Minnesota Department of **Human Services**

December 18, 2012

Legislative Reference Library
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100 Constitution Avenue
St. Paul, Minnesota 55155

SENT VIA ELECTRONIC MAIL TO SONAR@LRL.LEG.MN

Re: Proposed Rules Governing Integrated Dual Diagnosis Treatment Programs, **Minnesota Rules, Parts 9533.0100 to 9533.0810; Revisor's ID Number R-04126**

Dear Librarian:

The Minnesota Department of Human Services intends to adopt rules Governing Integrated Dual Diagnosis Treatment Programs, **Minnesota Rules, Parts 9533.0100 to 9533.0810; Revisor's ID Number R-04126**. We plan to publish a Notice of Hearing in the December 24, 2012 publication of the State Register.

The Department has prepared a Statement of Need and Reasonableness. In accordance with Minnesota Statutes, sections 14.131 and 14.23, the Department is sending the Library an electronic copy of the Statement of Need and Reasonableness before we mail our Notice of Hearing on December 20, 2012.

If you would also like to receive a hard copy of the SONAR, please let me know. If you have any questions, please contact me at (651) 431-4336.

Yours very truly,

Beth Scheffer

Beth Scheffer
Acting Administrative Law Manager
Appeals and Regulations Division

Attachment to Electronic Mail: Statement of Need and Reasonableness

Minnesota Department of Human Services

STATEMENT OF NEED AND REASONABLENESS

Proposed New Permanent Rules Governing Certification of Integrated Dual Diagnosis Treatment, Minnesota Rules Parts 9533.0010 to 9533.0180

INTRODUCTION

It has been estimated that co-occurring substance use disorders and mental illness affect somewhere between 5 and 15 million Americans. In Minnesota, nearly one out of five individuals receiving chemical dependency treatment have a mental illness, and almost 40% of persons served in the mental health system have a substance-related disorder. Treatment outcomes are poor for individuals with co-occurring disorders, a group that tends to include high users of the most expensive, crisis-oriented health care services.

In contrast to the 'system as usual' approach, research shows that people with co-occurring disorders experience improved treatment outcomes when they receive a holistic, specialized form of treatment known as *integrated* treatment. In this model, the contributions of professionals from both the mental health and substance use fields are merged into a single treatment regimen and setting. Integrated treatment services are provided according to treatment protocol based on research.

The Minnesota Department of Human Services (department) proposes the adoption of a new rule to certify integrated dual diagnosis treatment (IDDT) programs that incorporate these evidence-based practices. Certification is voluntary, and will reflect to the public an IDDT program that incorporates evidence-based practices. This is an important step toward ensuring the availability of these programs for dually-diagnosed individuals and their families.

Objective. To adopt the proposed rules, the department must demonstrate that it has complied with all procedural and substantive requirements for rulemaking. These requirements are as follows: 1) there is statutory authority to adopt rules; 2) the rules are necessary and reasonable; 3) all necessary procedural steps have been taken; and 4) any additional requirements imposed by law have been satisfied. This statement demonstrates that the department has met all requirements.

Statutory Authority. The 2011 Minnesota Legislature directed the department to adopt a new rule regulating integrated dual diagnosis treatment in Minnesota. Minnesota Statutes, section 245.4863 states:

> The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and either a serious mental illness or emotional disturbance.

Background. "Individuals with co-occurring disorders are increasingly recognized as a population with poorer [treatment] outcomes and higher [health care] costs."[1] Among the group of 10 percent of Americans who use over 70 percent of the nation's health care resources, persons with co-occurring disorders comprise the majority.

In the past, mental health and substance-related treatment have been discrete systems of care. In contrast, "[t]wo decades of research with a wide variety of populations, from adults with serious and persistent mental illness, to adolescents ..., have provided increasing support for the increased efficacy of integrated treatment programs and interventions."[2]

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) has been an important national leader in the movement from research to application of integrated treatment models. From 2004 through 2006, SAMHSA awarded 15 Co-Occurring Disorder State Infrastructure Grants (COSIGs) to build core capacity in state systems to improve the capability to identify co-occurring clients, provide integrated assessment and treatment, and track integrated outcomes.

In 2006, SAMHSA awarded a $3.35 million COSIG to the department. The department used this grant money to:

- increase screening and assessment for co-occurring disorders;
- build networks between mental health and substance use providers; and
- define competency standards for clinicians wanting to provide integrated treatment.

