mental health interventions, traditional substance abuse interventions and dual diagnosis treatment.
- c.) be accepting and non-judgmental of all symptoms of both mental illness and substance disorders.
- d.) demonstrate ability to administer a screening form upon intake.
- e.) demonstrate ability to determine each consumer's level of readiness to participate in treatment for mental illness and/or substance disorders. (Sciacca, 1990, 1991, Sciacca, Thompson, 1996).
- f.) view abstinence as a goal and not a requirement for treatment.
- g.) determine and chart increments of progress from a given readiness level and utilize specialized forms and treatment plans to integrate this information (Sciacca, 1990, Sciacca, 1991, Sciacca 1994, Sciacca, Thompson, 1996).
- h.) understand both mental illness and substance disorders
Curriculum, page 7, K. Sciacca.

as illnesses that require treatment.

- i.) demonstrate knowledge about the physiological aspects of both mental illness and substance disorders.
- j.) demonstrate ability to diagnostically (DSM IV) differentiate substance abuse and substance dependence and to utilize criteria for each of these.
- k.) be knowledgeable about basic pharmacology.

MODULE TWO: Engagement and Treatment:

1. Engagement and Treatment: Training and Competencies:

- a.) Education and training in engagement strategies and interventions for consumers at all levels of treatment readiness and motivation (Miller, Rollnick, 1991, Sciacca 1990, Sciacca, Thompson, 1996, Sciacca, 1997).
- b.) Ability to be respectful, and dispel stigma and moral beliefs about mental illness and substance disorders.
- c.) Ability to convey an empathic and concerned style of intervention.
- d.) Ability to encourage and inspire hope for recovery and support self efficacy.
- e.) Ability to be persistent in follow up, engagement, providing assistance and flexible in one's ability to change course and remain engaged in a relationship/alliance with the consumer.
- f.) Ability to be respectful of family members and carefully consider information provided by families and other sources.
- g.) Ability to encourage consumers to take necessary medications and continue in treatment other than dual diagnosis as needed.
- h.) Gain experience in working with consumers who have Severe Persistent Mental Illness (SPMI).
- i.) Trained and experienced in on-going evaluation and differential diagnosis at various stages of the consumer's treatment and recovery.
- j.) Trained and able to assist the consumer along the continuum from denial and/or low motivation with the use of a non-confrontational approach to perceived denial or resistance.
- j.) Trained to assist the consumer along the continuum of more active involvement in dual diagnosis treatment leading to the acknowledgement of substance use, insight into substance abuse and dependence, insight into interaction effects with mental illness, motivation to abstain, active participation in treatment toward abstinence, abstinence and relapse prevention. Active participation in mental health treatment. (Sciacca, 1991, Sciacca, & Thompson,1996).
Curriculum, page 8, K. Sciacca.
- k.) Trained in group process, group leadership skills if they are assigned to provide group treatment. Demonstrated ability to provide individualized interventions within a group process.
- l.) Trained to provide education about the real properties of discrete MIDAA and dual/multiple disorders and recovery.
- m.) Educated about dynamic treatment considerations such as developmental arrest, separation issues, identity formation, and potential for intimacy.
The ability to provide interventions that foster the potential for growth and development in each of these areas.
- n.) Trained in the theory and practice of Motivational Interviewing strategies and interventions (Miller & Rollnick, 1991, Sciacca, 1997).
- o.) Trained to facilitate multiple family groups.
- p.) Ability to present a case for review in a comprehensive manner that includes all aspects of the consumer's profile and all disorders (Sciacca,1990, Sciacca,1994, Sciacca & Thompson,1996).

- q.) Skilled in assisting consumers to adjust to adjunct programs such as self help, additional treatment, social programs and other supports and services.
- r.) Knowledge and understanding of consumer/provider dynamics of transference and counter-transference and ability to seek supervision to sustain provider objectivity and integrity.
- s.) should be knowledgeable about the effects of sexual and physical abuse and relationship to mental health symptoms and substance disorders. Trained in appropriate interventions to address these symptoms.
- t.) Should be skilled in providing treatment interventions for consumers who have been abused and traumatized. Skills should include appropriate timing for interventions; follow up for residual effects of disclosure; debriefing to minimize residual effects of disclosure or exposure to subjects that may evoke memories of past trauma and abuse.
- u.) should be knowledgeable about issues surrounding ACOA's and co-dependency.

