Performance Standards
Co-Occurring Disorder Competency

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members.

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.
Co-Occurring Disorder Competency

PERFORMANCE STANDARDS

These standards represent an effort to build on the joint work of the Department of Health and Department of Public Welfare, while incorporating Recovery/Resiliency Principles and input from providers and stakeholders to emphasize the importance of implementing “best practice” treatment and recovery methods, to increase the consistency of service delivery, and to improve outcomes across all levels of care for members with co-occurring psychiatric and substance use disorders. As with all Performance Standards developed by Community Care, these Standards are intended to define the parameters of desired care for most members. To that end, these should NOT be interpreted as regulations, or as requirements for specific interventions for specific individuals. All individuals receiving services should have treatment plans developed to address their individual strengths and needs.

Co-Occurring Disorder Philosophy and Mission

The program shall have a mission statement and philosophy that includes but is not limited to:

- The target population to be served as individuals with co-occurring psychiatric and substance use disorders.
- A welcoming, integrated approach to treatment and recovery of individuals with co-occurring disorders (COD) is written in the mission statement, philosophy, and program descriptions.
- Program policies and procedures are written in a manner that indicates individuals with COD are routinely welcomed.
- Programs display information and literature for education purposes regarding integrated services for mental health and substance use disorders.
- Evidence-based practices are incorporated into treatment practices.
- Recovery and resiliency are considered processes that develop over time, not single events.
- Quality improvement plans are linked to monitoring compliance of the philosophy, integrated treatment services, and consumer satisfaction.
- Outcome measures are linked to the quality indicators in the Quality Improvement Plan.

Co-Occurring Disorder Screening

The program shall have:

- Written procedures to screen for both mental health and substance use disorders in children, adolescents, and adults.
• The screening tool should be universal and simple enough for any staff member to use. Two examples of standard tools available are the GAIN and MIDAS. Other resources can be found at http://www.pa-co-occurring.org/toolbox.
• Screening is the “point of entrance” and staff performing the screening should have documented training on the screening tool and procedures.
• A “no wrong door” policy should be implemented. Screening should result in a referral or initiation of services.
• Integrated screening tools should at the minimum address the following:
  1. Reason the caller is requesting services
  2. A current risk assessment
  3. Current psychiatric symptoms
  4. Current use of alcohol or other drugs
  5. The callers perception of substance use
  6. Current use of medication
  7. Legal status
  8. Contact information
  9. Date and time of call
  10. Date and time of the scheduled assessment

Co-Occurring Disorder Assessment Process

The program shall have:

• Written procedures that require an age appropriate, culturally sensitive, integrated, strength-based assessment occurs.
• A formal assessment process that requires administration of standardized instruments, clinical interviews and/or review of historical information.
• Assessment instruments that are widely accepted as reliable and valid in gathering information about both psychiatric and substance use disorders. Examples of such instruments are the SCID and GAIN. Other resources can be found at http://www.pa-co-occurring.org/toolbox.
• A process to document the identification of an individual’s potential barriers to treatment and recovery, and recommended measures to address these areas.
• Assessment findings incorporated into the treatment planning process.
• Trained staff to complete the assessment and documentation of the staff training.
• Documentation of follow up appointments scheduled after assessments.

Co-Occurring Disorder Program Services

It should be documented how the following groups, education, and evidence based interventions are individualized and provided in the context of current licensed activities and existing array of program services:
• Individual and Group Interventions
• Skill Building Interventions
• Mental Health Education and Addiction Education
• Individuals in substance use disorder treatment programs receive education promoting psychotropic medication adherence and are provided support for taking medication while in recovery
• Co-occurring Disorder Education for individuals and families
• Co-occurring Disorder Relapse Prevention education, and
• Access to Peer Support Services and Self Help Recovery Resources

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

• Stage of Change Matched Interventions
• Motivational Enhancement Interventions
• Treatment interventions incorporate contingency management strategies to promote treatment adherence for both disorders. These strategies emphasize treatment continuity and recovery management rather than treatment termination.

Co-Occurring Disorder Integrated Care Planning

The program shall have comprehensive, individualized, and integrated care plans that include the following at a minimum:

• The individual’s full participation in the development of his/her integrated care plan, crisis plan and an individual driven recovery and wellness plan.
• Input from the multidisciplinary team, collaborating agencies, practitioners, family, and significant supports if appropriate.
• Identify each co-occurring disorder as a presenting problem.
• 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.
• Individualized goals that are stage-specific based upon the assessment of co-occurring needs and readiness for change.
• Identification and incorporation of the individual’s strengths and supports needed to accomplish the identified goals.
• Identification and monitoring of physical health issues.
• Reviews and revisions based upon additional clinical information obtained through the ongoing assessment and evaluation process.
• Development, reviews, and revisions are done according to licensing standards, regulatory agencies, and/or organizational policies and procedures.
• Recovery and resiliency supports for both disorders; e.g., a certified recovery specialist, certified peer specialist, Alcoholics Anonymous sponsor, Narcotics Anonymous sponsor and or support groups.
Co-Occurring Disorder Medications

Programs shall develop policies regarding prescription medications which address the following:

