Implementing Co-occurring Capable Mental Health and Addiction Services

The guide is designed to assist providers and planners to move from addiction only or mental health only services to co-occurring capable. It also briefly describes the key components in moving to co-occurring enhanced.
The implementation process considers seven categories: Program Structure, Program Milieu, Clinical Process: Assessment, Clinical Process: Treatment, Continuity of Care, Staffing, Training.
Each category has subcategories for implementation which are outlined below. This guide is aligned to the DDCAT (Dual Diagnosis Capability in Addiction Treatment.), The DDCAT is designed to measure co-occurring capacity

I. Program structure

II. Program milieu

III. Screening and Assessment.

IV. Treatment

V. Continuity of Care

VI. Staffing

VII. Training

I. Program structure

Addiction or mental health only: Program certified/licensed to provide only MH or SA treatment; no formal collaboration or coordination with other MH or SA agencies; can bill for only MH or SA.

Capable: No barriers to providing treatment for both disorders; formalized and documented coordination with other disorder (MH or SA) agencies; can bill for both MH and SA (but stipulations on what disorder must be primary).

Enhanced: Licensed and/or certified to provide treatment for MH and SA; integrated services within existing program; can bill for MH or SA or the combination/integration.

IA. Primary treatment focus as stated in mission statement

Definition: Programs that offer treatment for individuals with COD should have this philosophy reflected in their mission statements.

Enhancing IA. Primary treatment focus as stated in mission statement.
Example: AO or MH only programs are likely have a more traditional mission statement such as: "The North Side Alcohol and Drug Treatment Center (NSADTC) is dedicated to assisting persons with alcohol and drug problems regain control over their lives."
Although mission statements may not translate into actual practice in any given treatment program or organization, a change in a mission statement is emblematic of a "sea change" in leadership philosophy and commitment. A subtle shift in the last phrase of the NSADTC mission statement to: "The North Side Alcohol and Drug Treatment Center (NSADTC) is dedicated to assisting persons initiate a process of recovery from substance use and its associated problems." This change would begin to position the AO/M.H.O program as DDC.

IB. Organizational certification & licensure
Definition: Organizations that provide integrated COD treatment are able to provide unrestricted services to individuals with COD without barriers that have traditionally divided the services for mental health disorders from the services for substance related disorders. The primary examples of organizational barriers include licenses or certifications of clinics or programs that restrict the types of services that can be delivered.

Enhancing IB. Organizational certification and licensure
Example: A program's legitimate licensure restrictions encumber a program to provide solely to persons who meet criteria for a substance use or mental health disorder. Even though up to 80% of such persons will likely have a co-occurring disorder, the program must declare the substance use or mental health disorder as primary if not singular. Some programs have "spoken" mythologies but non-reality based constraints of their inability to treat persons with co-occurring disorders. Two practical strategies are possible to elevate to DDC level services. First, actual state and regional policies must be verified so that restrictions, if they do exist, can be encountered as reality-based. Some state authorities have considered making special allocations for persons with co-occurring disorders (i.e. substance use disorders with complications). Other programs have sought either joint substance abuse/mental health licensure or hired or enabled licensed staff to bill for unbundled services. Finally, it is common for a program to provide services in the context of one areas license but provide treatment services in the other area in a general approach and with treatment individualized accordingly.

IC. Coordination and collaboration with mental health/addiction services

Definition: Programs that transform themselves from ones that only provide for one disorder into ones that can provide integrated COD services typically follow a pattern of staged advances in their service systems. The steps indicate the degree of communication and shared responsibility between providers who offer services for mental health and substance related disorders. The following terms are used to denote the stepwise advances and were provided from SAMHSA (Drafted PPG Measures, SAMHSA, 2004). Within the PPG Measures document, the following reference is made: *The coordination, consultation, collaboration, and integration categories and definitions were developed by a Task Force known as the CMHS-CSAT-NASMHPD-NASADAD Workgroup comprised of Federal and State officials and representatives of the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol Drug Abuse Directors (NASADAD).*

AO/MHO PROGRAMS

Enhancing IC. Coordination and collaboration with mental health services

Example: AO/M.H.O level programs either have no existing or a rather informal relationship with the local mental health provider or vice versa. Programs intending to achieve DDC status must develop more formalized procedures and protocols to coordinate services for persons with co-occurring disorders.

The North Shore Alcohol and Drug Treatment Center (NSADTC) generally referred patients to the Lakeland Mental Health agency for psychiatric emergencies or for a medication evaluation if deemed appropriate. Psychiatric emergencies would occur 1-2 times per year, and would usually be dealt with by calling the local 9-1-1 line. A social worker at NSADTC, who formerly worked at Lakeland, was often asked to call to squeeze in the most "needy" of potential medication patients, so that they might be evaluated within a more expedient time frame (less than the typical 45 day wait).

To become DDC, NSADTC initiated a series of meetings with Lakeland and the agencies composed a memorandum of understanding (MOU) that addressed admission, transfer and referral procedures. Monthly meetings between program coordinators and designated intake clinicians were also initiated to review the protocol and discuss plans for common patients. An AO/M.H.O program moves from a loose and clinician-driven consultation model to a collaborative one in order to become DDC.

ID. Financial Considerations

Definition: Programs that are able to merge funding for the treatment of substance related disorders with funding for the treatment of mental health disorders have a greater capacity to provide integrated services for individuals with CODs.

AO/MHO PROGRAMS
Enhancing ID. Financial considerations

Example: Programs that are AO/M.H.O level typically cannot bill or receive reimbursement for any other services. AO programs that have shifted to DDC services have been able to locate physicians or prescribers on whose behalf they can bill for unbundled services. Another mechanism is to obtain contract or grant funding to provide adjunctive pharmacological or psychosocial services. The methadone maintenance program at Comprehensive Options for Drugs and Alcohol (CODA) in Portland Oregon secured additional county grant funding to provide psychiatric and mental health counseling for methadone clients with mental health problems. This additional funding from the Multnomah County Board covered the human resources of a psychiatrist (.1 FTE) and a clinical social worker (.5 FTE). Similarly, MHO programs moving to DDC have added substance abuse counselors to their team.