SUMMARY: Demonstrate abilities to provide a dual diagnosis treatment approach effective with all populations including persons with severe, persistent mental illness: Includes use of Readiness scale for treatment starting points; engagement strategies, pre-group interview (Sciacca) and motivational interviewing (Miller and Rollnick); the development of educational treatment groups and individual interventions from "denial to recovery;" Treatment content, education & materials.

Curriculum, page 9, K. Sciacca.

process, and interventions used along the continuum of change; charting progress with progress review criteria to match starting points and progress; Recovery from substance dependence and relapse prevention. Outcome measures. Integration of dual diagnosis treatment strategies, interventions and techniques correlated with motivational interviewing skills and techniques.

ADDITIONAL COMPETENCIES:

- v.) Knowledgeable about the program procedures to follow to assist consumers with acute symptoms or in crisis.
- w.) Knowledge of when it is appropriate to refer consumer for further evaluation and treatment.
- x.) Knowledgeable about understand gender issues specific to men and women in substance abuse treatment and recovery.
- y.) Knowledgeable about self help programs both traditional AA, NA and new models for dual diagnosis.
- z.) Knowledgeable about the resources and programs available in their community for treatment enhancement and referral.

Clinician's who prescribe and administer medication,

Additional Competencies:

- a.) receive education and training regarding considerations for providing medication to consumers who are using/abusing illicit substances, alcohol and medication. Including

medication adjustments at various stages of treatment and recovery.

- b.) should provide services that include educating consumers and non-medical staff about interaction effects of medication and substance use.
- c.) should be knowledgeable about symptoms of tolerance and withdrawal.
- d.) should be knowledgeable and experienced in guiding consumers through outpatient/inpatient detoxification.

ADDITIONAL SPECIAL TOPICS:

- a.) Education regarding fetal alcohol syndrome and effects;
- b.) Fetal effects of crack/cocaine on infants and child development;
- c.) Programs and interventions specific to adolescents.
- d.) Special considerations for the treatment of women.
- e.) Programs for families of dually diagnosed clients.
- f.) Consumer led self help.

Curriculum, page 10, K. Sciacca.

MODULE THREE: COMPREHENSIVE ASSESSMENT, TREATMENT PLANNING AND OUTCOME MEASURES. TRAINING AND COMPETENCIES:

1. COMPREHENSIVE ASSESSMENT:

- a.) Training and demonstrated ability administer an assessment that includes mental illness, substance disorders and interaction effects (Sciacca, 1990, Sciacca, 1994, Sciacca, Thompson, 1996).
- b.) Training and demonstrated ability to integrate the findings of comprehensive assessment into short and long term treatment plans and on-going evaluations.
- c.) Treatment planning for the attainment of stability and/or remission.
- d.) Treatment planning for relapse prevention.
- e.) Training and demonstrated ability to provide on-going comprehensive assessment of families of the dually diagnosed (Sciacca, Hatfield, 1995).
- f.) Training and demonstrated ability to integrate information from family assessment into a plan and evaluation.
- g.) Training and experience in diagnostic and remission criteria (DSM IV). Basic knowledge of diagnostic criteria for SPMI, personality disorders, substance disorders and organic impairment.
- h.) Basic knowledge of symptoms of tolerance and withdrawal.

2. TREATMENT PLANNING AND OUTCOME MEASURES: Training and Competencies:

- a.) Demonstrated ability to follow treatment planning guidelines that address each of the dual or multiple disorders, interaction effects and other pertinent factors.
- b.) Demonstrated ability to develop goals and objectives that flow from the consumer's levels of motivation and readiness for each of the discrete disorders and interaction effects.

