*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.

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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 MICAA Training Site for Program and Staff Development New York State-wide. Ms. Sciacca has a certificate as trainer of Motivational Interviewing.

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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).

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 administrated by a trained professional at a time when the consumer is comfortable to discuss his/her symptoms about the disorder that is not

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 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

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 it's objectives. Implementation and refinement of these processes and materials should result in standards for each program model along

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).

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 1V 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

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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).

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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.

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.

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.

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.

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Cross-Training and Program Development.
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