II. Program milieu

Addiction or mental health only: Expect MH or SA clients only; might deflect clients with other disorder; literature and patient educational materials available for either MH or SA.

Capable: Expect both MH and SA clients; accept other disorder routinely if stable; literature and patient educational materials available for both MH and SA.

Enhanced: Documented in mission statement to expect, accept and treat MH and SA disorders; literature and patient educational materials available for COD.

IIA. Routine expectation of and welcome to treatment for both disorders

Definition: Persons with COD are welcomed by the program or facility, and this concept is communicated in supporting documents. Persons who present with co-occurring mental disorders are not rejected from the program because of the presence of this disorder.

Enhancing IIA. Routine expectation of and welcome to treatment for both disorders

Example: AO programs typically foster a more traditional ambiance and environment. This cultural "atmosphere" is focused on substance-related issues and recovery from addiction only. Often this focus edges out the possibility of a dialogue or openness about psychiatric problems or concerns. This milieu may not enable a patient to inquire about the potential for recovery from psychiatric disorders also.

AO/M.H.O programs seeking to become DDC can decrease the stigma and elevate the status of each disorders by providing in waiting areas brochures that describe psychiatric problems (e.g. depression), substance abuse problems and co-occurring disorders. Also these subjects can be routinely raised in orientation sessions, community meetings, "rap" sessions, or family visits. Doing so explicitly conveys a welcoming and acceptance of persons with co-occurring

IIB. Display and distribution of literature and patient educational materials.
Definition: Programs that treat persons with co-occurring disorders create an environment which displays and provides literature and educational materials that address both mental and substance use disorders.

III. Screening and Assessment

Addiction or mental health only: pre-admission screening for other disorder based on self report; make and document only MH or SA diagnosis; can provide care only to MH or SA clients; stage of change/motivation for treatment not assessed.

Capable: clinicians screen for other disorder using a routine set of questions and conduct a formal assessment on site, if indicated; variably make and document both MH and SA diagnosis; can provide care to MH and SA clients, if other disorder is primarily stable; stage of change/motivation for treatment assessed and documented by clinician.

Enhanced: Clinicians use standardized instruments with established psychometric properties to screen for disorders and, if indicated, assess using a formal integrated assessment; standard and routine diagnosis of both disorders; can provide care to clients with COD, regardless of stability of other disorder; stage of change/motivation for treatment assessed with formal measure and documented

Screening

IIIA. Routine screening methods for psychiatric symptoms
Definition: Programs that provide services to individuals with COD routinely and systematically screen for both substance related and mental disorders. The following text box provides a standard definition of "screening" and originates from SAMHSA (Drafted PPG Measures, SAMHSA, 2004)

Screening: The purpose of screening is to determine the *likelihood* that a person has a co-occurring substance use or mental disorder. The purpose is *not* to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services. There are three essential elements that characterize screening: intent, formal process, and early implementation.

- Intent: Screening is intended to determine the possibility of a co-occurring disorder, not to establish definitively the presence, or absence, or specific type of such a disorder.
- Formal Process: The information gathered during screening is substantially the same no matter who collects it. Although a standardized scale or test need not be used, the same information must be gathered in a consistently applied process and interpreted or used in essentially the same way for everyone screened.
- Early Implementation: Screening is conducted early in a person's treatment episode. Screening would routinely be conducted within the first four (4) visits or within the first month following admission

AO/MHO PROGRAMS
Enhancing IIIA. Routine screening methods for psychiatric symptoms

Example: AOS programs typically attempt to capture or detect psychiatric problems via an initial phone interview. This may be attempted by inquiring about current and past , medications, prior psychiatric hospitalizations, and if the caller ever received a "mental health" diagnosis. Some AOS programs extend this procedure to include clinician-driven questions at intake, broadly under the concept or rubric of a "biopsychosocial" assessment. In order to become DDC, the program must at least incorporate a routine set of specific questions (such as to assess mood, PTSD, or trauma symptoms), and a routine mental status screening, including questions to assess risk of harm to self or others.

Assessment

IIIB. Routine assessment if screened positive for psychiatric or s.a symptoms
Definition: Programs that provide services to persons with COD should routinely and systematically assess for psychiatric problems as indicated by a positive screen. The following text box provides a standard definition of "assessment" and originates from SAMHSA (Drafted PPG Measures, SAMHSA, 2004).

Assessment: An assessment consists of gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of a co-occurring disorder; determine the client's readiness for change; identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage a person in the development of an appropriate treatment relationship. The purpose of the assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan. Although a diagnosis is often an outcome of an assessment, a formal diagnosis IS NOT required to meet the definition of assessment, as long as the assessment establishes (or rules out) the existence of some mental health or substance use disorder. Assessment is a formal process that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. For instance, if reasonably current and credible assessment information is available at the time of program entry, the (full) process need not be repeated. There are two essential elements for the definition of assessment: establish or rule-out a co-occurring disorder (diagnosis) and results of assessment are used in treatment plan.
Establish (rule-out) Co-occurring Disorder: The assessment must establish justification for services and yield sufficient information to determine or rule-out the existence of co-occurring mental health and substance use disorders. [A specific diagnosis is NOT required.]
Results used in treatment plan: The assessment results must routinely be included in the development of a treatment plan.