- c.) Demonstrated ability to measure outcome in increments that follow the consumer's present status. Determine short term, interim and long term goals.
- d.) Demonstrated ability to provide interventions that meet the consumer at the level of readiness and participation for each disorder. Identify goals and objectives and facilitate movement in each area.
- e.) Document change in progress reviews, readiness scales, progress notes and other forms of documentation.

Curriculum, page 11, K. Sciacca.

MODULE FOUR: PROGRAM DEVELOPMENT AND IMPLEMENTATION: Training and Competencies:

- a.) Develop and implement rules and guidelines that assure safety for all consumers.
- b.) Develop procedures for staff to follow for crisis situations and acute symptoms.
- c.) Every acute care, emergency and crisis program should perform drug and alcohol screens on each consumer upon intake or as soon as possible thereafter.
- d.) Implement forms and program underpinnings: screening, readiness scales, comprehensive assessment, outcome measures, data collection and others.
- e.) Develop a protocol that follows dually diagnosed consumers from initial intake to participation in services and outcome measures. Maintain information regarding disposition for each dually diagnosed consumer.
- f.) Compile data regarding statistics and consumer profiles.
- g.) Develop procedures and locate resources for referral and access to special services. Special services should include:
 - * emergency psychiatric evaluation and services.
 - * emergency medical services.
 - * emergency detoxification services.
 - * crises care facilities.
 - * neurological and psychological testing.
 - * shelter services and facilities.
 - * vocational services.
 - * medical benefits.
 - * residential care.
- h.) Adaptation of program elements to existing program parameters, i.e., length of stay, program goals, etc.
- i.) Staff development curriculum and strategies. In-service training, education, and supervision.
- j.) Staff development outcome measures.
- k.) The development of systematic, consistent programs, services and interventions in contrast to diverse services unrelated in philosophy or methodology.

l.) Interagency dual diagnosis program implementation across a variety of treatment settings, i.e., inpatient, outpatient, residential, clubhouse, case management, ACT teams, day treatment, clinics, shelters, etc.

Curriculum for MICAA and CAMI Direct Care Providers: Training,

Curriculum, page 12, K. Sciacca.

Cross-Training and Program Development.

Developed by: Kathleen Sciacca, M.A, Sciacca Comprehensive Service Development for MIDAA. New York City, Tel.212-866-5935.

*Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997. Copyright, Kathleen Sciacca, 1997,1998,2003, 2006.

References:

Sciacca, K. 1987. "New Initiatives in the Treatment of the Chronic Patient with Alcohol /Substance Use Problems" TIE-Lines, Published by the Information Exchange on Young Adult Chronic Patients, Bert Pepper, M.D., Executive Director Vol. 1V, No. 3, July 1987.

Sciacca, K., 1990-2002. "MIDAA SERVICE MANUAL: A Step by Step Guide to Program Implementation and Comprehensive Services for Dual/Multiple Disorders. Pub. Sciacca Comprehensive Service Development for MIDAA, NYC, revised 1995, 2000, 2001, 2002.

Sciacca, K., 1991. "An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders" New Directions for Mental Health Services, Dual Diagnosis of Major Mental Illness and Substance Disorders, Eds., Minkoff, K. and Drake, R., Jossey-Bass, publishers, summer 1991, #50.

Sciacca, K., 1995 Video: "Integrated Treatment for MIDAA: The Alaska Example." Producer, Sciacca Comprehensive Service Development for MIDAA, New York, N. Y. 1995. Invited and included in the Library of Congress.

Sciacca, K., Hatfield, A.B., 1995. "The Family and the Dually Diagnosed Patient" Double Jeopardy, Eds. Lehman, A.F., and Dixon, L.B., Harwood Academic Publishers, 1995, Chapter 12, pp.193-209.

Sciacca, K., and Thompson, C. M.,1996. "Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction and Alcoholism, MIDAA," The Journal of Mental Health Admin. Vol.23, No.3. Summer 1996, pp.288-297.

