
Co-Occurring Enhanced Program Guidelines

February 2009

Connecticut Department of Mental Health and Addiction Services

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. 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 treating 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 Enhanced Program Guidelines

Program Structure and Milieu

1. Agency mission statement and/or policy is inclusive of people with co-occurring disorders.
2. Program is licensed to provide both mental health and addiction treatment services.
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. The program performs a formal, integrated, and comprehensive assessment. Psychiatric, substance use and trauma history is reflected in the medical record, including longitudinal information about the interaction between an individual's mental health symptoms and substance use. The individual's stage of change for both disorders is documented. An integrated formulation of strengths, history, current symptoms, and other assessment information must be part of the assessment. The program documents both psychiatric and substance use diagnoses for people with co-occurring disorders.
6. The treatment/recovery planning process focuses on the recovery potential of an individual. It includes a focus on the co-occurring conditions, including co-occurring medical conditions, and incorporates stage of change principles. Relapse or non-adherence to medication or other treatment is not an automatic cause for termination from the program. Co-occurring disorders are reflected as dual primary disorders, and a plan is developed in which each condition receives stage-specific and diagnostic-specific services concurrently. Treatment for mental illnesses, including psychotropic medications if deemed clinically appropriate, continues at the needed intensity even when individuals are actively using substances. Treatment for substance use disorders continues at the needed intensity even when individuals have psychiatric symptoms and are receiving interventions focused on their mental illnesses.

Services

7. The program has the ability and capacity to provide care to individuals with moderate to high *symptom acuity*. "Moderate to high" is defined as a level of instability such that extensive support, monitoring and accommodation is necessary for the individual to participate in the treatment process, but there is no evidence of significant danger to self or others, a need for detoxification or 24-hour psychiatric supervision. These individuals may be actively using substances, and/or have a history of suicidality.

The program has the ability to provide care to persons with moderate to high *severity of disability*, including those who may be on chemical maintenance and/or psychotropic medication. "Moderate to high" is defined as long-term, potentially lifelong, functional impairment as a result of substance dependence and/or a mental health disorder, including

persons with severe and persistent mental illnesses, a significant history of substance use relapse, multiple recurrences of a mental health disorder and/or evidence of continued impairment in *several* functional areas (capacity to manage relationships, job, finances, and social interactions).

The program admits individuals who fall into what may be commonly known as ***Quadrant IV***, as described in the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol/TIP 42,, including individuals with substance dependence and:

- Schizophrenia-spectrum disorders
- Severe mood disorders with psychotic features
- Severe anxiety or personality disorders

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. Through multiple modalities (e.g., individual, group) the program includes motivational interventions, education about the symptoms, course, and treatments for specific mental health and substance use disorders, information about the interactive nature of co-occurring conditions, addiction treatment and mental health treatment (e.g., cognitive behavioural therapy), and relapse prevention planning. Trauma-informed and trauma-specific services are an integral component.
9. Psychopharmacologic and addiction pharmacotherapy interventions are provided on-site, except for methadone or bupernorphine, which require specific federal approvals.
 - A psychiatrist or advanced practice registered nurse, with experience in prescribing for people with co-occurring disorders, must be available to provide psychiatric evaluation, psychopharmacologic and addiction pharmacotherapy (e.g., naltrexone, disulfiram) interventions, and medication monitoring.
 - For individuals with known substance dependence (active or remitted), the adjunctive use of benzodiazepines, addictive pain medications, or non-specific sedatives/hypnotics should be decided on a case-by-case basis, after careful consideration of alternative medications with reduced risk potential. The adjunctive use of these medications requires careful monitoring and close coordination between prescribing physicians. Medications with addiction potential should not be withheld from carefully selected individuals who demonstrate specific beneficial responses to them without signs of misuse.
 - The on-site prescriber will be available to staff for consultation, to participate in clinical team meetings, and provide staff in-services, as needed.
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)).
11. Assessment and treatment incorporates families and friends. These interventions include, but are not limited to, family psychoeducation, multi-family groups, and family therapy, and incorporate a focus on co-occurring disorders.

12. Co-occurring disorders are addressed in the discharge planning process and aftercare planning. Program must be credentialed by DMHAS as a Clinical Recovery Check-up provider. Upon discharge, willing individuals are connected with recovery support services, including, but not limited to clinical recovery check-ups and telephone recovery support services.

Staffing

13. Written human resource policies incorporate the DMHAS list of staff competencies for providing services to people with co-occurring disorders. Status of attainment of these competencies must be documented for each direct care staff person, clinical supervisor and clinical director in the program. Documentation includes a recognized credential¹ for providing services to people with co-occurring disorders or the equivalent in training and experience. Documentation may include copies of staff evaluations, training certificates, related credentials, verified employment history, and clinical supervision that documents development of the competencies to serve individuals with co-occurring disorders. In addition to attainment of the COD competencies, the following is required of the program:
- At least one direct care staff member, in addition to the prescriber, has mental health licensure (i.e., LCSW, LPC, LMFT, licensed psychologist) and at least one direct care staff member has addiction treatment licensure (i.e., LADC);
 - Clinical supervisors must be licensed or certified 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, including a minimum of two hours of face-to-face clinical supervision for every four weeks worked for staff without a professional license. One of these hours can be in a group supervision format. Licensed (non-medical, non-prescribing) direct care staff will receive at least one hour for every four weeks worked in either a group or individual format.
15. Program has 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, in-service trainings, and external trainings. The plan needs to include training in specialized treatment approaches and pharmacotherapies.

Quality Assurance

16. Program has 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 has a written procedure for self-monitoring their adherence to these co-occurring enhanced program guidelines over time.

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.

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"; Kenneth Minkoff, M.D., "Psychopharmacology Practice Guidelines for Individuals with Co-Occurring Psychiatric and Substance Use Disorders".

Co-Occurring Enhanced Program Guidelines Workgroup: Jim Baker, United Services; Asher Delerme, Chemical Abuse Services Agency (CASA); Rick Fisher, DMHAS; Ron Fleming, Alcohol and Drug Recovery Centers (ADRC); Julianne Giard, DMHAS; Bill Gilbert, Community Prevention and Addiction Services (CPAS); Waldemar Gracia, Institute for the Hispanic Family; Rhonda Kincaid, DMHAS; Rob Lambert, Connecticut Counseling Centers; Susan Niemitz, Hartford Behavioral Health; Jim O'Dea, Backus Hospital; Kate Powell, SWCMHS, DMHAS; Alyssa Rose, CT Community Providers Association (CCPA); Nic Scibelli, Wheeler Clinic; Lauren Siembab, DMHAS; Kathy Ulm, Rushford Center; Phillip Valentine, Connecticut Community for Addiction Recovery (CCAR).