AO/MHO PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for psychiatric symptoms

Example: DDC programs offer a mental health assessment (or S.A assessment if MHO) to persons who are identified via screening, by history or by observable behaviors. Such assessments are guided by the belief that there is a potential benefit for a mental health treatment (e.g. medication). DDC programs offer such assessments on site and these can be conducted on a routine and consistent basis. The assessments themselves need not be overly formalized, however, consistency across clinicians would be insured if they were. The New London Clinic provides a mental health assessment to patients who are identified as "in need" of a psychiatric evaluation. This evaluation is performed by the consultant nurse practitioner who is at the program one day per week.

DDC PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for psychiatric symptoms

Example: To achieve a DDE level on this item, DDC programs must institute a systematic mental health assessment (or S.A assessment) for all cases. This is based on the clear expectation that all patients entering the treatment will have a co-occurring psychiatric disorder. A DDE program will conduct these assessments in a consistent manner across clinicians. This can either be accomplished by an electronic clinical decision support tool (EMR), or a semi-structured clinical interview (GAIN, Addiction Severity Index (ASI), Structured Clinical Interview for DSM-IV-TR (SCID)), or another well-defined and thorough protocol developed by the program.

IIIC. Psychiatric and substance use diagnoses made and documented.

Definition: Programs serving persons with co-occurring disorders have the capacity to routinely and systematically diagnose both mental disorders and substance related disorders.

AO/MHO PROGRAMS

Enhancing IIIC. Psychiatric and substance use diagnoses made and documented

Example: AOS programs only register a substance use disorder diagnosis in their medical record or patient chart. There are numerous reasons for this exclusive focus. To become DDC however, AO programs must follow the process from screening to assessment to a formal diagnosis. This diagnosis must be regularly included in the program's documentation or electronic record. Including a problem (e.g. depression problem) or a rule out (e.g. R/O dysthymia) are not acceptable at the DDC level.

DDC PROGRAMS

Enhancing IIIC. Psychiatric and substance use diagnoses made and documented.

Example: Most DDC programs already can provide mental health diagnoses. These diagnoses are reflected in a sample of medical records. To attain DDE level services, these diagnoses, when present, are more systematically and routine ascertained. Further, they are observable in a sample of all records and all patients being treated. The diagnoses are specific, and may include all five of the axes on the DSM-IV multi-axial system.

IIID. Psychiatric and substance use history reflected in medical record

Definition: COD assessment and evaluative processes routinely assess and describe past history and the chronological or sequential relationship between substance related and psychiatric disorders or problems.

AO/MHO PROGRAMS

Enhancing IIID. Psychiatric and substance use history reflected in medical record

Example: Assessing and diagnosing psychiatric disorders in addiction treatment are complicated by the effects of substances, from intoxication to craving to withdrawal to protracted withdrawal. The DSM-IV provides some guidelines in making differential diagnosis (substance-induced vs. independent disorders) and the Clinical Institute for Withdrawal Assessment (CIWA) assists in identifying the type and severity of withdrawal symptoms.

Programs at the DDC level have narrative documentation of the substance use and psychiatric disorders in terms of ages of onset, the course of the psychiatric disorders during active substance use or periods of abstinence, and the course of the substance use during treatments or remission of the mental health disorder. This is recorded in the client chart and typically documented as a narrative in a quasi-chronological format.

DDC PROGRAMS

Enhancing IIID. Psychiatric and substance use history reflected in medical record

Example: DDE programs recognize the complexity of the interaction of these disorders, and that only by conducting a longitudinal and systematic observation will the relationship between disorders be comprehended. DDC programs have specific and dedicated segments in their initial evaluation process to record dates of onset, course of illness, and the interaction between disorders during periods of abstinence, treatment, institutionalization, etc.

DDE programs do not rely on individual clinicians to probe these chronologies, but insure consistency by formats within the medical record or EMR. Time line follow-back (TLFB) calendars are a helpful tool to assess and document histories of substance use and psychiatric symptoms

IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high

Definition: Programs offering services to individuals with CODs use psychiatric symptom acuity or instability within the current presentation to assist with the determination of the individual's needs and appropriateness, and whether the program is capable of effectively addressing these needs.

AO/MHO PROGRAMS

Enhancing IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high

Example: AOS programs routinely base admission decisions on psychiatric history (e.g. prior hospitalizations), present diagnoses (e.g. bipolar disorder), or medications (e.g. olanzapine). Even if persons with psychiatric disorders are presently stable, by virtue of their history, the AOS program will decline or defer admission. Determination of these patients' entry may be based upon clinical appropriateness ("We can't get their meds if they run out.") or milieu driven ("We don't want other patients to be distracted.") or staff driven ("We only have one person at this residential program here on nights and weekends."). To be DDC, AOS programs must be able, within the capacity of their staff resources and level of care, to accept patients regardless of their history of psychiatric disorders.

IIIF. Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high

Definition: Programs offering services to individuals with CODs use severity as defined by the diagnosis, persistence, and disability as an indicator to assist with the determination of the individual's needs and whether the program is capable of effectively addressing these needs.

AO/MHO PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high

Example: AOS programs intending to be at the DDC level will need to accept patients for services who have histories and/or current mental health diagnoses that may be associated with severity and impairment. These diagnostic categories may include: mood, anxiety, PTSD, Axis II disorders, as well as persons with schizophrenia or bipolar disorders. DDC programs will often accept persons who are stable with a non-severe mental illness type. This may be commonly known as a person from Quadrant III (see the Quadrant Model of Co-occurring Disorders, SAMHSA Report to Congress, 2002).
http://alt.samhsa.gov/reports/congress2002/chap1nasmhpd.htm#fig1.1
Programs clearly operating at the DDC level will also routinely accept persons with bipolar disorder and less often persons with schizophrenic spectrum disorders, even with current stable clinical status.

DDC PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high

Example: DDC programs who seek DDE level on this item will extend their program acceptance to patients in both Quadrant III (mood, anxiety, PTSD, less severe Axis II disorders) and Quadrant IV (schizophrenia, bipolar disorder, schizoaffective disorder) on a more routine basis. Integrated with Item IIIE, these liberal program acceptance policies are based upon clinical appropriateness and not just an unrealistic willingness to accept all patients at admission. DDE programs must have a clear capacity to effectively treat persons of high levels of severity and high levels of acuity.