Sciacca, K., July-1996. "On Co-occurring Addictive and Mental Disorders: A Brief History of the Origins of Dual Diagnosis Treatment and Program Development." Invited Response, America Journal of Orthopsychiatry (66) 3, July 1996.

Sciacca, K. 1997. "Peer Support for People Challenged by Dual Diagnosis: Helpful People In Touch," Consumers as Providers in Psychosocial Rehabilitation, Eds. Mowbray, C.T., Moxley, D.P., Jasper, C.A.,Howell, L.L.,IAPSRs publisher, 1997.Chapter 6, 82.

Sciacca, K. 1997. "Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing" Professional Counselor, Volume 12, No.1, February 1997, pp. 41-46.

Sciacca, K. 1997, "Cross-Training Yields Continuity in Dual-Curriculum, page 13, K. Sciacca.

Diagnosis Programs." Mental Health Weekly, Vol. 7, No. 21, Page 6. Manisses Pub. Providence, RI.

Sciacca, K. 1998, "Curriculum for MICAA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism MIDAA(R): Training, Cross-Training and Program Development" Addendum to SAMHSA-CMHS Managed Care Initiative Co-Occurring Disorder Panel Report: Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curricula. Chair, K. Minkoff, 1998.

Sciacca, K. 1998, "Tennessee Initiates State-wide Dual Diagnosis Program Development." Alcoholism and Drug Abuse Weekly, Vol. 10, No. 7, Page 5. Manisses Pub. Providence, RI.

Sciacca, K. 1999, "D.C. Reports Progress with Dual Diagnosis Integration Initiative." Alcoholism and Drug Abuse Weekly, Vol. 11, No. 41, Page 5. Manisses Pub. Providence, RI.

Sciacca, K., 2001, "Kentucky Dual Diagnosis Residence Yields Remarkable Outcome." Mental Health Weekly, Vol. 11, No. 7, Page 5. Manisses Pub. Providence, RI.

Alcoholism and Drug Abuse Weekly, 2003, "GA seeks statewide implementation of dual-diagnosis strategy" Vol. 15, No. 17, Pgs. 1/6/7. April 28, 2003, Manisses, Inc. Providence, RI.

- A. Mehr J: Professional Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997
- B. Mehr J: Case Manager Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997
- C. MICA Case Management Curriculum Model. Final Report. Eastern Washington University Alcohol/Drug Studies Program, July 1993
- D. Ridgely MS, Osher FC, Johnson J: Integrating Clinical Care for People with Co-occurring Mental Health and Substance Abuse Disorders. Baltimore, MD: The University of Maryland and Baltimore and State of Maryland, Mental Hygiene Administration, 1995
- E. Sciacca Comprehensive Service Development for MIDAA: Curriculum for MICAA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism, MIDAA. Training, Cross-Training and Program Development. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997. Developed by Kathleen Sciacca, MA, New York, NY
- F. The Information Exchange, Inc.: Substance Abuse and Mental/Emotional Disorders: Counselor Training Manual and Trainer's Guide. Developed by Jackie Massaro, CSW. New York, 1995

BIBLIOGRAPHY

For a comprehensive listing of all the background material that was reviewed in the development of this report, the reader is referred to the report's companion document:

Center for Mental Health Services Managed Care Initiative:
Clinical Standards and Workforce Competencies Project

Co-Occurring Mental and Substance Disorders (Dual Diagnosis) Panel
Annotated Bibliography
July 1997

The following list includes from this Annotated Bibliography those references that were specifically cited or extensively utilized in the development of this report. The references are listed by code number as they appear in the Annotated Bibliography:

001

Action for Mental Health II. Improving Treatment for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders. SAMHSA Conference Report, 1996

002

Mee-Lee D: Managed care and dual diagnosis, in Treating Co-Existing Psychiatric and Addictive Disorders: A Practical Guide. Edited by Miller NS. Center City, MN, Hazelden, 1994, pp 257-269

005

Minkoff K: CHOICE-Dual (Choate Outline for Intensity of Care Evaluations for Dual Diagnosis Patients), 1997. Unpublished.

