
BEST PRACTICES

Dual Diagnosis Capability: Moving from Concept to Implementation

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What is dual diagnosis capability (DDC)? As mental health and substance abuse treatment programs are increasingly recognizing that they are serving more complex populations, commonly with co-occurring disorders, they face the following question: Within the context of scarce resources, how do they provide services in a manner that is consistent with their existing mission and program design, but that also recognizes, accommodates, and incorporates attention to the increasingly complex needs of their service population? The answer to this question is embodied in the concept of dual diagnosis capability (DDC), and while this concept is by no means universally understood, the meaning of DDC is becoming clearer through the work of hundreds of agencies and programs throughout the United States and Canada involved in the DDC development process.

The evolving concept of dual diagnosis capability refers to the notion that every agency/program providing behavioral health services must

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have a core capacity, defined through specific components of program infrastructure like policies, procedures, clinical practice instructions and standards, and clinician competencies and scopes of practice, to provide appropriate services to the individuals and families with co-occurring mental health and substance use issues who are already coming through its doors.

This is in contrast to Dual Diagnosis Enhancement (DDE). DDC refers to an evolving core capacity of all programs, while DDE programs are specialized mental health and/or substance abuse programs and services designed to provide more “integrated” programming for clients with co-occurring disorders with more specialized needs. Examples of DDE programs may include a “Dual Diagnosis Psychiatric Inpatient Unit” with an extensive array of addiction programming in a psychiatric acute care setting; an evidence based Integrated Dual Disorder Treatment (IDDT) team for adults with Serious and persistent mental illness and severe co-occurring disorders requiring high intensity case management and outreach; or an addiction residential program with higher levels of staffing and mental health specialization to provide addiction treatment to individuals with more acute or disabling psychiatric conditions. For reasons that will be clarified below, it is becoming clearer that while systems must have adequate capacity to provide specialized services to targeted populations, the capacity of a system to organize DDC throughout as a base standard is critical to strengthening the efficiency and efficacy of service delivery to the behavioral health population as a whole.

The history and characteristics of DDC will be described in more detail in this column. This column then presents an illustration of usual starting places for the implementation of DDC within agencies/programs engaged in a developmental process. It then ends with consideration of future challenges as DDC becomes better defined and organized throughout system of care.

BACKGROUND

Individuals with co-occurring disorders are increasingly recognized as a population with poorer outcomes and higher costs in multiple domains, with sufficiently high prevalence in all treatment and human service systems that the Substance Abuse and Mental Health Services Administration (SAMHSA) Report to Congress has acknowledged that “dual diagnosis is an expectation, rather than an exception” in all settings (SAMHSA, 2002). Further, two decades of research with a wide

variety of populations, from adults with serious and persistent mental illness, to adolescents and families involved with the court system (either criminal justice or child protection) have provided increasing support for the increased efficacy of integrated treatment programs and interventions, in which appropriately matched strategies for both mental health and substance abuse issues are combined, coordinated, or integrated into the context of a single treatment relationship, treatment team, or treatment setting. Specific program models, ranging from Integrated Dual Disorders Treatment (IDDT) (Drake et al., 2001) (one of the six SAMHSA evidence based practice toolkits for adults with serious and persistent mental illness), modified therapeutic communities (Sacks et al., 1999) (applied most extensively to adults with all levels of severity of mental illness who are in correctional settings), and multi-systemic family therapy (ref) (applied to adolescents with multisystem problems) have emerged from the research, and begun to be implemented as “specialized” (Dual Diagnosis Enhanced, or DDE) dual diagnosis or co-occurring disorder programs in real world systems. However, although these (and other) specialized programs have often had demonstrated success with the selected populations they have been able to treat, it has become increasingly apparent that because people with co-occurring disorders are an expectation in ALL programs, setting up a few specialized (and expensive) programs in systems with scarce resources only has a limited impact on the ability of the system as a whole to address the large, complex, and pervasive populations of individuals and families with co-occurring disorders. Thus, because dual diagnosis is an expectation, it has been more widely recognized that ALL programs are essentially becoming dual diagnosis programs (whether or not that was part of their original design) and require an infrastructure and operational procedures regarding the provision of appropriately matched services to their existing cohorts of dual diagnosis clients and families. (This is in marked contrast to the functioning of the many current disjointed systems of mental health and substance abuse treatment, in which mental health programs and substance abuse programs have almost NO design or instructions for how to provide appropriate services to their existing cohorts of co-occurring clients and families.) This recognition has become the foundation for defining the concept of Dual Diagnosis Capability as a core feature of any program. Consequently, research strategies have begun to evolve beyond the creation of special programs, to explore a wide range of specific intervention strategies that have been demonstrated to be successful in specialized settings, and to define how those same strategies might be