IV. Treatment

Addiction or mental health only: Treatment plans address MH or SA; no stage-based treatment; patients on psychotropic medications not accepted; no psychosocial treatment for other disorder and little education/treatment about the interaction of SA and MH; minimal family involvement or provides family education for only one disorder.

Capable: Treatment plans address both disorders (with stipulations on which disorder must be primary); coordinated policies and procedures for medication with consultant provider (including use of medications specifically to reduce substance use); program provides generic interventions for other disorder and generic education about the interaction of SA and MH; some availability of onsite family education and support for COD.

Enhanced: Treatment plans address both disorders as primary; formal stage-wise treatments provided; policies and procedures for medication with team provider (including use of medications specifically to reduce substance use); provide specific interventions for other disorder, and education and treatment for specific disorder comorbidities; staff members provide routine COD family groups integrated into standard program format.

IVA. Stage-wise treatment: Initial.

Definition: For individuals with substance related and mental health disorders, the assessment of readiness for change for both disorders is essential to the planning of appropriate services. The stages of change model has its origin in fostering intentional behavior changes and has therefore been used readily in the addiction field; assessment of motivational stages across the individual's identified areas of need (including both substance related and mental health) is a more comprehensive approach and helps to more strategically and efficiently match the individual to appropriate levels of service intensities.

AO/MHO PROGRAMS
Enhancing IVA. Stage-wise treatment-initial

Example: Assessing stages of patient motivation has added a new level of clinical sophistication to addiction treatment in recent years. Motivational interviewing (MI), motivational enhancement therapies (MET) are arguably evidence-based practices, and depend on a careful assessment of patient motivation. A variety of models have been developed to conceptualize the stages. All have advantages relative to the traditional bifurcation of motivation into two categories: "ready" or "not ready." For AOM.H.O programs to achieve DDC, they must have some notation at the initial assessment of motivational stage. This assessment can draw from the terminology of the motivational assessment models that are well established in the scientific literature

IVB. Recovery Plans

Definition: In the treatment of individuals with CODs, the recovery plans indicate that both the psychiatric disorder as well as the substance related disorder will be addressed.

AO/MHO PROGRAMS
Enhancing IVB. Treatment plans

Example: Treatment planning is the culmination of a process of assessment and the interaction between the program and the patient. Goals agreed to by both, using a shared decision-making approach, are generally agreed to be most associated with success. T he best example of this is the research on therapeutic alliance in psychotherapy. AOS programs, whether by screening, assessment or even diagnosis, identify psychiatric problems, and will routinely leave these same psychiatric problems out of the treatment plan. To score at the DDC level, these psychiatric problems need to be identified, and then targeted by at least generic treatment interventions, and then monitored for treatment response. Although substance use problems may continue to be the major focus of the treatment plan, psychiatric problems and disorders are increasingly listed.

DDC PROGRAMS
Enhancing IVB. Treatment plans

Example: In order for DDC programs to transition to DDE on this item, there must be a documented and equivalent focus on treatment planning for both substance use and psychiatric disorders. A review of records finds this to be normative, and interventions are targeted, generally "in house." In the case of both disorders as problems, the objectives are clear, measurable and specific (vs. generic). One defining characteristic of the DDE program is the use of interventions in addition to medications to address and leverage a psychiatric problem.

IVC. Assess and monitor interactive courses of both disorders.

Definition: In the treatment of persons with CODs, the continued assessment and monitoring of substance related and mental health disorders as well as the interactive course of the disorders is necessary.

AO/MHO PROGRAMS

Enhancing IVC. Assess and monitor interactive courses of both disorders

Example: Data obtained on this item flow from the assessment process, in particular item IIID-Psychiatric and substance use history reflected in medical record.

In AOS level services, the chronologies of the disorders are not well documented during the assessment, so treatment is not likely to anticipate the exacerbation or diminution of psychiatric symptoms with abstinence.

DDC programs have attempted to record these chronologies in the assessment, and monitor psychiatric symptom change in early addiction treatment experiences. They may assist patients in preparing for this (e.g. the return of social phobia symptoms after benzodiazepine and alcohol are discontinued). DDC programs may also be prepared to rapidly intervene by initiating pharmacotherapy. The DDC record captures the ebbs and flows of both substance use and psychiatric symptoms.

DDC PROGRAMS

Enhancing IVC. Assess and monitor interactive courses of both disorders

Example: DDE programs improve on DDC services by the use of more systematic tracking and monitoring of patient symptoms during treatment (and correlated with abstinence or continued use). DDE programs have a medical record structure so that these changes can be regularly observed and recorded. DDE records consistently have documentation of progress or deterioration on both substance use and mental health domains. For example, clinician and/or patient use of time line follow-back (TLFB) calendars are likely to be used by DDE programs (see Appendix D).

IVD. Procedures for psychiatric emergencies and crisis management

Definition: Programs that treat individuals with CODs use specific clinical guidelines to manage crisis and mental health emergencies, according to documented protocols.

AO/MHO PROGRAMS

Enhancing IVD. Procedures for psychiatric emergencies and crisis management

Example: AOS programs often have undocumented, informal outdated or loose arrangements for dealing with psychiatric emergencies. Often, by deferring admission to cases of even moderate risk, these events are kept to a minimum. Calling 9-1-1 is often the plan given such an event. MHO programs usually do not have policies to deal with client alcohol or drug use. MHO programs will often either tolerate such behavior or send the client home.

