Co-Occurring Capable Program Guidelines For Non-Clinical Services

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Connecticut Department of Mental Health and Addiction Services

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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 in all non-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 serving individuals with co-occurring disorders. These program guidelines are consistent with the larger context of a recovery-oriented system of care, and more detailed "Practice Guidelines for Recovery-Oriented Behavioral Health Care" that have been disseminated by the Connecticut Department of Mental Health and Addiction Services. This document begins below with some guiding principles for serving individuals with co-occurring disorders from two key publications in the field, followed by the DMHAS 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.

Co-Occurring Capable Program Guidelines

For Non-Clinical Services

Program Structure and Milieu

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

2. The program has a formal process to ensure that individuals have access to those services that are not provided by the agency and that there is coordination with concurrent services. Staff should be familiar with treatment resources, levels of care, and referral processes and make every effort to obtain signed releases to insure routine communication with treatment providers.

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 required by the Department of Mental Health and Addiction Services, 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 program assessment in addition to treatment history, current symptoms, any self-reported diagnoses, the stages of change for both disorders and other pertinent assessment information.

6. The recovery/service planning process focuses on the recovery potential of an individual. It takes into consideration the co-occurring conditions, and incorporates stage of change principles and stage-specific approaches.

Services

7. The program, at a minimum, has the ability and capacity to provide services 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 services.

   Substance use 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 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, at a minimum, has the ability and capacity to provide services 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 service providers, at a minimum, 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 Protocol/TIP 42, including individuals with:

- stable Axis I mood, anxiety or posttraumatic stress disorders,
- less severe Axis II disorders or stable schizophrenia or bipolar disorders.

Mental health service providers, at a minimum, 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.

Individuals falling into Quadrant IV are admitted to substance use and/or mental health services based on individual presentation and need.

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 use motivational interventions and stage of change principles, and have the ability to provide 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, as needed and as relevant to the services provided.

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, All Recovery Groups at Recovery Centers sponsored by the Connecticut Community for Addiction Recovery (CCAR), Dual Recovery Anonymous, Double Trouble in Recovery, Bi-Polar Disorder Support Groups, Warm Lines, NAMI, Nicotine Anonymous, Gambling Anonymous, etc.).

11. Services incorporate families and/or others that are likely to support the individual's recovery process as the individual chooses. The program or agency offers family psycho-education or multi-family peer support groups that incorporate a focus on co-occurring disorders or a linkage to such a group.

12. Co-occurring disorders are addressed in the discharge planning process of time-limited programs/services. Upon discharge, individuals are given information on how to access additional support and crisis services as needed, and willing individuals are connected with recovery support services in the community.

13. The program has procedures for managing crises, e.g., an individual's potential harm to self or others, and protocols in place so a crisis does not result in a referral or linkage issue. Individuals are not discharged from services unless the severity of the circumstances indicates alternative services are necessary.

Staffing

13. Written human resource policies incorporate at least the *"basic"* portion of the DMHAS list of staff competencies for providing non-clinical services to people with co-occurring disorders. Status of attainment of these competencies is documented for each staff person and, supervisor. Attainment can be achieved through one of the following ways: a recognized

credential[1] for providing services to people with co-occurring disorders, or documented training and experience, e.g. staff evaluations, training certificates, related credentials, verified employment history, and supervision logs that document development of the competencies to serve individuals with co-occurring disorders.

14. On-site, documented individual and/or group supervision sessions, including a focus on co-occurring disorders, are provided, as determined by the program director or contracted level of care requirements, but no less frequently than once/month.

15. The program has a written training plan that includes 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, in-service trainings, and external trainings.

Quality Assurance

16. The program has a written quality assurance procedure, and evidence of its implementation, for identifying the percentage of clients with co-occurring disorders and some related outcome indicators to help measure the program's effectiveness in serving individuals with co-occurring disorders (e.g., critical incidents, level of functioning, progress toward goals, client satisfaction survey responses).

17. The agency has a written procedure for self-monitoring its adherence to these co-occurring capable program guidelines over time.

Primary Sources: *DMHAS, "Commissioner'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".*

Co-Occurring Capable Program Guidelines for Non-Clinical Services Workgroup:

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[1] Connecticut Certification Board, National Association of Social Workers, American Psychological Association's College of Professional Psychology, American Society of Addiction Medicine, American Academy of Addiction Psychiatry.