

STANDARDS OF CARE
Presented by Kenneth Minkoff, MD

THE NEED FOR SYSTEM CHANGE

Dual diagnosis is an expectation not an exception so in order to develop appropriate interventions within our scarce resource system for people with co-occurring disorders, we need to look at change throughout and at every level of the system. We need to move beyond the idea that dual diagnosis interventions are only specialized interventions that require specialized funding. Collaboratively we need to figure out how to use our joint resources to achieve the goal of dual diagnosis services in all programs.

HOW SYSTEM CHANGE OCCURRS

Integrated service system planning happens more and more frequently across the country as awareness increases about the issue of dual diagnosis. One of the ways in which these initiatives have been supported at the Federal level is through Community Action Grants. The Federal government has discovered in recent years that although they have funded many demonstration projects that have established best practice models, people do not use them. There are many more established best practice models than there are models in use around the country. The purpose of the Community Action Grant, therefore, is an attempt to take existing models of successful treatment and figure out how to implement them in real systems. Typically this process of system change occurs through a process of building consensus within a system around a particular best practice and then building on the consensus to develop an implementation plan that identifies barriers to using the models and strategies for overcoming the barriers.

MASSACHUSETT'S EXPERIENCE

One of the first Community Action Grants to address dual diagnosis issues on a systems level started in Massachusetts in late fall 1997 (fiscal 1998). Massachusetts identified a comprehensive, continuous, integrated system of care (“CCISC”) model and built consensus for the model and on how to implement the model throughout the state. Similar Community Action Grant processes are currently funded in Arizona and Louisiana. Other states, like Pennsylvania, are doing this without the benefit of a Community Action Grant. For system change, the

emphasis is on the process of consensus building. It is an active process in which people at various levels of the system actually sign on in a formal way that they agree with the model that is being presented and support its implementation. This is actually quite a challenging process for people to wrestle with, especially where there are controversial philosophies like with co-occurring disorders. One of the things that was done in Massachusetts to build consensus was to use the technology of continuous quality improvement (“CQI”) to create a formal structure for building consensus. This can be done by creating a centralized leadership group that is empowered to develop goals with measurable objectives which then involves the participation of front line people in a bottom up structured process. In Massachusetts this was done by creating a leadership council with representatives from the Department of Mental health, the Bureau of Substance Abuse Services (which is in the Department of Public Health), the Division of Medical Assistance, the statewide managed medical MCO (Massachusetts Behavioral Health Partnership), consumers and family constituencies from both mental health and substance areas, provider constituencies from mental health and substance areas, and key legislators. A CQI facilitator was hired to facilitate the process and create regional work groups in each state region with input from front line clinicians, consumers and families. It took about a year for the community consensus building collaborative to arrive at a consensus that the entire state then signed off on.

MASSACHUSETT'S CONSENSUS DOCUMENT

Key elements of the developed consensus document for the care and treatment of individuals with co-occurring psychiatric and substance disorders in Massachusetts include the following. There is a preamble that says people with co-occurring disorders experience many difficulties and that they are too often not well served in the current service system. Therefore, all of these groups collectively are willing to address the needs. This willingness for shared responsibility is in writing and key people signed the document. The consensus document states that the named constituents will address co-occurring disorders according to the principles in the document to which they agree, to plan collaboratively how to use all existing resources to support this goal, to identify which components cannot be met with current resources and to recommend collaborative strategies for funding to fill the gaps over time.

KEYS TO CONSENSUS BUILDING

One of the keys to this process was that from the beginning money was taken off the table. Thereby there was an opportunity for people to talk about the model that they wanted to adopt without being immediately concerned about how it was going to be paid for. The emphasis was on what are we going to do differently with the money we have, rather than what new monies are we going to find. A process like this, if properly facilitated, builds trust and a solution that everyone supports.

Complex bureaucracies are fragile systems that require special attention to support change. They respond poorly to criticism. They also tend when under stress to use primitive defense mechanisms of splitting and projective identification much like children and families under stress. Bureaucracies respond much better when you approach them in an empathic, hopeful, strength based way, building upon their strengths to give them courage to move forward. It is helpful to create opportunities for safe play. Consensus building is such a safe play opportunity; you bring the agencies together and give them a project that is designed to succeed. As they engage in safe play, they find that there are areas of communality, which they may not have experienced. They begin to build a certain amount of trust. They begin to take more risks. This consensus building model can take place, not just at the state level but at any level. It can be done in our agencies, in our programs, to create a network among agencies, or in any number of ways.