006

Minkoff K, Rossi A: Treatment Interventions By Phase Of Recovery And Type Of Dual Diagnosis, 1996. Unpublished workshop outline and table

007

ASAM PPC-2 Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd Edition, American Society of Addiction Medicine, 1996

008

Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse. Treatment Improvement Protocol (TIP) Series. U.S. Department of Health and Human Services. Center for Substance Abuse Treatment, 1994

010

Drake RE, Mueser KT, Clark RE, Wallach MA: The course, treatment, and outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry* 1996;66(1):42-51

011

Integrating Mental Health and Substance Abuse Services for Homeless People with Co-Occurring Mental and Substance Abuse Disorders - A Technical Assistance Report. Center for Mental Health Services Policy Research Associates. Delmar, N.Y. Undated

015

The Mental Health Center of Greater Manchester (New Hampshire) Practice Guideline: Substance Abuse. Undated. Submitted by Douglas Noordsy, MD

017

Minkoff K: An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry* 1989; 40:1031-1036

018

Minkoff K: Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders, in *Dual Diagnosis of Major Mental Illness and Substance Disorder*. New Directions for Mental Health Services No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1991, pp 13-27

022

Osher FC: A vision for the future: toward a service system responsive to those with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry* 1996;66(1):71-76

023

Osher FC, Drake RE: Reversing a history of unmet needs: approaches to care for persons with co-occurring addictive and mental disorders. *Am J Orthopsychiatry* 1996; 66(1):4-11

024

Osher FC, Kofoed LL: Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hosp and Community Psychiatry* 1989;40:1025-1030

026

Ries RK, Miller NS: Dual diagnosis: concept, diagnosis, and treatment, in *Current Psychiatric Therapy*. Edited by Dunner DL. Philadelphia, W. B. Saunders, 1993, pp 131-138

028

Sciacca K, Thompson CM: Program development and integrated treatment across systems for dual diagnosis: mental illness, drug addiction, and alcoholism (MIDAA). *J Mental Health Admin* 1996; 23(3): 288-297

033

Wilens TE, O'Keefe J, O'Connell JJ, et al.: A public dual diagnosis detoxification unit. Part I: organization and structure. *Am J Addictions* 1993; 2:91-98

Wilens TE, O'Keefe J, O'Connell JJ, et al.: A public dual diagnosis detoxification unit. Part II: observation of 70 dually diagnosed patients. *Am J Addictions* 1993; 3:181-193

040

Godley SH: A Treatment System United for Persons With Mental Illness and Substance Abuse. The Illinois MI/SA Project, Bloomington, IL: Lighthouse Institute, 1995

049

Pennsylvania's Client Placement Criteria for Adults. Pennsylvania Department of Health, Office of Drug and Alcohol Programs, 1997

053

Washington State Materials (submitted by R. Ries, MD)

1. Regulations Governing MICA Providers , Draft 1992

2. MICA Case Management Curriculum Model. Final Report. Eastern Washington University Alcohol/ Drug Studies Program, July 1993

055

1996 Utilization Management Guidelines. Merit Behavioral Care Corporation. Park Ridge, NJ, Merit Behavioral Care

074

Regier DA, Farmer ME, et al.: Comorbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area (ECA) study. *JAMA* 1990; 264(19):2511-2518

077

Green VL: The resurrection and the life. *American Journal of Orthopsychiatry* 1996; 66(1):12-16

078

Hazelden Foundation. The Dual Disorders Recovery Book. Center City, MN, Hazelden, 1993

081

Sciacca K: Peer support for people challenged by dual diagnosis: "helpful people in touch," in Consumers as Providers in Psychiatric Rehabilitation. Edited by Mowbray CT, Moxley DP, Jasper CA, Howell LL. Columbia, MD, IAPSRs, 1997, pp 82-94

088

Drake RE, Bartels SJ, et al.: Treatment of substance abuse in severely mentally ill patients. *Journal of Nervous and Mental Disorders* 1993; 181:606-41