of value in the other settings. Recent summaries of the best practice literature (e.g., Treatment Improvement Protocol #42 (CSAT, 2005), and Mueser et al.'s textbook on integrated dual disorders treatment (Mueser et al., 2003)) support the dissemination of this knowledge base to a wider array of clinicians and programs, and begin to create more capacity to apply evidence supported intervention strategies in all types of clinical programs and clinical settings. These intervention strategies range from empathic, hopeful, integrated relationships to best practice methods for integrated screening and assessment, to integrated instructions for the application of various interventions for each type of disorder: e.g., psychopharmacology, case management matched to level of disability, stage-specific motivational strategies, cognitive behavioral skill building adapted to level of impairment, peer and family education and support, contingency management, and rehabilitative strategies to promote vocational, social, and housing outcomes. This emerging awareness of treatment intervention strategies that can be generally, and cost effectively, applied in all settings has supported the evolution of the concept of Dual Diagnosis Capability in real system applications.

HISTORY OF DUAL DIAGNOSIS CAPABILITY

In 1991, Minkoff first described a model for system design, termed the Comprehensive Continuous Integrated System of Care, in which there was acknowledgment that all programs in either the mental health and substance abuse systems were already likely to be serving a range of populations with co-occurring disorders, and therefore needed to begin to develop appropriate approaches to these existing populations within the context of standard treatment. This initial conceptualization was further defined in a consensus panel report developed as part of the SAMHSA Managed Care Initiative, entitled: "Co-occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula" (1998). This was the first report in which the recommendation for system design for any population incorporated the development of specific program standards for each type of program in the system, and in which some of the specific "jobs" of each type of program were briefly described. In the same year, NASMHPD and NASADAD (the National Associations of State Mental Health Program Directors and Alcohol

and Drug Abuse Directors, respectively) agreed on a national consensus four quadrant model for describing the system distribution and responsibility for individuals with co-occurring disorders, implying that different systems and programs might have distinct responsibilities with existing clients, reflecting the different characteristics of the quadrants (e.g., Quadrant 2—High MH, Low SA—were to be treated in the MH system; Quadrant 3—High SA, Low MH—in the SA system) (NASMHPD/NASADAD, 1998).

The terms Dual Diagnosis Capable and Dual Diagnosis Enhanced grew from the Managed Care Initiative 1998 report, and emerged first in the national literature with the release of the American Society of Addiction Medicine Patient Placement Criteria, Second Edition, Revised (Mee-Lee et al., 2001) which described DDC as a recommended core feature of any addiction program at any level of care, reflecting the fact that standard addiction services needed to be capable of appropriately serving a growing population of individuals represented in Quadrant 3 with mild to moderate Axis I and Axis II disorders co-occurring with their substance dependence. ASAM PPC 2R asserted that while there were addiction programs that would remain Addiction Only (AOS) (with little or no organized capacity to meet the needs of co-occurring clients), the need for these types of programs would be likely to narrow over time, due to the increasing pressure and volume of co-occurring clients needing services. The definitions of DDC and DDE in ASAM PPC 2R were quite general, however, and fell short of providing addiction programs with specific instructions for what these concepts would mean in practice. The following is the definition of DDC, and a partial description of DDE, from ASAM PPC 2R:

Throughout the adult criteria in the PPC-2R (addiction) treatment programs are described as generally of two types—Dual Diagnosis Capable or Dual Diagnosis Enhanced—to reflect their ability to address co-occurring substance-related and mental disorders.

- Dual Diagnosis Capable programs have a primary focus on the treatment of substance-related disorders, but also are capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health problems related to an emotional, behavioral, or cognitive disorder.
- Dual Diagnosis Enhanced programs, by contrast, are designed to treat patients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders.

