

June 18, 2001

**AACP POSITION STATEMENT ON PROGRAM COMPETENCIES IN A
COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEM OF CARE
FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND
SUBSTANCE DISORDERS**

Introduction:

In June, 2000, AACP released a consensus position statement entitled Principles of Treatment for Individuals with Co-occurring Psychiatric and Substance Disorders, indicating the need for welcoming, accessible, integrated, continuous, and comprehensive treatment interventions and treatment programs, organized into a comprehensive, continuous, integrated system of care (CCISC).

The current document builds upon that position statement, by indicating AACP support for recently disseminated program categories for mental health and substance disorder programs, that define Dual Diagnosis Capable (DDC-MH, DDC-CD) programs and Dual Diagnosis Enhanced (DDE-MH, DDC-CD) programs within each service system, and recommend the following important principles of system design:

1. **All MH and CD programs should be expected to be Dual Diagnosis Capable, according to the definitions below.**
2. **Within any system of care, at each level of care, there should be a plan for appropriate DDE capacity.**
3. **Within any system of care, there needs to be a full range of housing options for individuals with psychiatric disabilities, as described below.**

Definitions:

System of Care: For purposes of this document, mental health (MH) programs are any programs organized, licensed, and/or funded to specifically treat individuals with psychiatric disorders, often prioritizing individuals with serious mental illness; the array of such programs serving a defined population is termed the mental health system of care for that population. Similarly, addiction or chemical dependency (CD) programs are any programs organized, licensed and/or funded specifically to treat individuals with substance disorders; the array of such programs serving a defined population is termed the chemical dependency system of care for that population.

Program Categories: DDC-CD; DDE-CD;DDC-MH;DDE-MH

DDC-CD: The concept of Dual Diagnosis Capability in CD programs is incorporated in the ASAM PPC2R (ASAM, 2001), in which DDC is described as a standard of care for

ALL addiction treatment programs, based on the high prevalence of expected comorbidity among individuals seeking addiction treatment.

DDC-CD represents a measurable basic standard of care, which can be implemented within the context of existing program requirements, with additional technical assistance and training support, but without additional clinical operational cost, and can be reliably assessed through routine program audit, such as would occur during licensure review.

DDC-CD applies to any and all levels of care in the addiction treatment system, and implies that the program routinely admits individuals with co-occurring disorders, provided that the symptomatology and disability associated with those disorders is not severe enough to substantially interfere with participation in routine program functions or require substantially increased levels of staff support in order to sustain such functioning. Thus, an individual may have baseline psychotic symptoms or suicidal ideation, but these symptoms are sufficiently limited or controllable that the individual can participate in groups, complete assignments, perform independent ADLs, etc.

The measurable criteria that define DDC status are as follows:

1. **Mission and Philosophy:** The program's mission, philosophy, and admission policies specifically welcome individuals with co-occurring disorders, and create no barriers to admission based solely on psychiatric history, diagnosis, or non-addictive prescribed medication. Assessment of motivation and functional capacity to participate in treatment are assessed for this purpose, as they would be for anyone seeking admission. (Note that individuals with psychiatric presentations or medication regimes that are more complex or controversial will ordinarily require DDE-CD programs for addiction treatment.)
2. **Screening for Comorbidity:** There are specific screening procedures for the presence of psychiatric disorders and symptoms, and evidence that such procedures or tools are followed and used competently.
3. **Assessment:** The assessment process is ongoing, and incorporates routinely gathering information about psychiatric history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability. There is evidence that this process, and the associated forms, are followed and used competently. In addition, proactive linkage is provided to ensure access to mental health treatment for those individuals who need mental health services beyond the capabilities of the program.
4. **Diagnosis and Treatment Planning:** Psychiatric diagnoses are identified in the treatment record, and, where current treatment is required, listed as problems on the treatment plan. Specific goals and objectives are identified for each such problem.
 - Ex. Problem: Major Depression, on meds, currently minimal symptoms
 - Goal: Maintain stability and prevent interference with addiction rx.
 - Objective: Patient demonstrates competency in taking meds as prescribed.
 - Patient identifies techniques for addressing med issues in 12 Step meetings
5. **Documentation:** Progress notes document monitoring of the psychiatric disorder in relation to the treatment plan.