Whereas DDC level programs have more formalized and documented guidelines. Staff can clearly articulate the policy in place. The response to emergencies and crises is typically characterized by a more formalized relationship with the local mental health agency or the psychiatric emergency service of the nearby hospital. This is a significant upgrade in capability from an internal or familiar relationship with paramedics or the local hospital emergency department staff. Psychiatric advance directives may be offered to patients to complete as an option upon intake.

DDC PROGRAMS

Enhancing IVD. Procedures for psychiatric emergencies and crisis management

Example: DDE programs have more thorough and articulated emergency and crisis intervention plans, expect events to occur more regularly, and have protocols in place so that the emergency or crisis does not result in referral or linkage issues. DDC programs can evaluate the nature and level of emergency they may be able to handle in house, and consider clearer documented guidelines, staff training in risk management and assessment, and if possible, a review of current staffing patterns. Psychiatric advance directives are completed with every patient upon intake to prepare for any psychiatric crises they may have during their treatment episode.

Under no circumstances should the DDC program overextend its clinical capability in this area, solely for the purposes of perceived enhancement of services. Taking on more clinical risk must be carefully planned and prepared for in protocol, staffing and prudence.

IV E. Stage-wise treatment ongoing

Definition: Within programs that treat individuals with COD, ongoing assessment of readiness to change contributes to the determination of continued services which appropriately fit that stage, in terms of treatment content, intensity, and utilization of outside agencies.

AO/MHO PROGRAMS

Enhancing IVE. Stage-wise treatment-ongoing

Example: Data obtained on this item flow from the assessment process, in particular item IIIG-stage-wise assessment-initial.

AO/M.H.O programs may not assess stage of motivation upon admission, and are therefore even less likely to do so during treatment. Clinicians understand the dynamic nature of motivation, in terms of its non-linearity and difficulty assessing its verbalized, inferred, and behavioral components.

DDC programs routinely assess motivational stage during treatment and consider modifications of treatments accordingly. For example, instead of working with a patient as if she is at the relapse prevention stage, by recognizing she is at the precontemplative / comtemplative stage interventions may be more appropriate to the extent they are motivational enhancement strategies, engagement of significant others in treatment planning, or even psychoeducational in nature. DDC programs therefore document stages of motivation on an ongoing basis, but do so in a fairly general way, and which may not be closely linked to intervention choice.

DDC PROGRAMS

Enhancing IVE. Stage-wise treatment-ongoing

Example: DDE programs extend beyond DDC by more routinely and reliably assessing stage of motivation during treatment, and especially during treatment or level of care transitions. Stage is directly correlated to the treatment plan, and can drive the particular approach used by clinicians in individual, group and even determine level of care.

A residential program in Portland Oregon has operationalized the ASAM Dimension IV (Treatment Acceptance or Resistance) and reduces the length of stay based upon stage of readiness assessed at 2-week intervals. Ratings of precontremplative or contemplative stages result in earlier transitions to an intensive outpatient level of care. This conserves a more expensive resource (residential services) and enables patients at preparation, action or relapse prevention stages more access.

DDE programs may also strive to assess differential motivation to address substance use and motivation to address psychiatric problems.

IVF. Policies and procedures for medication evaluation, management, monitoring, and adherence

Definition: Programs that treat individuals with COD are capable of evaluating medication needs, coordinating and managing medication regimens, monitoring for adherence to regimens, and responding to any challenges or difficulties with medication adherence, as documented in policy/procedure.

AO/MHO PROGRAMS

Enhancing IVF. Policies and procedures for medication evaluation, management, monitoring and adherence

Example: AOS programs may either have no patients who are on medication or have very informal undocumented policies about what medications are appropriate. AO/M.H.O programs moving toward DDC will need to develop clearer medication policies and protocols, and likely will increase the range of acceptable medications. Medications may be kept in a secure, locked storage area, and be self-administered but observed. Medications may be brought in by a patient, renewed by prescribers, a new prescription during treatment. Necessary adjustments to medications can be made and such protocols are formalized. DDC programs document the use of medications and the patient's compliance with them, and this is evident in the patient medical record.

IVG. Specialized interventions with mental health/AOD content

Definition: Programs that treat individuals with COD utilize specific therapeutic interventions and practices that target specific mental health and alcohol and drug related symptoms and disorders. There is a broad array of interventions and practices that can be effectively integrated into the treatment of individuals with co-occurring disorders that target mental health/alcohol and other drug symptoms and disorders. Some interventions can be generically applied to programs; these interventions might include stress management, relaxation training, anger management, coping skills, assertiveness training, and problem solving, symptom reduction, etc. [In some cases, programs may already use some of these techniques in their treatment programs.] Other more advanced interventions that could be applied to persons with CODs include brief motivational or cognitive behavioral therapies that target specific disorders such as: PTSD, depression, anxiety disorders, and Axis II disorders, relapse prevention, urge reduction, etc.

AO/MHO PROGRAMS

Enhancing IVG. Specialized interventions with mental health content

Example: As the previous item pertains to pharmacological interventions for psychiatric disorders in addiction treatment, this item pertains to psychosocial interventions. These interventions do not necessarily require a licensed or certified mental health professional to deliver. They do however, require a trained clinician, who may also have additional certifications, or has attended workshops and received supervision in therapies with that particular co-occurring disorder (e.g. borderline personality disorder) or has had good training in cognitive behavioral therapy.

AOS programs tend to address the psychiatric problem as a side effect of basic addiction treatment: reviewing relapse triggers may touch on negative mood associated with depression; bringing a patient to a mutual peer support meeting may help with social anxiety disorder; or "working the steps" may sand down the rough edges of a personality disorder. To be DDC level however, the program must address the psychiatric problem more intentionally, and explicitly. In DDC programs, this may be accomplished thru generic interventions such as cognitive behavioral therapy for substance use, feelings or anger management groups, and individual counseling. The application of these treatments to patients is likely more clinician vs. program driven.

IVH. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment.