Dual Diagnosis Capable Programs

These programs typically meet the needs of patients whose psychiatric disorders are stable and who are capable of independent functioning, so that their mental disorders do not interfere significantly with their participation in addiction treatment. Such patients may have severe and persistent mental illnesses that are in a relatively stable phase at the time that they need addiction treatment. Other patients may have difficulties in mood, behavior, or cognition as the result of a psychiatric or substance-induced disorder, or their emotional, behavioral, or cognitive symptoms may not rise to the level of a diagnosable mental disorder. Such patients need counseling and coordinated mental health interventions so that primary therapy can be focused on their substance-related disorders.

Dual Diagnosis Capable programs typically address dual diagnosis in their policies and procedures, assessment, treatment planning, program content, and discharge planning. They have arrangements in place for coordination and collaboration with mental health services. They also can provide psychopharmacologic monitoring and psychological assessment and consultation, either on site or through coordinated consultation off site. Program staff are able to address the interaction of the substance-related and mental disorders in assessing the patient's readiness to change, relapse risk, and recovery environment. Nevertheless, the primary focus of such programs is on addiction treatment rather than dual diagnosis concerns.

Dual Diagnosis Enhanced Programs

These programs are appropriate for patients who need primary addiction treatment but who are more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder than are patients treated in Dual Diagnosis Capable programs. Patients in need of Dual Diagnosis Enhanced programs typically are unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in treatment (Mee-Lee et al., 2001, pp. 9-10).

Simultaneously with the release of ASAM PPC 2R, the concepts of DDC (and DDE) were beginning to be further defined in real world systems. The state of Oregon, as a result of a statewide task force that had begun in 2000, developed in 2001 a draft set of program standards for all mental health and substance abuse programs, in which specific criteria for DDC and DDE were included (ODMH, 2001). This set of

standards was widely circulated, but never implemented. At the same time, Cline and Minkoff embarked on a project in New Mexico (Cline and Minkoff, 2002) in which the Comprehensive Continuous Integrated System of Care (CCISC) model was utilized to organize a strength based system change process to build dual diagnosis capability throughout the safety net service system overseen by the NM Department of Health Behavioral Health Services Division (of which Dr. Cline was the Medical Director). Out of their efforts to define DDC in the process of implementation, Minkoff and Cline developed a CCISC toolkit, one of the tools of which (the COMPASS (Minkoff and Cline, 2001)) was intended to be a self-assessment for any program to look at various elements that might contribute to dual diagnosis capability, and to use that self-assessment to develop a quality improvement process to begin to achieve those elements. The design of the COMPASS expanded upon the definition of DDC in the ASAM criteria by encouraging programs to review each element of program infrastructure (e.g., mission statements, policy and procedure manuals, consumer involvement, funding, information collection and use, clinical practice instructions, charting and documentation requirements, program content, interagency relationships, staff scopes of practice and competencies) to determine whether there was clear support for providing matched interventions to the existing cohort of co-occurring clients, within the context of the program's purpose and mission (e.g., a psychiatric inpatient unit; an outpatient mental health clinic, a residential substance abuse treatment program, and so on). Currently, the CCISC toolkit has been expanded to include the first iteration of a Dual Diagnosis Capability implementation guidebook for behavioral health agencies called the COCAP™ (Cline and Minkoff, 2005).

Subsequent to the New Mexico Co-occurring Disorder Services Enhancement Initiative cited above, Minkoff and Cline have further elaborated the use of the CCISC in multiple state and regional or county projects in over 20 states and 2 Canadian provinces (Minkoff and Cline, 2004, 2005). A critical feature of the CCISC model is the utilization of DDC for a core system standard: *Every program becomes a dual diagnosis program, meeting at least minimal standards of dual diagnosis capability (some programs in the system are dual diagnosis enhanced); however, each program has a different job, based on providing matched services within the context of current program mission to the existing cohort of co-occurring clients already attempting to access services in that program.* This requires that the system begins to develop

expectation and guidance, within its basic infrastructure, to assist each program in moving toward the goal of DDC.