The department established demonstration sites among fourteen community providers, two prison settings and one tribal behavioral health agency to implement these objectives. These sites were primarily outpatient providers who are dually-licensed to deliver both mental health treatment and chemical dependency treatment. In addition, six hospital-based mental health treatment programs were included to begin to develop a continuum of care. The department's objectives were largely accomplished. Data was collected from the pilot sites, and showed improved screening, assessment and treatment of co-occurring disorders.[3] The department and participating providers gained valuable knowledge and experience through this project, which were used to inform the development of the proposed rule.

Rule Advisory Group. The department invited community stakeholders to a number of public meetings to provide input on the proposed rule. This ad hoc rule advisory group included providers who participated in the COSIG project, other providers who are also providing integrated services, inpatient and outpatient providers from the substance use and mental health fields, and health care insurance representatives. Below are the meeting dates and topics addressed.

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[1] Kenneth Minkoff, M.D., and Christie A. Cline, *Dual Diagnosis Capability: Moving from Concept to Implementation,* Journal of Dual Diagnosis, Vol. 2(2) 2006.
[2] *Id.* at page 122-23.
[3] *Minnesota's [COSIG] Lessons Learned: Report,* Minnesota Department of Human Services, Chemical and Mental Health Services Administration (2012).

Rule advisory group meeting date	Topic addressed
12/08/2011	Screening for co-occurring disorders; and integrated assessment.
01/20/2012	Program administration; and service components.
02/23.2012	Integrated treatment services.
03/22/2012	Staff qualifications.
04/26/2012	Monitoring treatment outcomes.

After the department drafted the rule, the department met with the rule advisory group again on August 27, 2012, to obtain input on that draft. The department considered the feedback received and modified the rule as a result.

Proposed rule standards. The department relied on the work of Kim T. Mueser, et. al., in their book "Integrated Treatment for Dual Disorders: A Guide to Effective Practice" published by the Guilford Press in 2003. This is a comprehensive clinical textbook written by experts in dual disorders, including Dartmouth Medical School psychiatry professors and the director of the New Hampshire-Dartmouth Psychiatric Research Center. The department also used an instrument that corresponds to the textbook by evaluating fidelity to evidence-based practices. The instrument is known as the Integrated Dual Disorders Treatment Fidelity Scale ("Fidelity Scale") and has been endorsed by SAMHSA.

The department also relied on two similar instruments, both dual diagnosis capability measures designed for specific settings. These measures are also endorsed by SAMHSA, and have been adopted in thirty states and internationally. They are the Dual Diagnosis Capability in Addiction Treatment Index (DDCAT), which evaluates a chemical dependency treatment program's capability to effectively use dual disorder treatment; and the Dual Diagnosis Capability in Mental Health Treatment Index (DDCMHT), which evaluates a mental health treatment setting's capability to effectively use dual disorder treatment. The latter is the companion tool that followed development of the former.

The DDCAT and DDCMHT use measures based on consensus clinical guidelines and evidence-based practices. Both instruments have been extensively measured for psychometric properties, and have proven to be reliable and valid. These instruments examine thirty-five elements in seven areas, namely: program structure, program milieu, assessment, treatment, continuity of care, staffing and training. The rule contains requirements that correspond to each of these seven areas.

ALTERNATIVE FORMAT/ACCOMMODATIONS

Upon request, this Statement of Need and Reasonableness can be made available in an alternative format, such as large print, Braille or cassette tape. To make a request, contact Beth Scheffer, Minnesota Department of Human Services, P.O. Box 64941, Saint Paul, MN 55164-0941, or by phone at 651-431-4336, fax at 651-431-7523, or email:

Elizabeth.scheffer@state.mn.us. TTY users may call the Department of Human Services at 1-800-657-3513.

REGULATORY ANALYSIS

Minnesota Statutes, section 14.131, sets forth seven factors that must be included in the regulatory analysis portion of the SONAR. Paragraphs (1) through (7) below quote these factors and then provide the Department's analysis.

"(1) a description of the classes of persons who will probably be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit"

The proposed rules would likely affect:

- persons with co-occurring substance-related disorders and mental illness who seek or receive mental health treatment, or chemical dependency treatment, and their families;
- mental health clinics, chemical dependency treatment programs, and others who provide mental health or chemical dependency treatment services either directly, or through a vendor;
- providers that seek certification of an integrated dual diagnosis treatment program;
- insurance companies, health plans, self- insured entities, and persons who pay for mental health or chemical dependency treatment services; and
- persons who pay taxes to support public services including mental health and chemical dependency care, assessment, and treatment.