PRINCIPLES OF CARE

In Massachusetts, co-occurring disorders was the first real consensus building issue that was addressed within the State. Initially they limited their agreement to serious and persistent mental illness but now after a year and a half later they are discussing the possibility of expanding the principles to a broader population. The principles also have been adopted and extended by other projects such as a federally funded initiative to address the needs of women who were victims of violence and trauma with co-occurring disorders. The principles defined involve issues of integration, continuity, comprehensiveness, quality and implementation. They include agreement on disease and recovery models, common language, phases of treatment, peer support, phase-specific individualized treatment interventions, etceteras. The principles around

implementation were modified, extended and ultimately adopted by the American Association of Community Psychiatrist (AACP) to create a national set of principles. The final draft is in the AACP web site, www.comm.psych.pitt.edu. It defines that successful implementation involves the creation of an infrastructure with the power to oversee and direct the implementation processes. Quality monitors including structure monitors, process monitors and outcome define and support successful implementation. Structure monitors may include things like the number of programs that have adopted consensus principles or the number of programs that meet certain standards that are established. Outcomes include things like consumer and family satisfaction with the welcoming or accessibility of the system. Outcome might be the number of people with co-occurring disorders that exhibit reduction in utilization over time; high utilizes who become lower utilizes as a result of interventions. Outcome measures also involve documentation of people moving through stages of change over what time period. Process measures involve looking at things like treatment planning. A simple process measure is the diagnosis documented in the record and whether the assessment process identifies the phase of treatment with phased matched interventions. In the treatment plan, it might mean are both substance use and psychiatric problems identified and there specific interventions for the substance problem as well as for the psychiatric problem documented. In addition to system level change strategies, implementation involves change at the program, clinical practice and clinician competency level.

On the program level and clinical practice level there are a number of standards that can be put into place to support standards of care (see below for a discussion of program standards). Comprehensive strategies for flexible funding streams need to be identified. In addition on the clinician competency level, required clinical competencies and a comprehensive training evaluation plan to support achievement of these competencies can be implemented. One of the strategies that can be developed at any level of system organization is building consensus on what basic competencies all clinicians should be expected to have within the program.

An example of developing clinical competency is a project that we did in the Arbour Health System, that I was working in, which has three private mental health institutions, 16 outpatient clinics and a senior care nursing home consultation division. We created a dual diagnosis task force that adopted a mission statement and a set of principles. One of the projects

that we took on was the establishment of basic competencies. We took the national standards and distributed them to the members of our group and said everybody pick out at least two attitudes, two values, two areas of knowledge and two skills that you think everybody in our system should have regardless of who they are and where they work. We then condensed it into a list that was adopted by the board and incorporated into a human resource policy. We developed a competency exam for the adult clinicians and now are in the process of working on a children/adolescent exam. The exam has about 40 questions and has a self-learning workbook so that people can actually do the exam using a set of articles that answer the questions in the exam. Thereby, we were able to establish within this complex organization a set of mandatory basic competencies on substance use and dual diagnosis that was set up in such a way that we could easily require every clinician to have these competencies built into their basic orientation. We found that people who had taken the exam found it useful and stimulating. The next challenge is to create a continuous training plan so people continue to build upon their competencies as they go along. We are thinking about developing a state wide training strategy that is similar in design to the way in which we do competency around non-violent de-escalation and restraint. As such there would be an established set of skills with certified trainers that could recertify staff on a regular basis. An established curriculum would be created, reviewed and updated by a centralized curriculum development committee that would include senior people in the field. The whole process would fit into the regular and routine bureaucratic structure.

AMERICAN SOCIETY OF ADDICTION MEDICINE PATIENT PLACEMENT CRITERIA

All programs, in order to meet the expectation that people in their programs have co-occurring disorders, need to offer dual diagnosis programming. This implies that we need to start to create dual diagnosis program standards and competencies for all clinicians. In addition, incentives with special licensures or certifications such as a career ladder for more advanced clinicians need to be created. One way in which we are moving toward this has been through the American Society of Addiction Medicine (“ASAM”) patient placement criteria. The ASAM criteria are a multi-dimensional assessment set of tools, in which there are fixed dimensions for assessment for level of care determination. The assessment dimensions are the following: intoxication withdrawal risk or potential; biomedical complications; emotional behavioral complications; treatment acceptance and resistance; relapse/continued use potential; and

recovery environment. The ASAM criteria were originally developed in 1991 and in the next version, PPC2, which came out in 1995, were made more user friendly and describes a larger array of services such as early intervention, opioid maintenance, sober housing, half way housing, therapeutic medically monitored detoxification, not explicitly described in the first edition. Currently, it is again being revised and PPC2R is due out April 2001. The PPC2R incorporates more intensively dual diagnosis issues overall and has much more variation and severity on dimension three, emotional/behavioral. David Mee-Lee, M.D., is the chair of the national committee working on the ASAM criteria.

ASAM PPC2R

The PPC2R has developed a way of categorizing addiction programs according to their dual diagnosis capability: Addiction-Only Services (“AOS”); Dual Diagnosis Capable (“DDC”); and Dual Diagnosis Enhanced (“DDE”). AOS accepts people with dual disorders irregularly and does not routinely address dual diagnosis in their treatment. DDC, in contrast, routinely accepts people with co-occurring disorders, provided that the symptoms and functional impairment associated with those disorders while they are in the program do not substantially interfere with the person’s ability to participate in treatment. This means that the programs have to have policies and procedures regarding the assessment, treatment planning and discharge planning for dual disorders. It has to have programming that talks about medication and presence of co-occurring disorders and integrates that discussion into discussing addiction recovery. There are policies and procedures about providing medication that is routine and comfortable. There is a mechanism for accessing mental health and psychiatric consultation on a routine basis that ideally is integrated into the treatment planning process. Staff has to be cross-trained in basic competencies relating to their implementation of those program policies.

