

COMMONWEALTH OF PENNSYLVANIA
Department of Public Welfare
Department of Health

Co-Occurring Disorder Competency Approval Criteria Bulletin
OMHSAS 06-03

Interpretive Guidelines

The Departments are issuing the following interpretive guidelines to assist facilities with meeting the criteria outlined in the Competent Bulletin issued on February 10, 2006. This Bulletin provides the framework for delineating the objective criteria for defining Co-occurring Disorder Competency for any facility within the Commonwealth licensed by the Department of Health, Division of Drug and Alcohol Program Licensure or the Department of Public Welfare, Office of Mental Health and Substance Abuse Services. The goal of the Departments is to move the entire behavioral health system toward the achievement of core competency to serve individuals with a co-occurring psychiatric and substance use disorder by having all licensed mental health and substance abuse facilities approved as competent over time.

A. Co-Occurring Disorder Mission and Philosophy

The facility policies and procedures or operations manual shall include, but not be limited to, the following:

1. Mission statement and program philosophy which incorporates an understanding of the provision of effective co-occurring disorders services approved by the governing body of the facility.
2. Description of intervention strategies that include consensus and evidence-based practices for age and culturally appropriate co-occurring services.
3. Quality improvement plan that monitors compliance with program philosophies, intervention strategies, and consumer satisfaction with services.
4. Co-occurring program performance measures linked to the quality improvement activities.

The facility has a mission and philosophy statement that identifies the primary target population served based upon the licensure, but the statements also indicate an expectation and willingness to serve individuals with a co-occurring psychiatric and substance use disorder that are relatively stable, appropriate for the facility program and level of care.

B. Co-Occurring Disorder Screening

The facility shall:

1. Develop written procedures for screening for co-occurring issues.

2. Utilize population appropriate screening instruments that identify both psychiatric and substance use disorders.
3. Identify staff qualified to provide screening
4. Document staff training on screening procedures.

Written procedures shall indicate that the facility routinely and systematically screens all individuals for both mental health and substance related disorders within a reasonable time frame.

There are no professional restraints on who can be trained to conduct the screening process. The Bulletin criteria allow the facility to designate qualified staff to perform this function.

C. Co-Occurring Disorder Assessment Process

The facility shall:

1. Develop written procedures for a strength-based assessment process for co-occurring disorders.
2. Utilize assessment instruments that gather information about both psychiatric and substance use disorders, including information about symptoms of either disorder when the other is at baseline.
3. Identify how the assessment findings are incorporated into the treatment planning process.
4. Identify staff qualified to complete the assessment process for individuals with co-occurring disorders.
5. Document staff training on the co-occurring disorder assessment process.

An assessment consists of gathering information and engaging in a process with the individual that enables the program to establish the presence or absence of a co-occurring disorder, determines the individual's readiness to change, identifies strengths and potential problem areas that may impact the treatment and recovery process, and engages the individual in the program. It is a formal process that may involve clinical interviews, administration of standardized instruments, and/or the review of existing historical information.

There is no specific assessment instrument required by the Bulletin. (For facilities interested in utilizing a standard instrument, please reference Appendix G in the Treatment Improvement Protocol (TIP) 42 published by the U.S. Department of Health and Human Services at www.samhsa.gov)

The Bulletin criteria allow the facility to identify which staff have been designated as qualified and trained to perform the assessment process.

D. Program Content

In the context of current licensed activities, the facility shall document how, within its existing array of interventions, services, and programming, the

following consensus and evidence-based intervention strategies are routinely provided:

1. Individual and Group Interventions,
2. Skill-Building Interventions,
3. Mental Health Education or Addiction Education or both,
4. Medication Education,
5. Co-occurring Disorder Education for individuals and families,
6. Co-occurring Disorder Relapse Prevention, and
7. Access to Peer Support Services and Self-Help Recovery Resources.

In addition, it is recommended that facilities include the following strategies:

8. Stage of Change Matched Interventions,
9. Motivational Enhancement Interventions.
10. Contingency Management.

The facility complements the existing programming by ensuring that the interaction between psychiatric and substance related disorders is recognized as part of the program content through universal screening and assessment, motivational enhancements to support engagement, ongoing education about the connections between mental health symptoms and substance use, relapse and recovery skills, coordination of care, referral for ancillary services, and access to self-help recovery supports.

The Bulletin allows the facility to maintain a single clinical chart. Neither DOH nor DPW requires separate charts for co-occurring services.

E. Integrated Care Planning

The comprehensive integrated care plan shall, at a minimum, include the following:

1. The individual's full participation in the development of his integrated care plan.
2. Input from the multidisciplinary team, collaborating agencies, practitioners and family, if appropriate.
3. Goals and measurable learning and skill-building objectives that reflect the presence of both disorders and how intervention strategies may vary to meet the needs of the individual.
4. Individualized goals that are stage-specific based upon the assessment of co-occurring needs.
5. Identification and incorporation of the individual's strengths and supports needed to accomplish the identified goals.
6. Reviews and revisions based upon additional clinical information obtained through the ongoing assessment and evaluation process.
7. Recovery supports for both disorders.

F. Medications

All facilities shall develop policies regarding prescription medications which address the following:

1. Documentation that includes medication, dose, frequency, and prescribing physician.
2. Monitoring medication adherence, including self-report.
3. Access to medication, if not available within the facility.
4. Documentation of communication and coordination of care between all programs providing treatment services and medications to the individual.
5. Education about the medications, including side effects.

