CENTER FOR EXCELLENCE IN INTEGRATED CARE

Co-Occurring Capable Program Guidelines

Introduction

This document presents program guidelines to ensure responsiveness to the needs of individuals with co-occurring mental health and substance use disorders in treatment programs at all clinical levels of care. The intent of these guidelines is to provide direction, without being prescriptive, and to emphasize those factors that are of particular importance in the treatment of individuals with co-occurring disorders. This document begins below with some guiding principles for treating individuals with co-occurring disorders from two key publications in the field, followed by the CEIC guidelines starting on the next page.

Guiding Principles in Treating Individuals with Co-Occurring Disorders
(CSAT, Treatment Improvement Protocol #42, 2005)

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

Principles of Integrated Treatment
(Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L., Integrated Treatment for Dual Disorders, 2003)

1. Core value: Shared decision making
2. 7 Principles of integrated treatment:
    - **Integrated:** The same clinician (or team of clinicians) provides treatment for mental illnesses and substance use disorders at the same time.
    - **Comprehensiveness:** When needed, access to residential services, case management, supported employment, family psychoeducation, social skills training, training in illness management, and pharmacological treatment is available.
    - **Assertiveness:** Clinicians must make every effort possible to actively engage reluctant individuals in the process of treatment and recovery.
    - **Reduction of negative consequences:** Reduce the negative consequences of substance use, while developing a good working alliance that can ultimately help develop the motivation to address their substance use and mental health challenges.
    - **Long-term perspective:** Recognizing that each individual recovers at his or her own pace, given sufficient time and support.
    - **Motivation-based treatment:** Interventions must be motivation-based - that is, adapted to clients' motivation for change.
    - **Multiple psychotherapeutic modalities:** Including individual, group, and family approaches has been found to be effective.

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Program Structure and Milieu

1. Agency mission statement and or policy is inclusive of people with co-occurring disorders.

2. If a program is not licensed to provide both mental health and addiction treatment services, it has a formal process to ensure that individuals have access to those services that are not provided by the agency, and that concurrent services are integrated.

3. Program displays, distributes, and utilizes literature and client/family educational materials addressing both mental health and substance use disorders.

Screening, Assessment and Treatment Planning

4. As recommended by OMH and OASAS, the program uses standardized mental health and substance use screening instruments with established psychometric properties for routine screening for psychiatric and substance use symptoms.

5. Psychiatric and substance use history is reflected in the bio-psychosocial assessment in addition to an integrated formulation of strengths, history, current symptoms, any self-reported diagnoses, the stages of change for both disorders and other pertinent assessment information.

6. The treatment/recovery planning process focuses on the recovery potential of an individual. It includes a focus on the co-occurring conditions, and incorporates stage of change principles. A plan is developed that addresses each condition with stage-specific approaches.

Services

7. The program has the ability and capacity to provide care to individuals with mild to moderate *symptom acuity* regardless of any prior history of more significant impairment. Mild to moderate is defined as a degree of disability such that the individual is capable of independent functioning and the co-occurring disorder does not interfere significantly with participation in treatment. Substance use treatment programs admit individuals whose psychiatric disorders are primarily stable, i.e. no active suicidality or homicidality and who have some capacity for self-regulation. Mental health treatment programs admit individuals who do not require medical attention for symptoms of substance withdrawal and who have some capacity to limit drug-seeking behavior.

   The program has the ability and capacity to provide care to individuals with mild to moderate *severity* of *disability*, including those who may be on chemical maintenance and/or psychotropic medication. Mild to moderate is defined as the degree of disability is such that there may be some substantial history of recurrence of the co-occurring disorder, and/or there is evidence of continued impairment in at least one functional area (person's capacity to manage relationships, job, finances, and social interactions) as a result of that disorder.

Substance use treatment programs admit individuals who fall into what may be commonly known as ***Quadrant III,*** as described in the Center for Substance Abuse Treatment (CSAT) Treatment Improvement ProtocoliTIP 42, including individuals with:

- stable Axis 1 mood, anxiety or posttraumatic stress disorders,
- less severe Axis I1 disorders or stable schizophrenia or bipolar disorders.

Mental health treatment programs admit individuals who fall into what may be commonly known as ***Quadrant II,*** as described in the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol/TIP 42, including individuals who are not physiologically dependent on a substance.

The Four Quadrants	
III. Less severe mental disorder/more severe substance disorder.	IV. More severe mental disorder/more severe substance disorder.
I. Less severe mental disorder/less severe substance disorder.	**II. More severe mental disorder//less severe substance disorder.**

8. Program services integrate motivational interventions, education about the symptoms, course, and treatments for both mental health and substance use disorders, and information about the interactive nature of co-occurring conditions.

9. If psychopharmacologic and addiction pharmacotherapy interventions are not provided onsite, the program has a process in place to ensure that individuals have access to such interventions through a seamless and integrated collaboration with an appropriate entity.

10. Peer supports for people with co-occurring disorders are available on-site or through collaboration (e.g., assertive linkage to 12-step groups that are welcoming to people with co-occurring disorders, alumni groups, Dual Disorders Anonymous, Double Trouble in Recovery.

11. Assessment and treatment incorporates families andlor others that are likely to support the individual's recovery process. These interventions might include family psycho-education or multi-family peer support groups or family therapy, and incorporate a focus on co-occurring disorders.

12. Co-occurring disorders are addressed in the discharge planning process. Upon discharge, willing individuals are connected with recovery support services, including, but not limited to clinical recovery check-ups and a referral to telephone peer recovery support.

Staffing

Co-Occurring Capable recommended staffing goal (resource dependent)

13.
    - At least one direct care staff member, in addition to the prescriber, has mental health licensure (i.e., LCSW, LPC, LMFT, licensed psychologist) and a minimum of fifty (50) hours of documented addiction disorders training ***or*** at least one direct care staff member has addiction treatment licensure (CASAC) and a minimum of fifty (50) hours of mental health disorders training;
    - Clinical supervisors must be licensed in either the addictions or mental health fields;
    - Agency clinical directors must be licensed Master's prepared professionals (or higher degree).

14. On-site, documented clinical supervision sessions, including a focus on co-occurring disorders, are provided, at the frequency of at least one hour per week for individuals providing clinical services. Other non-clinical, service delivery staff should also receive clinical supervision at the frequency determined by the clinical director.

15. Program must have a written training plan. The plan needs to include how the program will assist staff in maintaining and enhancing their competencies to provide services for people with co-occurring disorders through the use of current literature, films, other medium, inservice trainings, and external trainings. The plan needs to include training in specialized treatment approaches and pharmacotherapies.

Quality Assurance

16. Program must have a written quality assurance procedure, and evidence of its implementation, for identifying the percentage of clients with co-occurring disorders and some outcome indicators (e.g., critical incidents, level of functioning, treatment completion, improvements since admission).

17. Program must have a written procedure for self-monitoring their adherence to these co-occurring capable program guidelines over time.

Primary Sources: *DMHAS Connecticut, "Commssioner's Policy Statement No.84 on Serving People with Co-Occurring Mental Health and Substance Use Disorders* "; *Mark P. McGovern, Ph.D., Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index; Mueser, K.T., et al., "Integrated Treatment for Dual Disorders"; CSAT, "Substance Abuse Treatment,for Persons with Co-Occurring Disorders: TIP 42"; Kenneth Minkoff M. D., "Psychopharmacology Practice Guidelines for 1ndividuals with Co-Occurring Psychiatric and Substance Use Disorders".*