089

Drake RE, Mueser KT (eds): Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. San Francisco, Jossey-Bass, 1996

099

Lehman AF, Dixon LB (eds): Double Jeopardy: Chronic Mental Illness and Substance Use Disorders. Switzerland, Harwood Academic Publishers, 1995

101

McHugo G, Drake R, Burton H, Ackerson T: A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *J Nervous Mental Disorder* 1995; 183:762-767

102

McLaughlin P, Pepper B: Modifying the therapeutic community for the mentally ill substance abuser, in *Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50.* Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 85-93

105

Mueser KT, Drake RE, et. al.: Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness. Evaluation Center @ Human Services Research Institute, 1995

111

Mercer-McFadden C, Drake RE: Review And Summaries: National Demonstration of Services for Young Adults with Severe Mental Illness and Substance Use Disorders, 1995

114

Executive Summaries From 16 Federally-Funded Programs For Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders. Center for Mental Health Services and Center for Substance Abuse Treatment, 1995

116

Daley DC, Thase ME: *Dual Disorders Recovery Counseling.* Independence, MO, Independence Press, 1994

119

Evans K, Sullivan JM: *Treating Addicted Survivors of Trauma.* New York, NY, The Guilford Press, 1995

124

Coexisting Mental Illness and Alcohol and Other Drug Dependencies in Pregnant and Parenting Women. Special Issue. Edited by Jessup M. *Journal of Psychoactive Drugs* 1996; 28(4)

128

Sullivan JM, Evans K: Integrated treatment for the survivor of childhood trauma who is chemically dependent. *Journal of Psychoactive Drugs* 1994; 26 (4):369-78

140

The Principles and Practice of Addictions in Psychiatry. Edited by Miller NS. Philadelphia, PA, J. W. Saunders, 1997

141

Montrose K, Daley D: *Celebrating Small Victories.* Center City, Minnesota, Hazelden Press, 1995.

142

Miller WR, Rollnick S: *Motivational Interviewing.* New York, NY, The Guilford Press, 1991

143

Sciacca K: *Removing barriers: dual diagnosis treatment and motivational interviewing.* Professional

Counselor 1997 (in press)

144

Zweben JE, Smith DE, Stewart P: Psychotic conditions and substance use: prescribing guidelines and other treatment issues. *Journal of Psychoactive Drugs* 1991; 23(4):387-95

A few additional materials were referenced in this report which were not specifically listed in the Annotated Bibliography:

1. American Association of Community Psychiatrists: Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) - Adult Version 1.5. 1997
2. Connecticut Department of Mental Health and Addiction Services. Dual Diagnosis Task Force Report. Douglas Ziedonis and Jay Simsarian, Co-Chairs, 1997
3. Mehr J: Professional Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997
4. Mehr J: Case Manager Curriculum for MISA/MICA. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997
5. MICA Case Management Curriculum Model. Final Report. Eastern Washington University Alcohol/Drug Studies Program, July 1993
6. O'Keefe CO, Potenza DP, Mueser KT: Treatment outcomes for severely mentally ill patients on conditional discharge to community-based treatment. *J Nerv Mental Dis* 1997;185:409-411
7. Prochaska JO, DiClemente CC, Norcross JC: In search of how people change: applications to addictive disorders. *Am Psychol* 1992;47:1102-1114
8. Ridgely MS, Osher FC, Johnson J: Integrating Clinical Care for People with Co-occurring Mental Health and Substance Abuse Disorders. Baltimore, MD: The University of Maryland and Baltimore and State of Maryland, Mental Hygiene Administration, 1995
9. Sciacca Comprehensive Service Development for MIDAA: Curriculum for MICA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism, MIDAA. Training, Cross-Training and Program Development. Developed for Managed Care Initiative Panel on Co-Occurring Disorders, 1997. Developed by Kathleen Sciacca, MA, New York, NY
10. The Information Exchange, Inc.: Substance Abuse and Mental/Emotional Disorders: Counselor Training Manual and Trainer's Guide. Developed by Jackie Massaro, CSW. New York, 1995