This fundamental approach has been further reinforced by recent efforts on the part of SAMHSA to work in partnership with state and local systems to develop system infrastructure to more routinely support integrated services. In the past two years, SAMHSA has issued 15 Co-occurring Disorder State Infrastructure Grants (COSIGs) for the purpose of building core capacity throughout the state system in improving the capability of the entire behavioral health system in the state to screen and identify co-occurring clients and families, and to provide integrated assessment and treatment, and track integrated outcomes. This implies the need for core capability standards for each program, and in fact at least 12 of the 15 states are using the CCISC model as part of their implementation process (Alaska, District of Columbia, Hawaii, Louisiana, Maine, Pennsylvania, Arkansas, New Mexico, Arizona, Oklahoma, Virginia, and Vermont). Texas (TDMHMR, 2004; TCADA, 2004) has issued a set of Co-occurring Disorder standards which are a means of defining DDC (though without using that term) for each public mental health and substance abuse program in the community, as well as in the state hospitals. New York (not a COSIG state) is in the process of incorporating DDC standards into statewide substance abuse regulations (OASAS, 2005). Thus, the concept of Dual Diagnosis Capability is evolving from a very general sense of direction to concrete implementation, through a process of self-assessment and continuous quality improvement supported by a range of infrastructure development activities, including new standards in several states.

What are the criteria for Dual Diagnosis Capability? As noted above, the specific criteria by which any program can be determined to be DDC are evolving. The challenge of defining these criteria precisely is twofold: First, little research has been done to identify what criteria are actually necessary and sufficient to promote better outcomes. In the implementation of the IDDT toolkit, Drake and others have studied the use of the GOI as a means of measuring a range of organizational variables that support achieving successful implementation of specialized IDDT programs (SAMHSA, 2004) but this research has not been extended to the development of broad DDC throughout the whole agency or the whole system. Vermont, however, is currently engaged in a project in which both CCISC tools and IDDT tools are being used to evaluate program and system progress.

Second, and more important, systems are constrained to build the implementation of DDC within the context of existing resources.

Consequently, there is little ability to simply mandate already scarce resourced programs to immediately meet a new set of standards. Rather, systems need to exercise judicious leverage and support to assist programs to engage in an improvement process within the context of existing resources, with the major reward being that they then become more successful serving their existing clients.

Therefore, as more and more systems begin to engage in the process of more accurately matching program design and supportive infrastructure to strengthen the capacity of all their programs to meet the needs and wants of diverse populations of people with co-occurring issues, systems are proceeding to define and implement “working definitions” of DDC to support the change process. Further, these working definitions are gradually being incorporated into system-specific sets of instructions (e.g., standards, interpretive guidelines, and contract language). Within the framework of CCISC, these sets of instructions are being designed to support the goal of DDC as a core capacity of every program throughout the system. As such, programs are organizing their own efforts to meet the goal of DDC, using these “working definitions” as a framework.

Typical starting places in most behavioral health agencies/programs may include the following activities:

1. Establish the *baseline DDC of each program in the agency (both routine and specialized programs)* as the first step in initiating a quality improvement process.
Example: The agency conducts a baseline self-assessment of DDC using the COMPASS™ or its equivalent.
2. Formally demonstrate commitment of the organization to *DDC as an agency-wide goal*.
Example: The Agency develops and institutes a specific policy statement that sets forth DDC as a goal for all aspects of the Agency’s programming (not just to specialized aspects of the programming such as a dual diagnosis unit or group).
3. Develop a formal *philosophy that welcomes clients with complex needs*.
Example: The Agency officially recognizes, through a formal written mission statement, the co-occurring population as welcome and as a priority for service because of poor outcomes and high costs. In addition, clinical practice instructions are developed and disseminated to support the expectation of welcoming challenging individuals with co-occurring disorders. *For child and*

adolescent programs, welcoming is specifically extended to parents or caregivers with co-occurring issues.

4. Create a design process as a component of infrastructure in the Agency that has the capacity to *implement DDC through Continuous Quality Improvement.*

Example: The Agency uses a written QI plan to implement DDC that has strategic objectives, an implementation approach that is measurable and realistic given scarce program resources, and incorporates a feedback loop for frequent realignment at appropriate time intervals.

5. *Incorporate the consumer perspective* in design, delivery, and evaluation of dual recovery oriented services.

Example: Consumer representatives (including consumers with co-occurring disorders) are present on leadership and design committees that generate policy, procedures, CQI initiatives, and peer support and training activities.

6. *Identify and count the co-occurring disorder population*, and track individual service needs, including populations that have poor outcomes and high costs that “fall through the cracks.”

Examples: The program has a documented screening protocol for identifying co-occurring disorders, with instructions for reporting positive responses, including for those individuals not yet diagnosed, and instructions for obtaining follow up assessment. *For child services, screening includes a process for identification of co-occurring issues in families or caregivers.*

The program establishes a continuous quality improvement to more accurately capture the prevalence of individuals with co-occurring disorders (both pre-diagnostic and post-diagnostic) in the program data system.