The facility is not required to prescribe medication on-site but shall have policies and procedures indicating the ability to refer an individual with a co-occurring disorder for medication evaluation or on-going medication monitoring where appropriate.

The facility shall provide medication education resources on-site.

G. Crisis Intervention

The facility shall develop policies and procedures to address the following situations in a manner that facilitates engagement, safety, and continuity of care, and does not create barriers to accessing appropriate care based upon the presence of a co-occurring disorder:

1. Psychiatric emergencies
2. Withdrawal emergencies
3. Medication emergencies
4. Medical emergencies
5. Intoxication
6. Social Safety emergencies (e.g., Child Abuse, Domestic Violence, Unexpected Homelessness)

The facility shall have policies and procedures to address crisis situations, such as psychiatric and medical emergencies, in a manner that facilitates engagement, safety, and continuity of care, and does not create barriers to accessing appropriate care based upon the presence of a co-occurring disorder. This may include written protocols for risk assessments and linkages with other collaborative entities to assist in the management of the crisis situation.

H. Communication, Collaboration, and Consultation

The facility shall, at a minimum, develop the following:

1. Written agreements to maintain linkages with practitioners and organizations necessary to support co-occurring service needs.
2. Policies and procedures for integrating input from collaborating agencies and family members, if appropriate.

3. Procedures for obtaining written consent from the individual receiving services for all communication and collaboration with other agencies.
4. Procedures for identifying situations requiring consultation
5. Protocols for referrals to integrated co-occurring services or ancillary treatment services, when indicated.

I. Staff Competencies

The facility must be able to demonstrate staff competency, and supervision capability regarding co-occurring disorders as evidenced by:

1. The number of credentialed clinical staff should be appropriate for the size of the facility and the number of programs; however, there shall be documentation of, at a minimum, one credentialed clinical staff such as the CCDP, or the Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders through the American Psychological Association (APA), a Certificate of Specialty in Addiction through the National Association of Social Work (NASW), or the American Society of Addiction Medicine (ASAM) certification for physicians, involved in the direct provision of co-occurring services.
2. Documentation of all clinical staff attendance at Co-Occurring Core training that, at a minimum, includes:
 - a. Co-Occurring Psychiatric and Substance Use Overview
 - b. Principles of Engagement with Individuals with a Co-Occurring Disorder and Family Members
 - c. Individualized Approaches and Supports for Co-Occurring Disorders
 - d. Co-occurring Care Planning and Documentation Issues
 - e. Psychopharmacology
 - f. Crisis and Relapse Intervention
 - g. Recovery, Rehabilitation, and Self-help for Co-Occurring Disorders
 - h. Ethics and Boundaries for Effective Co-occurring Services
 - i. Working Respectfully with Family Members
3. The number of credentialed supervisors should be commensurate with and appropriate for the size of the facility and the number of programs; however, there shall be documentation of, at a minimum, one credentialed supervisor, such as the CCDP-Diplomate, or the Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders through the American Psychological Association (APA), a Certificate of Specialty in Addiction through the National Association of Social Work (NASW), or the American Society of Addiction Medicine (ASAM) certification for physicians, who is responsible for the direct supervision of staff providing co-occurring services.
4. Documentation of ongoing supervision to address co-occurring services.

To apply for Co-Occurring Competent approval, the facility shall have:

*one credentialed staff providing direct services to individuals with a co-occurring disorder, and
one credentialed supervisor.*

Credentials indicate proficiency in treating individuals with a co-occurring disorder and may be based upon professional licensure and/or affiliation.

All additional clinical staff that will provide services to individuals with a co-occurring disorder shall document participation in the identified core training topics (I, 2 of the Bulletin) within one year of facility approval as co-occurring competent; or for staff hired after facility approval, within one year of hire date. Training shall be on a pro-rated basis of three (3) courses every four months.

All core training topics shall be, at a minimum, three hours in length. The core training can be provided as a combination of web-based, internal agency training, and external training from a variety of sources with the following limitations:

Web-based training shall be limited to the following core topics:

Co-Occurring psychiatric and substance use overview

Recovery, Rehabilitation, and Self-Help

(The University of Southern Florida offers a co-occurring web-based curriculum that can be utilized. It can be accessed at http://cmhwbt.fmhi.usf.edu/co-occurring/intro_00_title.cfm)

Training in Psychopharmacology shall be provided by a Department approved training entity only.

Any Department approved Ethics training will be accepted.

Educational transcripts can be substituted for any of the core trainings with appropriate documentation of course content.

Documentation of participation in the core training topics shall be provided at the on-site review.

Any internal training curriculum shall be approved by either Department. Please submit the curriculum outline with the facility letter of request for approval as a competent facility.

There shall be written documentation, such as notes or logs, of ongoing supervision of co-occurring service oversight and review.

J. Transition, Discharge, and Aftercare

The facility shall demonstrate that the following can be provided:

1. Transition, Discharge, and Aftercare needs planning commencing upon admission to the program.
2. Referral for psychiatric access and medication management.
3. Identification of and referral to appropriate community support services including peer support services, recovery self-help groups, co-occurring self-help groups, co-occurring self-help groups, and other individualized support services.
4. Instructions for accessing crisis services for both psychiatric and substance use needs.
5. Linkage with case management services for community resources, if appropriate and available.

The facility routinely provides appropriate linkage for both mental health and substance related disorders as part of the discharge/aftercare planning process including the utilization of community resources such as self-help and peer support services.

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