Definition: Programs that offer treatment to individuals with COD provide education about mental health and substance related disorders, including treatment information and the characteristics and features of both types of disorders as well as the interactive course of the disorders.

AO/MHO PROGRAMS

Enhancing IVH. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment

Example: It is widely believed in medical care that educating patients about the nature and treatment of their disease will improve compliance and likely increase the likelihood of positive outcomes. A longstanding tradition in addiction treatment is the didactic presentation of a variety of aspects to the disease of addiction, the effect on the family, and the role of mutual self-help groups in long-term recovery. AOS programs may continue with this tradition without much attention to the fact of the prevalence and importance of psychiatric disorders among addicted persons and their influence on outcomes.

DDC programs offer information about psychiatric disorders through general lectures, occasionally through group therapy or community meetings, through family sessions and/or through individual sessions. These efforts are a substantial improvement over the attention paid to the common psychiatric problems by AOS programs. These services may include some effort to have people be able to verbalize their diagnosis, understand the current treatments, express the risks in not following through with treatments in terms of their abstinence of substance use, and lastly have some understanding of the role of the family (including inheritability issues) in both the psychiatric and substance use disorders. DDC programs may offer didactics on co-occurring disorders, or perhaps one medication group for patients on medication, where the differences between drugs and medications are discussed, and the role of medication in self-help recovery traditions are explored. The DDC program offers these services in a fairly generic format, and is frequently driven by the interests of individual clinicians, rather than systematically delivered in a protocol.

IVI. Family education and support

Definition: Programs that offer treatment to individuals with COD provide education and support to the individuals' family members (or significant others) regarding CODs, including treatment information and the characteristics and features of both types of disorders in order to educate collaterals about realistic expectations and the interactive course of the disorders.

AO/MHO PROGRAMS

Enhancing IVI. Family education and support

Example: The AOS program seeking to attain DDC status on this item will need to include many of the same ingredients from IVG but directed towards family members. Addiction treatment programs vary in the inclusion of family members in services. "Family" has been broadened to include any significant other(s), and are understood to be a major support or risk factor in ongoing recovery. For this reason, in times past, family members were excluded from treatment. Many evidence-based practices for substance use disorders are family or couples formats, and it is now widely believed that including family members will augment outcomes. AOS programs may educate families about addiction and recovery, with a singular focus on substance issues. Al-Anon may be introduced.

DDC programs take the time, either through individual family sessions, or by using a segment in multi-family groups (which are often required in order to visit the identified patient). These sessions and groups often present the comorbid psychiatric problem as a complicating factor in recovery. The importance of medications to manage the psychiatric problem may be emphasized. Advanced DDC programs may begin to discuss familial and genetic predispositions, medications vs. drugs, and mutual support organizations for family members. These are not protocol driven but are more so driven by individual clinicians, particularly ones with an emphasis on family systems or therapies.

IVJ. Specialized interventions to facilitate use of (COD) self-help groups

Definition: Substance abuse programs that offer treatment to individuals with COD provide assistance to individuals in developing a support system through self-help groups. Individuals with mental health symptoms and disorders often face additional barriers in linking with self-help groups and require additional assistance such as being referred/ accompanied/ introduced to self-help groups by clinical staff, designated liaisons, or mutual self-help group peer volunteers. Specific issues related to the use of pharmacotherapy by individuals with COD also require additional education and guidance with regard to linking with self help groups.

AO/MHO PROGRAMS

Enhancing IV J. Specialized interventions to facilitate use of self-help groups

Example: Involvement with mutual support groups, including twelve-step groups, is associated with long-term recovery and positive life change. These groups typically embrace a chronic disease model that understands addiction as a lifelong vulnerability, they offer a fellowship of non-using others, they provide an explanatory model with suggested steps for change, and there are no dues or fees. There is some evidence to suggest persons with co-occurring disorders have difficulty affiliating and participating in traditional peer support groups. Double trouble, dual recovery anonymous and other groups have been developed to address this challenge. These groups have had varying degrees of success. The more traditional twelve step groups may be optimal, since they have more members with significant periods of sobriety, have clearer guidelines about operations (traditions), and there are more available meetings in the community.

AOS programs typically do not offer special services to bridge the person with a co-occurring disorder into traditional peer support. DDC programs, by identifying the psychiatric problem, will individualize the referral to mutual self-help groups. The DDC program through individual sessions, through group sessions or through in house meetings may help a person with a co-occurring disorder learn how to join and participate (and presumably benefit) from these groups. These efforts are not systematic but are more driven by individual clinicians, many of whom have a personal or working understanding of how certain groups in the community tolerate persons with psychiatric problems, and to what degree.

IVK. Peer recovery supports for patients with MH

Definition: Substance abuse programs that offer treatment to individuals with a co-occurring mental disorder encourage and support the use of peer supports and role models that include consumer liaisons, alumni groups, etc.

AO/MHO PROGRAMS

Enhancing IVK. Peer recovery supports for patients with CODs

Example: AOS programs' advancement on this item is highly associated with their advancement on the previous item (IV.I). AOS programs make no specialized effort to link persons to support group meetings, and likewise there is no effort to connect persons with co-occurring disorders from mutual support groups with current patients. DDC programs often have staff members who make special introductions to individuals from the community who either attend or organize meetings on site at the program. DDC programs may have staff members who are in personal recovery who attempt to "match" patients with temporary sponsors based upon aspects of psychiatric disorders commonality. These efforts are typically clinician driven and not a routine aspect of a protocol designed to link peers who may identify with one another on common co-occurring disorder bases.

V. Continuity of Care

Addiction or mental health only: CODs are not addressed as part of the discharge planning process; little to no facilitation of linkage to self-help support groups for clients with COD.

Capable: CODs are systematically addressed as secondary in the planning process for off-site referral; programs provide variable facilitation of linkage to self-help support groups for clients with COD.