6. **Programming:** Treatment programming (at least one group per week) addresses issues related to co-occurring mental illness directly and openly, educating ALL clients about basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working an addiction recovery program.
7. **Medication Policies:** Program policies address obtaining medication prescriptions, as well as medication distribution and compliance, directly, and support medication compliance with MD prescription as a program requirement, including staff's responsibility to support such compliance.
8. **Psychiatric Emergency Policies:** Program has specific procedures for dealing with psychiatric emergencies.
9. **Mental Health Consultation:** Program has access to MH consultation for diagnostic assessment and treatment planning assistance. (Ideally, an existing program supervisor has MH background and training.)
10. **Collaboration with MH Treaters:** Program has defined policies and procedures for integrating input from outside MH treaters into treatment plans, progress notes, and discharge plans, including obtaining routine input from psychiatric prescribers. (Psychiatrist on site is preferable, but not required.)
11. **Competencies:** Human resource policies and staff training and supervision policies incorporate attention to specific competencies in co-occurring disorders related to program function (eg, screening, running the group), and continuing education to support and enhance those competencies.
12. **Discharge Planning:** Discharge or transition planning documents specific attention to continuity of care for psychiatric disorder.

DDE-CD: DDE-CD programs are psychiatrically enhanced programs at any level of care or type of treatment in the addiction system, in which additional resources and capabilities are added to an existing addiction program model in order to accommodate individuals with psychiatric disorders who have moderate levels of acute symptomatology or psychiatric disability. This type of program may include individuals who are motivated for addiction treatment, but also have active symptoms of PTSD which may include intermittent flashbacks and/or suicidal ideas, or who also have stable schizophrenia with persistent disability that may interfere with usual functioning required in a DDC addiction program.

DDE-CD programs are more costly than usual DDC addiction programs, and require additional funding, often through braiding or blending MH funding into the addiction program funding base. The ASAM recommendation is that within each system of care, at each level of care in the addiction system, there is a plan for DDE-CD capacity. This may involve distinct programs, or it may involve a component of an existing DDC program.

The specific characteristics of DDE programs are as follows:

1. Meets all DDC criteria, plus:
2. Increased staffing levels, with more staff with MH training
3. Direct **availability of a licensed prescriber with training in psychopharmacology** on site.

4. On site availability of MH supervision/consultation
5. Smaller group size, with more flexible expectations, and more specific MH symptom management incorporated into program content.
6. Documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes
7. Continuing documentation of collaboration with continuing care mental health treaters, and involvement of those treaters in treatment planning meetings.
8. Program materials, such as skills training modules for substance reduction or relapse prevention, adapted to individuals with psychiatric impairment who may have impediments to learning new skills, by utilizing shorter, simpler, and more flexible assignments.
9. Policies that support welcoming return for individuals who lapse in treatment or who are unable to adhere to rules during the current treatment episode. More likelihood to accommodate more than one lapse before discharge.
10. Increased availability of individualized counseling and case management.

DDC-MH: The concept of DDC-MH was developed by Minkoff (Minkoff, 2000) as an extension of conceptualizations developed in the 1998 CMHS Expert Consensus Panel Report on Standards of Care for individuals with co-occurring disorders. Like DDC-CD, DDC-MH is considered to be an expectation for ALL mental health programs, and can be implemented with technical assistance and training support, but without additional clinical operational resources.

DDC-MH programs routinely welcome individuals with active co-occurring substance disorders, and provide appropriate phase specific interventions to treat those disorders. Capacity for medically-monitored detoxification is dependent upon the availability of medical and nursing care comparable to that found in an ASAM Level III detoxification program, but intoxicated individuals who do not require medical detoxification can be routinely stabilized in appropriately staffed settings.

Like DDC-CD, DDC-MH is evaluated through routine program audit procedures, through chart review of specific, measurable criteria.

Specific characteristics of DDC-MH programs include:

1. **Mission and Philosophy:** Mission statement and philosophy clearly welcome individuals with active substance use, and promote continued mental health treatment of such individuals even when actively using.
2. **Screening for Comorbidity:** Specific screening for substance use disorders documented, with evidence that such screening is performed competently.
3. **Assessment:** For individuals who are screened positively for past or present disorder, there is documentation of substance assessment, incorporating types and amounts of use, patterns of use, problems associated with use, specific substance diagnoses, past successful interventions, characteristic mh symptoms during previous sobriety periods, current treatment if any, and specific documentation of stage of change. In addition, proactive linkage is provided to ensure access to substance disorder treatment for those individuals who need substance disorder services beyond the capabilities of the program.

4. **Treatment Planning:** Substance diagnoses are routinely recorded in the clinical record, and identified as problems in the treatment plan, with specific goals, objectives, and interventions.
5. **Substance Disorder Consultation:** Documentation of access to consultation with CADAC or another clinician with documented substance expertise, and integration of this input into progress notes and treatment plans.
6. **Continuity:** In programs responsible for continuity of care, no denial of access or continuity based on continuing substance use for individuals who require treatment for continuing psychiatric disorders, and program policies specify that primary clinicians provide integrated continuous treatment relationships.
7. **Stage-Specific Treatment:** Availability of stage-specific treatment interventions, including a range of group interventions in programs that offer groups
8. **Competencies:** Human resource policies incorporate basic competencies in substance use disorders consistent with job requirements, and supervision and training policies include continuing education plans to support and enhance those competencies.
9. **Collaboration with CD Treaters:** Documentation of coordination of care with collaborative substance providers integrated into treatment record.
10. **Discharge Planning:** Discharge or transition planning incorporates specific attention to continuity of phase-specific treatment for co-occurring substance disorder.