7. Clarify *billing and documentation instructions for integrated services* using existing funding streams.

Example: The Agency has written billing instructions for clinicians that support the use of existing mental health (or substance abuse) funding streams to provide integrated attention to individuals with co-occurring disorders within a single billing event.

8. *Improve access to integrated assessments.*

Examples: There are protocols for how individuals presenting with multiple symptoms gain access to integrated assessments as a routine process.

There are no barriers to access to an evaluation based on arbitrary criteria connected to co-morbidity (e.g., substance levels or length of sobriety in mental health settings; types of psychiatric diagnoses or medications in substance abuse settings).

9. Develop *integrated treatment planning* protocols that support interventions appropriate to *stage of change or stage of treatment*, and develop programmatic materials and structures (e.g., groups) to organize the provision of those interventions more easily.
Examples: Individual treatment plans identify multiple goals, problems, or disorders, document stage of change for each problem, and have specific stage-matched attention to each goal or problem integrated into the treatment plan in a manner appropriate to the service setting.

The program has a library of appropriately matched educational and skills training manuals to assist clients to improve motivation or manage symptoms of co-occurring disorders, and clinicians have access to materials for incorporation into individual and group treatment.

The program has, when appropriate, an array of educational and treatment groups that provide stage-matched interventions for co-occurring issues within the framework of the program's existing treatment array.

10. Develop procedures and protocols for *interagency care coordination* and collaboration to facilitate the ability of each agency to help the other provide dual diagnosis capable treatment, and to help each clinician have clear instructions about how to coordinate care.

Examples: There are instructions for mental health case managers who refer clients to addiction settings regarding routine information sharing, regular communication and documentation, participation in treatment planning, and supporting addiction treatment recommendations, AND similar instructions in reverse for addiction counselors (including linkage with psychopharmacology providers).

11. Develop *core integrated scopes of practice for singly trained mental health and substance abuse clinicians*.

Example: The Agency has a set of guidelines that describe the appropriate activities for each singly trained clinician to address issues related to the co-occurring disorder within the context of an

integrated treatment relationship. These guidelines may include: welcoming, screening, motivational enhancement, skill building, management of symptoms without using substances, and so on.

12. Design and implement *strategic training plans* where training is aligned with the development of supportive infrastructure to implement new clinical practices (e.g., screening or stage-matched treatment planning) and targeted to the development of core competencies articulated in the integrated scopes of practice.

Example: Training plans may include developing competencies related to basic attitudes and values (welcoming, empathy, hope), core principles of integrated treatment relationships, screening and assessment, stage-matched treatment planning, and so on.

These are but a selection of examples. Other areas which are being addressed in a number of systems as part of creating “working definitions” for the purpose of dual diagnosis capability development include: interagency care coordination protocols and meetings, psychopharmacology procedures or practice guidelines, human resource policies for orientation and evaluation, and so on.

IMPORTANT FUTURE CHALLENGES

As we are learning more about the process of DDC development in multiple systems, several key challenges emerge. The first challenge relates to the need for system leaders to achieve the right balance between evoking programmatic development of DDC by using formal standards as a “system driver” to more or less force change, AND using system incentives to create “carrots” to promote natural improvement processes within each program. Of concern is that standards developed out of context and mismatched to the developmental stage of change of the programs, particularly when there are no additional resources for clinical services, may have the unfortunate capacity to stall growth and cause undue burden on consumers, families, and providers. On the other hand, well-matched and developmentally appropriate DDC standards can offer clarity, direction, and support to developing provider agencies helping them become more efficient and helpful to those who rely on them. As we move forward in the field of behavioral health, we must all pay attention to encouraging working partnerships between system administrators, provider agencies, clinicians, and consumers to understand how to achieve the balance that best stimulates innovative practice to improve quality of care.

The second challenge relates to the need to achieve a similar balance between the implementation of specific DDE “evidence based practice programs,” such as that represented by the IDDT toolkit, and the development of more system wide dual diagnosis capability. This challenge also requires clear conceptualization of the differences between core integrated services capacity, integrated scopes of practice, and integrated treatment relationships (which are components of dual diagnosis capability) and the concept of “integrated treatment,” as defined in the IDDT toolkit.

A future issue of this column will be used for a more detailed discussion of the concept of “Integration” as applied to systems, programs, treatment, services, and relationships.

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