Enhanced: Both disorders are addressed as primary in the discharge planning process and discharge plans are made and insured; programs provide routine and systematic facilitation of linkage to self-help support groups for clients with COD.

VA. Co-occurring disorder addressed in discharge planning process

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder develop discharge plans that include an equivalent focus on needed follow-up services for both psychiatric and substance related disorders.

AO/MHO PROGRAMS

Enhancing VA. Co-occurring disorder addressed in discharge planning process

Example: Since AOS programs often have not listed the co-existing psychiatric disorder or problem on the treatment plan, it may not be a subject for intentional discharge planning. In order to achieve DDC status, the AOS program must make a more deliberate plan post-discharge and consider the influence of the co-occurring disorders on one another. DDC programs will conceptualize the substance use disorder as primary, but will underscore the importance of treatments for the psychiatric disorder (pharmacological and psychosocial) and will make discharge plans accordingly. Collaborative relationships (see Program Structure items) are particularly important here, since successful linkage is predicated on a close relationship and clear protocol shared by providers. The discharge process, in considering both disorders, retains a largely clinician-driven vs. protocol driven format.

VB. Capacity to maintain treatment continuity

Definition: There should be a formal mechanism for providing on-going needed mental health follow-up. The program emphasizes continuity of care within the program's scope of practice but if a linkage with another level of care is necessary it sets forth the expectation that treatment continues indefinitely with a goal of illness management.

AO/MHO PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity

Example: AO/M.H.O programs may discharge persons with co-occurring disorders who become symptomatic psychiatrically, or who relapse or "slip" in substance use. In order to achieve DDC status, AO/M.H.O programs will need to develop increased clinical flexibility to explore the exacerbation of psychiatric symptoms (and deliver treatments) or relapse to substances (and consider the potential for a "therapeutic" approach to relapse). These shifts in protocol must not exceed the program's capability in level of care. DDC programs will evaluate the psychiatric problem and if sufficiently stable will retain the patient in the current program and if a referral is required (preferably within the same agency or to a mental health agency with whom there is a memorandum of understanding), will accept the patient back once stabilized. Likewise, within the constraints particular to level of care and patient safety, relapse to substances may be approached from the context of an exacerbation of symptoms, potentially managed within the program, or once stabilized, the patient is accepted back. Outpatient DDC programs have the capacity to treat both disorders (substance use and psychiatric) for an extended if not open-ended period of time. Residential DDC programs strive to maintain patients with co-occurring disorders within their agency (if they offer a comprehensive array of services) or with a collaborative relationship with the local mental health provider.

VC. Focus on ongoing recovery issues for both disorders

Definition: Programs that offer services to individuals with COD support the use of a recovery philosophy (vs. symptom remission only) for both substance related as well as mental health disorders.

AO/MHO PROGRAMS

Enhancing VC. Focus on ongoing recovery issues for both disorders

Example: AOS programs will typically focus on recovery from alcohol or drug addiction. Emphasis will be placed on those traditional approaches that have been found to be effective: aftercare, twelve-step group affiliation, finding a sponsor, working the steps, and remaining abstinent one day at a time. Although these processes are in fact associated with long-term positive outcomes, for the person with a co-occurring disorder, another disease and recovery process will need to be embraced.

DDC programs add to the recovery path outlined above with some emphasis on how psychiatric problems complicate or are a risk factor to one's recovery from substances. This may include the importance of medication compliance, attendance at therapy sessions for CBT, or perhaps staying close to the community mental health center's case management staff members.

V.D. Facilitation of self-help support groups for COD is documented

Definition: Programs that offer services to individuals with COD anticipate difficulties that the individuals with COD might experience when linking or continuing with self-help support groups and thus provide the needed assistance to support this transition beyond active treatment.

AO/MHO PROGRAMS

Enhancing VD. Facilitation of self-help support groups for COD is documented

Example: Item IV.I describes the benefits of specialized interventions to facilitate the use of mutual support groups for persons with co-occurring disorders. This item is an extension of this line of clinical reasoning through the discharge and future of the patient. AO/M.H.O programs have not made specialized interventions up to this point. Nonetheless, many patients will have successfully linked with mutual support groups. Many patients will have only linked to the degree it satisfies program requirements and once these are lifted may no longer attend or benefit. Other patients will attend but not participate. This may be helpful in fostering remission, but not in the possible lifestyle and psychological changes (transformations) that a person who participates fully can more likely expect.
DDC programs have made efforts to match the patient with community support groups, with a plan to foster the connection and deepen the patient's relationships with other non-using people. Further, it is hypothesized that these connections serve as mentors or role models, who can guide the newcomer on a course of recovery. DDC programs note this in the discharge planning process, and perhaps offer the patient the opportunity to return for alumni events.

VE. Sufficient supply and adherence plan for medications is documented
Definition: Programs that serve individuals with a co-occurring mental health disorder have the capacity to assist these individuals with psychotropic medication planning, prescription and medication access and monitoring, and providing sufficient supplies of medications at discharge.

VI. Staffing

Addiction or mental health only: No formal relationship with psychiatrist or other physician; no staff members on site with other disorder certification/licensure; little to no access to supervision or consultation for other disorder.

Capable: Program consults or contracts with psychiatrist for on site services; at least 25% of staff members have certification/licensure in other disorder; staff has on site access to other disorder supervision or consultation (documented PRN).

Enhanced: Psychiatrist on team; on site staff member for clinical supervision, treatment team and/or administration; at least 50% of staff members have certification/licensure in other disorder; staff have on site, documented, regular supervision sessions for other disorder.

VIA. Psychiatrist or other prescriber
Definition: Programs that offer treatment to individuals with COD offer pharmacotherapy for both the mental health disorder as well as the substance related disorder through the services of prescribing professionals. These programs may have a formal relationship with a psychiatrist, physician, or nurse practitioner (or other licensed prescriber) who works with the clinical team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as disulfiram, naltrexone, or acamprosate that may help to reduce addictive behavior.

