



COMMONWEALTH OF PENNSYLVANIA

Department of Health
P.O. Box 90
Harrisburg, Pennsylvania 17108

JUN 16 1999

Department of Public Welfare
P.O. Box 2675
Harrisburg, Pennsylvania 17105

Dear Interested Party:

We are pleased to provide you with the MISA Consortium's initial recommendations for services to people with co-occurring mental health and substance use disorders.

In the fall of 1997, the Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) and the Department of Health's Bureau of Drug and Alcohol Programs (BDAP) convened a group of stakeholders from the mental health and drug and alcohol systems to develop recommendations for services to persons with co-occurring mental health and substance use disorders hereafter referred to as MISA. The group, known as the MISA Consortium, identified four initial areas for recommendation: assessment, staff credentials and training, service standards and protocols, and services to adolescents. Subcommittees were formed and charged to develop reports of recommendations for their respective topics. We are now sharing the recommendations with numerous stakeholders and interested parties within the drug and alcohol and mental health systems to solicit feedback and increase awareness of the vision for a MISA system of care in Pennsylvania.

This is an important opportunity for your input into the development of MISA services in Pennsylvania. While the reports contain a lot of information, we encourage you to read them thoroughly and to provide thoughtful comments. All comments must be submitted, in writing, no later than August 31, 1999 to:

Ms. Carolyn Cass
Director for Treatment
Bureau of Drug and Alcohol Programs
PO Box 90
Harrisburg, PA 17108
FAX: (717) 787-6285

OR

Ms. Sherry Snyder
Special Assistant for Substance
Abuse Services
Office of Mental Health and
Substance Abuse Services
PO Box 2675
Harrisburg, PA 17105
FAX: (717) 787-5394

In addition to requesting written comments, we are also providing the opportunity for interested parties to provide public testimony on the MISA recommendations. Public forums are scheduled from 10:00 AM to 3:00 PM on August 23, 25 and 26 at the following locations:

Monday, August 23, 1999
Norristown State Hospital, Building #33
Multipurpose Room
Norristown, Pennsylvania
Directions enclosed. Lunch on your own.

Wednesday, August 25, 1999
The Meadows Psychiatric Center Gymnasium
Centre Hall, Pennsylvania
Map enclosed. Lunch arrangements in this area are limited. The Meadows will provide a boxed lunch for \$5.00 per person if you indicate interest when you register.

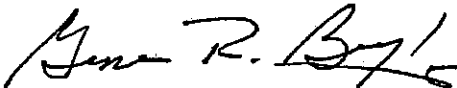
Thursday, August 26, 1999
Mayview State Hospital
Auditorium
New Bridgeville, Pennsylvania
Directions enclosed. Lunch on your own.

All presenters must call Ms. Wendy Roberson, OMHSAS, at (717) 787-8011 to register for a time slot. Each presenter will be allotted 15 minutes. Two copies of the written testimony must be submitted at the time of their presentation. All other persons are to notify Ms. Roberson of the session they plan to attend in order to ensure sufficient seating.

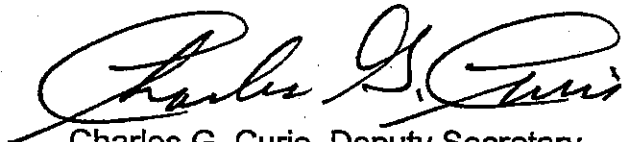
The MISA Consortium's recommendations are the first step in developing a MISA system of care. The reports will likely raise many questions about how the recommendations will be implemented. Some recommendations will be easier and quicker to implement than others. Some recommendations may require a change in policy or regulations. We view this as work in progress, which requires time and ongoing commitment to fully achieve positive results.

We thank you in advance for your interest and look forward to receiving your input regarding the recommendations of the Consortium.

Sincerely,



Gene R. Boyle, Director
Department of Health
Office of Drug and
Alcohol Programs



Charles G. Curie, Deputy Secretary
Department of Public Welfare
Office of Mental Health and
Substance Abuse Services

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Executive Summary

EXECUTIVE SUMMARY

The prevalence of persons with co-occurring mental health and substance abuse disorders (hereafter referred to as MISA) has varied over time and among populations. Estimates range from 5% among the general population to 80% among persons who are chronically homeless or involved with the criminal justice system. The variance in numbers can be attributed not only to the differences in populations, but to the differences in definitions of "MISA" as well.

The Mental Health and Substance Abuse service systems have struggled for many years with how to identify and treat people with co-occurring mental health and substance use disorders. Each system has attempted to serve people with dual disorders using clinical interventions and program structures developed specifically to treat either mental illness or substance abuse, but not both. These efforts have been well-intended but not very effective; yet, conflicting program philosophies, different languages and fear of losing autonomy have prevented both systems from reaching out to each other for answers. This intentional segregation is now being challenged by a growing body of research findings that chronological treatment (treat one disorder first, then treat the other) has minor success, and coordinated treatment, while better, also has limited success. Research is finding that the most effective treatment approaches for MISA are integrated.