The costs of the proposed rules for the most part will be borne by providers who develop a program that meets certification criteria. As noted below, there may be some offsets to those costs due to enhanced treatment outcomes, the creation of system efficiencies, and the message communicated to the public by the certification, which may spur referrals to the program.

Persons with co-occurring substance-related disorders and mental illness will be the primary beneficiaries of the proposed rule. This is because the rules are likely to increase the availability of integrated treatment that conforms to evidence-based best practices, and therefore results in better treatment outcomes for those served by the programs. In the long term, persons who pay for mental health and chemical dependency treatment, and persons who pay taxes to support public services, will also benefit due to the improved treatment outcomes because this is a population that has historically been difficult to successfully treat, and better treatment outcomes contribute towards health care cost containment. As explained in relation to the second factor, below, this end result of cost containment is borne out by data.

"(2) the probable costs to the agency and to any other agency of implementing and enforcing the proposed rule and any anticipated effect on state revenues"

The department's licensing division estimates that for these rules, the initial costs during the first year would be approximately $20,000, and each year thereafter would be approximately $6,000. There are additional expenses during the first year of implementing a new rule, which in this case would be related to processing applications for certification and answering questions from providers about the rules. A worksheet showing the analysis that leads to these numbers is attached to this statement of need and reasonableness as Attachment 1. The department does not anticipate hiring new employees to implement or enforce the proposed rules. The costs represent a regular part of the cost of doing business. While the department's policy divisions anticipate providing additional training to providers about the proposed rules, these could be absorbed by replacing training that would otherwise have been offered to provider new hires, and as part of ongoing provider training.

In the short term, the department planned that the impact on payments for public health care through medical assistance would be cost neutral. The medical assistance program is the name given to Minnesota's joint federal-state Medicaid program. The legislature did not appropriate funds for integrated dual diagnosis treatment, but directed the department to "apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation." Minnesota Statutes, section 245.4863, paragraph (c). Review is underway to seek this federal financial participation. Until that occurs, reimbursement for integrated dual disorder treatment will occur based on the traditional reimbursement categories for discrete mental health and chemical dependency treatment services.

In the longer term, the department anticipates that improved treatment outcomes will better contain health care costs for the population being served. As described below, data supports this belief.

In the State of Ohio, data analysis of integrated dual disorder treatment outcomes shows significant cost savings. Researchers from the Center for Evidence-Based Practices at Case Western Reserve University conducted an analysis of the state's claims data, and found that, for those 160 people who used the greatest amount of behavioral health care services, IDDT produced a $1.4 million reduction in total annual claims after one year. The target population of persons who will receive services under the proposed rule includes those with the most severe forms of mental illness, and a substance-related disorder. Although the results for the target population of the proposed rule will certainly not be as sudden and dramatic as those for the top 160 health care users in Ohio, substantial costs savings can be anticipated. Indeed, the efficacy of the integrated treatment protocol indicates that notable improvements in treatment outcomes can be expected, which aids the containment of health care costs for these individuals.

The proposed rule requirement alone to screen individuals to identify those with dual disorders is a cost-effective practice. Although this practice is now required by the same legislation that directs the adoption of this rule, the rule requirement to conduct screening will undoubtedly accelerate and expand implementation of the screening requirement. Screening is an inexpensive cost containment tool. For example, mental health screening done as part of a child

and teen medical check-up results in a cost to the health care plan of only $23.16. In many instances, the screening might indicate a low likelihood of co-occurring disorders, which enables health care professionals to avoid a referral for a full diagnostic assessment. Under current reimbursement rates, an extended mental health diagnostic assessment for an adolescent easily costs upward of $400, a cost that may sometimes be averted based on a negative screen result.

"(3) a determination of whether there are less costly methods or less intrusive methods for achieving the purposes of the proposed rule"

The Department has proposed the least costly method for achieving the purposes of the proposed rule. The rule objectives are to establish a certification process for IDDT programs, and ensure that persons with co-occurring disorders receive IDDT. Minnesota Statutes, section 245.4863, paragraph (b). Stated another way, the primary purpose of the rule is to ensure that quality IDDT services are available in Minnesota. The department designed program standards based on evidence-based practices and proven treatment models. Accordingly, consistent with the research on these practices and models, each of the selected program components are important to improve treatment outcomes. Thus, less costly methods for achieving the rule's purpose are not known. In addition, the voluntary nature of the certification program makes it the least intrusive method of achieving the rule's purpose.

"(4) a description of any alternative methods for achieving the purposes of the proposed rules that were seriously considered by the department and the reasons they were rejected in favor of the proposed rule"

The legislature has determined that the department should adopt rules to govern certification of programs providing integrated services to persons with dual disorders. Rulemaking meets the state legislative directive. As a result, the department did not consider alternative methods for achieving the purposes of the proposed rule.