AO/MHO PROGRAMS

Enhancing VIA. Psychiatrist or other prescriber

Example: Many addiction treatment providers consider this item to be pivotal. Having psychiatrist, physician or other prescriber access can leverage a program from AOS to DDC, and is associated with many other items on the DDCAT. Yet, many programs do have physician coverage, and based upon the role of the physician within the agency, policies for clinical practice, traditions, and patient admission criteria, a program may still be AOS, even with physician coverage.

AOS programs typically do not have a formal relationship with a prescriber. They must refer patients in need of medication or medication evaluations to a prescriber outside the program. DDC programs have contracted with a consultant prescriber who can evaluate and treat patients on site. These contracted arrangements may be inadequate to cover the needs of patients, but most patients can be initiated on medication when indicated. The DDC program consultant prescriber is typically available for circumscribed clinical duties only.

VIB. On site staff with MH licensure or demonstrated expertise/substance abuse licensure or expertise

Definition: Substance abuse programs that offer treatment to individuals with COD employ persons with expertise in mental health to enhance their capacity to treat the complexities of mental disorders that co-occur with substance related disorders.

AOS PROGRAMS

Enhancing VIB. On site staff with mental health licensure or demonstrated expertise

Example: The AOS program intending to become DDC is challenged to provide an increasing array of services in house. Some addiction clinicians can and will obtain additional training and certification to be able to deliver psychosocial treatments and assessments to persons with co-occurring disorders in addiction settings. DDC programs have sought to increase the number of mental health educated and trained (if not licensed and certified) clinicians who can deliver the most basic and generic treatments: CBT, motivational interviewing, family therapy, and assessments. A DDC program may have about 25% of staff in this category. The DDC program moving in this direction must be careful not to reduce its capability to effectively treat substance use disorders, by enhancing its capacity to treat mental health problems. Thus, in hiring mental health trained clinicians, those with addiction treatment education and/or experience should be the top priority.

VIC. Access to mental health supervision or consultation

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder provide formal mental health supervision for trained providers of mental health services who are unlicensed or who have insufficient competence or experience in the treatment setting.

AOS PROGRAMS

Enhancing VIC. Access to mental health supervision or consultation

Example: AOS programs may not have access to mental health consultation or supervision by a licensed professional. In order to become DDC on this item, mental health supervision must be provided. This supervision is typically scheduled either on an individual or group basis, and mental health treatments are encouraged and reviewed. Often the focus in this supervision is on diagnosis, appropriate referral to the prescriber for medication, development of empathy, and the management of countertransference issues. The supervision, although present in DDC programs, may tend to take on a crisis management or disposition "laundry list" vs. in depth quality.

VID. Supervision, case management or utilization review procedures emphasize and support COD treatment

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder conduct COD-specific case reviews or engage in a formal utilization review process of COD cases in order to continually monitor the appropriateness and effectiveness of services for this population.

AOS PROGRAMS

Enhancing VID. Supervision, case management or utilization review procedures emphasize and support COD treatment

Example: In contrast to AOS programs, DDC programs attend to the status and progress with the co-occurring disorder in supervision, case review, and disposition or rounds team meetings. AOS programs may focus on the achievement of tasks toward recovery or compliance with policy, DDC programs attend to these matters but also review the patient's progress with medications, talking about his/her psychiatric issues in group, the progress on this matter with significant others, and the status of these issues in mutual support group affiliation and ongoing recovery. The DDC program tends to review these issues in a general way but does so on a consistent basis.

VIE. Peer/Alumni supports are available with COD

Definition: Programs that offer treatment to individuals with co-occurring mental health disorders maintain staff or enlist volunteers who can serve as COD peer/alumni.

AOS PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with COD

Example: This item closely corresponds to item V.D. Facilitation of self-help support groups for COD. AOS programs approach this issue in a less intentional and less individualized fashion. In order to become DDC, the AOS program must consider being more targeted in trying to match persons with specific comorbidities with peer role models. The use of alumni, volunteers, or even carefully supervised recovering staff members may be one way to accomplish this. The key is to enable the patient with a co-occurring disorder to recognize that he or she is not alone in having a co-occurring disorder, and that someone who has been successful can assist them in navigating and connecting with mutual peer support groups in the community.

VII. Training

Addiction or mental health only: Staff receive no basic training in prevalence, common signs and symptoms, screening and assessment for other disorder; staff are not cross trained (advanced training) in MH and SA disorders.

Capable: Staff receives basic training in prevalence, common signs and symptoms, screening and assessment for other disorder per agency strategic training plan; at least 50% of staff are cross trained.

Enhanced: Staff receives training in prevalence, common signs and symptoms, screening and assessment for other disorder per agency strategic training plan and also has staff trained in specialized treatment approaches; at least 90% of staff are cross trained.

VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders

Definition: Programs that provide treatment to individuals with co-occurring mental health disorders have staff with basic skills and/or training in the prevalence of CODs, the screening & assessment of CODs, the signs & symptoms of CODs, and in triage and treatment decision-making.

VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies

Definition: Programs that offer treatment to individuals with CODs support cross-training of their staff to increase the needed capacity to provide COD treatment within the program. This aspect of training is incorporated into the program's strategic training plan.

AOS PROGRAMS

Enhancing VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies

Example: This item reviews the overall training profile of the staff working within a program. AOS programs may not have an overall training strategy and have developed no particular mechanism to track or direct staff needs for training or training actually received. The DDC program has made some effort to organize this critically important and common venture in addiction and mental health treatment systems. DDC programs aim to have 50 to 75% of staff cross-trained in addiction and mental health or COD services. This item has not been observed to be cost-intensive but rather forces an organization to be more intentional and strategic in the use of its training dollars and time allocations.