DDE-MH: Dual diagnosis enhanced mental health programs incorporate increased capacity to address co-occurring substance disorders in a variety of mental health settings. In general, in any mental health system, at each level of care, there needs to be a plan for appropriate availability of DDE-MH services. In almost every level of care in the MH system, a DDE service is no more costly than a comparable DDC service; creation of appropriate DDE services in a system with adequate baseline capacity often involves designating some of those services as DDC, and the remainder as DDE, in the planning process.

Characteristics of DDE-MH programs vary according to the type of program. All programs meet DDC criteria, plus additional criteria as follows.

1. One type of program involves provision of an active addiction treatment program in a mental health environment, such as an inpatient psychiatric unit, partial hospitalization program, or mental health group residential setting.
 - a. The program staff have increased training in addiction with available supervision by addiction credentialed staff.
 - b. Program content includes substantial addiction focus (approximately half time as a minimum.), with strong connections to standard (e.g., 12-Step) and dual recovery programs.
 - c. Program policies address abstinence expectations, and make provisions for transfer to a setting with lower expectations if the individual lapses.

2. The second type of program emphasizes motivational enhancement interventions for individuals with active substance disorders and severe psychiatric illnesses that are very disengaged: e.g., continuous treatment teams, “wet” housing programs.
 - a. Program staff have increased training and experience in working with actively using individuals with severe substance disorders.
 - b. Programs incorporate motivational interventions, along with contingency management (e.g., payeeships), and intensive case management, maintaining continuity with clients who are very disengaged.

3. The third type of program incorporates a range of phase-specific treatment options into a comprehensive program setting that emphasizes working with individuals with co-occurring disorders. Examples include: dual diagnosis specialized continuing day treatment, dual diagnosis specialized damp housing, as well as combinations of services in a comprehensive continuum.
 - a. Program staff members have increased training and access to supervision, as above.
 - b. Programs have a full range of phase-specific interventions, including connection to dual recovery programs
 - c. Programs have substance use policies that clarify consequences for various types of behavior in each phase of treatment, and procedures for connecting program contingencies to motivational enhancement strategies.
 - d. Programs incorporate a combination of continuing care strategies with interventions attached to increased expectation.

Housing Programs

In addition, as described in the AACP Position Statement on Housing Options for Individuals with SPMI, the comprehensive system of care in each local service area must include a full range of housing options for individuals with co-occurring disorders. In particular, psychiatric housing programs (which provide or support a place to live for individuals with psychiatric disability, in order to prevent homelessness) must be distinguished from addiction (or psychiatric) residential treatment programs (which provide episodes of treatment in a residential setting, usually with defined expectations or requirements). Both are important components of a comprehensive system of care.

In most service areas, the addiction treatment system provides a range of addiction residential treatment programs (both DDC-CD and DDE-CD) and sober housing programs (e.g., Oxford House model programs), all of which need to be abstinence-expected programs in order to protect the integrity of the addiction recovery support provided. Individuals who enter these settings are seeking a sober recovery environment, not merely housing, and expect these requirements to be enforced. Ideally, all such individuals have a plan for housing in the event that they fail to meet program requirements and are prematurely discharged.

The mental health system, by contrast, provides mainly housing support programs for individuals with SPMI. Many of these individuals have co-occurring substance use disorders, but vary in their willingness to define substance use as a problem and/or identify sobriety as a goal, even though they may desire assistance to maintain stable housing. Some of these individuals are simply unable or unwilling to limit substance use, even when all housing supports available require such limits; these individuals frequently become homeless as a result.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring disorder) who need housing assistance due to psychiatric disability, and who are at risk of homelessness, MUST include the following choices:

- a. **Abstinence-expected (“dry”) housing:** This model (usually a DDE-MH program) is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. This model may also be appropriate for individuals with no substance disorder who wish to live in an abstinent environment. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than “one strike and you’re out.”
- b. **Abstinence-encouraged (“damp”) housing:** This model (which can be either DDC or DDE) is most appropriate for individuals who recognize their need to limit use and are willing to live in supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built in to program design.
- c. **Consumer-choice (“wet”) housing:** This model of DDE-MH housing has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (cf. Tsemberis & Eisenberg, “Pathways to Housing Program” in *Psychiatric Services*, April, 2000). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use

related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach.

Each system needs to assess housing needs across all three options and provide an appropriate balance of availability. Consumers with psychiatric disabilities who need housing support, including those who choose to enter dry housing but are unsuccessful in remaining sober, should not be left homeless simply because of inability or unwillingness to maintain abstinence.