Until recently, the Departments of Public Welfare and Health have maintained regulations and funding practices that have reinforced the need to categorize services to persons with mental illness discreetly from services to persons with substance use disorders. In the summer of 1997, the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Bureau of Drug and Alcohol Programs (BDAP) agreed that a collaborative approach to MISA was necessary. Charles Curie, Deputy Secretary for OMHSAS, and Gene Boyle, Director for BDAP, approved the formation of a time-limited task force that would make recommendations to them on serving the MISA population. Each program office identified leaders in MISA within their respective systems. A Consortium was formed with a balanced representation of stakeholders from both the mental health and drug and alcohol systems.

The Consortium first met in October 1997. The group was charged to develop recommendations for an ideal system of care, to not be constrained by current rules or practices. It became evident during the first meeting that the Consortium could not, and should not, take on all the necessary work alone. The group decided that working committees should be established, again with broad-based, balanced drug and alcohol and mental health representation, to develop topic specific recommendations back to the Consortium. Four working groups were formed to address screening and assessment, service standards and protocols, staff credentials and training, and adolescents to include the three previous topics. (The list of participants from each of the working groups is

included with the group's respective report.) The frequency and duration of each group's meetings varied. Reports on progress were made to the Consortium quarterly, with immediate feedback from Consortium members. Final reports were prepared and presented to the Consortium for comments. Carolyn Cass and Sherry Snyder, co-facilitators of the Consortium, further processed the reports and generated comments. Final draft reports were presented to Deputy Secretary Curie and Director Boyle, who agreed that the recommendations could be widely distributed with the opportunity for written comments and public testimony.

Screening and Assessment –

The working subcommittee's final report recommended the necessary components of screening and assessment. Their initial recommendation was that a "screening" process be used to detect the presence of life-threatening indicators requiring emergency care, including D&A issues, mental health issues, medical issues and special needs. They believed, however, that few MISA clients would be identified through a brief screening. Your thoughts on that assumption are of interest.

The subcommittee reviewed various assessment tools, but did not find a satisfactory existing instrument. Their report contains the recommended essential components of a MISA assessment without prescribing a specific tool to be used. OMHSAS and BDAP support this position currently, but reserve the right to be more prescriptive should a satisfactory tool be identified/developed in the future. We also believe that the assessment instrument and process must be strengths-based.

The report also recommends the use of different placement criteria depending on the assessment results: the LOCUS to be used when determining the appropriate level of care for persons with a co-occurring disorder versus a sole substance use disorder; the Pennsylvania Client Placement Criteria for adults with a sole substance use disorder. Your thoughts on this recommendation are also of special interest.

Service Guidelines and Protocols –

This subcommittee used the recommendations from the Center for Mental Health Services Managed Care Initiative: Standards of Care and Practice Guidelines, prepared by Dr. Minkoff et.al., for the basis of this report.

The subcommittee was originally charged to develop "standards" of care for MISA services. The group approached this charge from the perspective of standards being the benchmark for care, rather than the regulatory language which is required for licensure. To help avoid confusion, we re-named the recommendations as "Service Guidelines and Protocols."

The subcommittee developed its own mission statement, as well as a mission statement for the state's system of care. The report begins with General Guidelines for the System to include structure and governance, services integration, comprehensiveness, continuous quality improvement, access standards, program standards, staff competencies, continuity standards, formulary standards, and cultural competency. The next section contains Practice Guidelines for Dual Diagnosis Treatment, to include general principles, assessment guidelines, treatment and rehabilitation guidelines and psychopharmacology. Next are Standards (guidelines) for the Continuum of Services Regarding Treatment Guidelines and Continuity, to include acute or intensive services, residential services and special programming. The report concludes with Standards (Guidelines) for Each Program within the Continuum, to include emergency/triage/crisis services, crisis stabilization beds, detoxification services, psychiatric inpatient services, inpatient residential rehabilitation, intensive/partial outpatient treatment services, intensive integrated case management, outpatient services and residential options.

The report contains a recommendation that all mental health and substance abuse programs be capable of treating MISA, based on the tenet that the presence of a co-occurring disorder is the expectation and not the exception. BDAP and OMHSAS agree that there is a high prevalence of MISA, and that all mental health and substance abuse programs must have the ability to assess for MISA treatment needs, but we believe that people with co-occurring disorders will enter treatment at varying levels of treatment need for each condition. We expect there will continue to be some need for discreet mental health and substance abuse programs. Therefore, we would not envision requiring all providers to become MISA credentialed. If a provider chose to put itself forward as a MISA program, the final guidelines and protocols would need to be met, but it would be the provider's choice to treat co-occurring conditions, thus requiring certification.

Staff Credentials and Training –

This subcommittee used the recommendations from the Center for Mental Health Services Managed Care Initiative: Workforce Competencies, and Training Curricula, presented by the Co-occurring Mental and Substance Disorders (Dual Diagnosis) Panel, in generating their report. This panel was chaired by Dr. Kenneth Minkoff, and consisted of national experts in the arena of dual-diagnosis.