- Documentation that explains rationale for the use of medication.
- Documentation that includes medication, dose, frequency, and prescribing physician.
- Monitoring medication adherence, including self report.
- Access to medication, if not available within the facility.
- Documentation of communication and coordination of care between all programs providing treatment services and medications to the individual.
- Education about the medications, including side effects, interactions with illicit substances, cost of the medication, and overdose.
- Medication education resources available on site.
- Necessary medications for serious mental illness are maintained even when individuals are continuing to use substances unless medically contraindicated and appropriately documented.
- Potentially addictive medications are not routinely initiated in the ongoing treatment of individuals with substance dependence and there is a mechanism for consultation and clinical review when this does occur.
- The provider documents and uses detoxification protocols for common substances and routinely maintains psychotropic medication during detoxification unless medically contraindicated.
- Psychopharmacology providers have documented certification, training, competency, and/or access to competent supervision/consultation regarding treatment of co-occurring disorders throughout all levels of care.
- Individuals on medication assisted treatment for their addiction to opiates are welcomed and not stigmatized.
- Individuals are not discharged solely due to not adhering to prescribed medications.
- No arbitrary period of sobriety is needed before a medication evaluation.
- Medication is not discontinued solely due to relapse.
- Staff is educated and regularly updated about medication, medication emergencies, and medication monitoring.

Co-Occurring Disorder Crisis Intervention

Programs shall have policies that address how they will handle a crisis. The policies should address the following crisis situations:

- Psychiatric emergencies
- Medical emergencies
- Withdrawal emergencies
- Medication emergencies
• Intoxication emergencies
• Social safety emergencies, e.g., child abuse, domestic violence, homelessness

Policies should allow for continuation of care upon resolution of the crisis.

Co-Occurring Disorder Communication, Collaboration, and Consultation

Programs shall develop the following:

• Written agreements to maintain linkages with practitioners and organizations necessary to support co-occurring service needs. Practitioners and organizations would include but are not solely limited to Primary Care Physician’s, Single County Authorities, certified recovery specialists, certified peer support specialists, drug and alcohol case management, psychiatrists, counselors, mental health, drug, and specialty courts, or physical health plans, etc.
• Procedures for obtaining written consent as well as documentation of care coordination and collaborative service planning from the individual receiving services for all communication and collaboration of other agencies.
• Procedures for identifying situations requiring consultation. Examples of situations requiring consultation are limited progress, worsening of symptoms, difficulty engaging, and any other issue that the clinician and/or individual receiving services believes warrants a consultation.
• Protocols for referrals to integrate co-occurring or ancillary treatment services and community recovery supports, when indicated. Examples of issues that may warrant a referral are worsening of mental health issues, relapse from the substance use disorder, unstable medical issues/physical health conditions, inadequate housing, parenting issues, educational/employment deficits, and any other issues that may hinder treatment and recovery.

Co-Occurring Disorder Staff Competencies

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

• Documentation of at least one certified staff involved in direct provision of co-occurring services. The number of certified staff shall be appropriate to the number of individuals with a co-occurring disorder serviced and the size of the program. Examples of certified staff are, but not limited to, the Certified Co-Occurring Disorders Professional (CCDP) or the Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders through the American Psychological Association, a Certificate of Specialty in Addiction through the National Association of Social Work, or the American Society of Addiction Medicine certification for physicians, involved in the direct provision of co-occurring services.
• Within one year of receiving approval as a co-occurring competent program, documentation of all clinical staff attendance at co-occurring core training, or any equivalent training includes the following topic areas:
  o Co-Occurring Psychiatric and Substance Use Disorder Overview
  o Principles of Engagement with individuals with a co-occurring disorder and their family members
  o Individualized Approaches and Supports for co-occurring disorders
  o Co-Occurring Care Planning and Documentation Issues
  o Psychopharmacology
  o Crisis and Relapse Prevention
  o Recovery, Rehabilitation, and Self-help for co-occurring disorders
  o Ethics and Boundaries for Effective Co-Occurring Services
  o Working Respectfully with Family Members
  o Impact of trauma on co-occurring disorders
• In addition to the core trainings, co-occurring competent programs shall document staff attendance at trainings for HIV counseling, STD counseling, and Hepatitis counseling.
• The individual responsible for the direct supervision of staff providing co-occurring services shall be certified.
• Documentation of ongoing supervision to address co-occurring services.

Co-Occurring Disorder Transition, Discharge, and Aftercare

The program shall demonstrate that the following begins upon admission and can be provided as aftercare upon transition or discharge:

• Referral for psychiatric access and medication management.
• Identification, education of, and referral to appropriate community support services including peer support services, recovery self-help services, co-occurring self-help groups, and other individualized support services indicated on a written discharge form to be given to the individual.
• Access to crisis services for both psychiatric and substance use needs and an identified safety plan upon discharge.
• Linkage with case management services for community resources, if appropriate and available.
• Documented coordination and collaboration with outpatient providers and plans for continuing integrated case management if applicable.
• Documented communication with family members and significant others where possible and engage caregivers to promote treatment and recovery participation, where appropriate.
• Documentation of conditions under which the individuals with co-occurring disorders may return for further treatment, for both planned and unplanned discharges.
• Discharge plans will include scheduled appointments and contact information, e.g., phone numbers, addresses that the individual may need. Contacts would include crisis, inpatient mental health facilities, drug and alcohol facilities,
Alcoholics Anonymous, Narcotics Anonymous, domestic violence resources, peer support providers, case management, Primary Care Physician's, community resources, detoxification centers, and the program from which the individual is being discharged. This information should be given to all program participants, even if the individual did not complete treatment.

- Written discharge plans will be provided to all aftercare providers and supports as indicated by the individual receiving services.