DUAL DIAGNOSIS CAPABLE

Funding for DDC programs typically would occur the same way as regular addiction programs are funded with the addition of a mechanism for obtaining the mental health input. In some states the addiction programs are becoming a priority for psychiatric consultation with the recognition that all addiction programs should have access to this consultation routinely. Sometimes this can be done through blended or braided funding in which you create the

possibility or the facility to actually have the mental health clinicians bill for mental health intervention under mental health dollars even though they are doing within the context of an addiction program. It can be an outreach project under a mental health license or it could be one program operating with two licenses with two billing streams. In some states, like Massachusetts, the state wide managed Medicaid MCO gives a lot more flexibility about creating new billing structures while in other states Medicaid can be very restrictive.

Another way of getting funding in place is through advocacy. However advocacy has to be targeted for this issue. One of the problems is that routine advocacy usually focuses on the amount of money in the budget while more change can actually be gained by focusing on the regulatory side. For example, a reasonable legislative advocacy target might be for the legislature to pass a law saying dual diagnosis is an expectation not an exception and we mandate that the licensure requirements facilitate integrated treatment as a more cost-effective treatment. The advocacy also might facilitate the ability to bill for two primary disorders under Medicaid within the state regulations. In these examples the legislature would then have the authority to direct the administrative departments to figure out how to carry out its mandate. A novel approach that is working in Massachusetts is the idea of performance based quality oriented incentive funding. Funding is based on the quality, not just the utilization. The managed Medicaid entity makes more money by meeting the quality parameters than by restructuring utilization. These quality parameters include dual diagnosis outcome variables and training variables.

The ASAM criteria therefore are very relevant because managed care companies can build their criteria from what is in ASAM. In addition, managed care organizations (“MCO”) can use established national principles of treatment to initiate more successful treatment models. For example, Massachusetts is just beginning to invest in continuous treatment team models with some shared initiatives between the Department of Mental Health and the MCO. They also created community support workers who can be attached to outpatient treatment teams to support more intensive engagement efforts that can support continuity in care.

DUAL DIAGNOSIS ENHANCED

The next category is DDE, which are dual diagnosis enhanced services that meet criteria for DDC services plus they can work with people who are more psychiatrically unstable or functionally impaired. DDE programs have more integrated and flexible programming with more involvement by mental health clinicians and psychiatry, staff are cross-trained with availability of senior mental health supervision, the staff to patient ratios are higher, they are more able to maintain continuity if a patient slips and are more costly. One of the models in Massachusetts, the Dual Diagnosis Acute Residential Treatment, is a 14 to 28 day program that costs about \$250-\$300 per day. That is about twice the cost of other residential programs and about half an inpatient cost, so it fills a gap within the system of care. What we are asking the ASAM task force to recommend as a benchmark is that all addiction only services become DDC and that in any system of care at each level of care there is at least one program that is DDE. Similarly, this benchmark can be applied to mental health programs and all programs would be capable and there would be a planned array of programs that were DDE. However, for mental health programs adding substance treatment is less costly. It can be built into the competencies of staff with training and supervision without changing the fundamental costs of services.

Program standards for DDC and DDE would be established. Program philosophy, policies and procedures would be required for co-occurring disorders including assessment, assessment instruments, treatment planning with phase specific treatment and motivational interventions, discharge planning and mandated staff competencies.

Practice guidelines also can be established as a way of structuring or creating standards for clinical practice. An example of a practice guideline includes phase specific assessment and treatment that is individualized accordingly. Harm reduction and abstinence orientations, for example, are both valid interventions provided that they are appropriately matched to individual's phase of treatment and diagnosis. For most adolescents, a lot of time is spent doing harm reduction, motivational enhancement interventions and dealing with people who have problematic substance use. Through these interventions the adolescent may come to realize that no matter how little they use they still get into trouble and choose abstinence or come to recognize that they have substance dependence and abstinence is the only thing they can do

because no matter how little they use, they lose control. Part of what the practice guidelines tell us is how to match treatment accordingly.

Another example of practice guidelines involves psychopharmacology. Psychopharmacology practice guidelines are one of the ways that I recommend that physicians get involved in the system change. Creating guidelines and a peer review process to enforce the guidelines can support better dual diagnosis practices. Those guidelines should include the following principles: initial psychopharmacologic evaluation of mental health should not require consumers to be abstinent, initial psychopharmacologic evaluations and substance evaluation should occur as early in treatment as possible and psychopharmacological interventions should incorporate the capacity to maintain existing nonaddictive psychotropic medication during detoxification and early recovery. If someone has a serious psychiatric disorder, medication for that disorder should be initiated and maintained even in the face of continuing substance use. If someone has a serious mental illness where without medication they would decompensate, you maintain medication regardless treating it aggressively while continuing to assess while you are continuing to work with the individual around maintaining sobriety. Standards become a way of influencing practice so people are welcomed into treatment, continued and engaged appropriately.

About the Presenter

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

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