The subcommittee's report identifies training and competency requirements for four levels of MISA practice: licensed mental health professionals; licensed drug and alcohol professionals; program administrators, educators and consultants; and other mental health and drug and alcohol practitioners. Competency requires passing a written exam and obtaining letters of reference. Competencies are identified for Relational Skills, Technical Skills, Treatment

Planning Skills, Treatment, Rehabilitation and Recovery-Focused Skills and Assessment Skills. The report then describes suggested course offerings and the competencies addressed in each course.

The report does not recommend providers of the training, nor the entity(s) responsible for certifying that the competencies are met. OMHSAS and BDAP agree that the training can be made available through the OMHSAS sponsored training institutes, BDAP's training institutes, the Pennsylvania Chemical Abuse Certification Board, and other available training resources. There are a number of options for staff certification, ranging from having one agency perform the function for staff statewide, to having each provider responsible for assuring its staff are certified and including state review as part of the licensure process.

The recommendations within this report are quite comprehensive. However, BDAP and OMHSAS agree that competent staff are the foundation for implementing a quality system of care. We fully support the recommendations.

Adolescents –

This subcommittee's task was to develop recommendations for screening and assessment, staff credential and training and service "standards" and protocols, and to tailor those recommendations to meet the needs of adolescents. The magnitude of their task is evidenced in a full-page mission statement.

The subcommittee cross-walked its work with the other three subcommittees, recognizing that the adolescent will eventually move onto the adult system of care, and that the more similar the systems are, the more likely the transition will be successful. This subcommittee also embraced the report of Dr. Minkoff and his colleagues in forming its recommendations.

The report begins with recommendation for Standards and Protocols for a Dual Diagnosis System of Care for Adolescents. As with the adult report, "Standards" would more accurately be described as "Service Guidelines". General Guidelines for a Dual Diagnosis System include integration, service intensity assessment methodology and outcome measurement policies, program standards, staff competencies, continuity standards and cultural competency. Practice Guidelines for Dual Diagnosis Treatment include general principles, assessment guidelines, and psychopharmacology. Standards for the Continuum of Services Regarding Treatment Guidelines and Continuity addresses acute or intensive services, therapeutic communities, and residential services/alternative living arrangements. As with the adult report, OMHSAS and BDAP do not believe that all adolescent treatment providers need to treat co-occurring disorders; however those providers that present themselves as treating co-occurring conditions will need to be certified. We do support the recommendation that all adolescent treatment providers have the ability to assess for the presence of MISA treatment needs.

The report continues with recommendations for screening and assessment. Screening, initial assessment and the biopsychosocial assessment are defined. Initial Screening Protocol for Adolescents are included. Two instruments used to conduct the initial assessment for adolescents are identified: the Adolescent Problem Severity Index and the Adolescent Drug Abuse Diagnosis.

The report concludes with recommendations for staff competencies and training for the treatment of adolescents with co-occurring disorders. A Core Curriculum is recommended, followed by intermediate and advanced training topics. The course content and goals for each session are identified. OMHSAS and BDAP agree that competencies and knowledge of child development, family dynamics, and the child serving systems are core to the delivery of care and services to MISA adolescents. We also are in support of the recommendation that providers who specialize in serving adolescents must have at minimum 30 hours of adolescent specific training, to be applied to the 65 hours of MISA training required over a three-year period.

The proposed process and timelines for finalizing the recommendations are as follows:

June 7 – 11, 1999	Reports distributed by BDAP and OMHSAS
August 23, 25 and 26	Public Forums held
August 31	Written comments are due
September	Comments processed by BDAP and OMHSAS
October	MISA Consortium reconvened to determine final recommendations
December, 1999	Final MISA recommendations issued

The Departments of Health and Public Welfare will then issue a work plan for implementation of the recommendations.

Our sincere thanks to each member of the Consortium and the Subcommittees for their hours of work and dedication to developing a MISA system of care in Pennsylvania. A special thanks goes out to each subcommittee co-chair for their work in organizing meetings, preparing materials and keeping the momentum going.



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MISA Consortium:

Mission Statement

MISA Consortium Mission Statement

The mission of the system of care in Pennsylvania will be to develop a welcoming, accessible, integrated, continuous, culturally/gender appropriate, and comprehensive system of care for all Dual Diagnosis consumers in the Commonwealth. The system will serve both those who are members of the traditional priority populations (mental health/substance abuse) and those consumers served by other systems who might otherwise fall through the cracks, e.g., correctional system, public assistance system, educational system, medical system, and rehabilitation system. This system will also provide proactive out-reach programming to engage the consumers who are most difficult to reach, e.g., homeless and IV drug users.

The system of care in Pennsylvania will develop a continuum of services that provides treatment and supports for people with varying needs, including those with (a) psychiatric disorders and no substance abuse disorder, (b) serious and persistently mentally ill (SPMI) and substance abuse, (c) SPMI and substance dependence, (d) substance dependence and other psychiatric disorders/symptoms, (e) substance abuse and other psychiatric disorders/symptoms, and (f) substance disorder and no psychiatric disorder. The system will be accessible to all persons at all levels of treatment readiness and motivation within these profiles, while remaining sensitive to cultural and gender differences.

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MISA Subcommittee Report:

Screening and Assessment