"(5) the probable costs of complying with the rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as classes of governmental units, businesses or individuals"

The explanation stated under factor (1) of this Regulatory Analysis indicates that the class that will primarily bear the costs of the proposed rules are providers who seek IDDT certification. The proposed rules will result in one-time, up-front costs for a treatment provider to develop and implement an IDDT program in compliance with the proposed rules. It is difficult to quantify these costs, due in large part to the varying degree to which different providers will need to change and develop their programs to bring their program into compliance with the rule standards. Some providers already operate consistently with many of the practices required in the proposed rules.

During the course of the COSIG project, however, the department acquired some knowledge of the costs to implement an integrated treatment program. In this project, the department worked with more than a dozen providers who implemented many aspects of an integrated treatment program, and was able to reimburse some of the associated up-front costs.

The department believes the type of provider most likely to seek IDDT certification is an outpatient provider that delivers both mental health treatment and chemical dependency treatment, for which IDDT certification is consistent with the provider's mission and treatment population. For such a provider, the primary program costs would be those for administrative expenses to update treatment policy and procedure manuals, staff training about these policies, staff training on IDDT treatment practices (which may encompass a broader array of treatment modes), updates to electronic health records, and data updates to reporting software for transmittal of treatment outcomes to the department. These costs would likely be incurred over a one-year period, and amount to roughly $20,000. In addition, there would be an up-front certification fee of $2,000.

Apart from the initial startup costs of bringing a program into compliance are the ongoing costs of continuing compliance. Once operational, however, the department believes that ongoing program costs would be similar to other treatment service costs as part of doing business as a treatment provider. Moreover, it is expected that operating a certified IDDT program would create efficiencies and improve quality of care as the program changes became fully operational and individuals were treated in the most appropriate treatment setting by trained IDDT staff.

"(6) a description of the probable costs or consequences of not adopting the rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses or individuals"

If the proposed rules are not adopted, many of the non-monetary benefits explained under factor (1) of this Regulatory Analysis would not be experienced. The primary consequence would be borne by persons with co-occurring disorders, who would be less likely to learn about and have access to comprehensive integrated dual disorder treatment programs to address their needs in a manner that benefits these individuals. In other words, without the incentive to fully develop an integrated treatment program that operates consistently with the best practices required in the proposed rule, the traditional, bifurcated systems of care are perpetuated, without positive outcomes for those with co-occurring disorders.

"(7) an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference"

The rule that the department proposes governs the certification of integrated dual diagnosis treatment programs. Federal regulation does not govern certification of integrated dual diagnosis treatment. Consequently, there are no differences between the proposed rules and existing federal regulations. The proposed rule does not differ from federal regulation.

"(8) an assessment of any cumulative effect of the state's rule changes with other related federal and state regulations."

Because the proposed rules cover an area that is not addressed by federal law, the consideration about related federal law is not applicable.

The rule standards are consistent with standards contained in Minnesota Statutes including the Comprehensive Adult Mental Health Act, Minnesota Statutes, section 245.461 to 245.486, and the Comprehensive Childrens Mental Health Act, Minnesota Statutes, sections 245.487 to 245.4889. These statutes define the service delivery standards applicable to a comprehensive mental health system and establish within the department the state mental health authority. In addition, the rule standards are consistent with Minnesota Statutes, chapter 254A. This chapter addresses alcohol and other drug dependency and abuse and establishes within the department the state authority on alcohol and other drug dependency and abuse. See Minnesota Statutes, section 254A.03. Establishing standards and practices for the certification of programs for persons with co-occurring disorders is wholly consistent with the department's role as the state authority for substance use and mental health.

Minnesota Statutes also contain some requirements that a particular mental health program adopt some elements of integrated treatment services. See, e.g., Minnesota Statutes, section 256B.0623, subdivision 5, paragraph (3)(peer support as part of qualified team for adult rehabilitative mental health services); section 256B.0947, subdivision 2(f)(youth mental health assertive community treatment programs required to provide integrated services for dually-diagnosed youth, which includes assertive outreach and stage-wise treatment). These requirements are consistent with the integrated services protocol. Therefore, the proposed rule applies in parity with these statutory requirements.

Some departmental rules governing particular mental health or chemical dependency treatment programs require some elements of integrated treatment services. See, e.g., part 9530.6495 (standards for chemical dependency program serving persons with mental illness). One consideration during rule development was whether these existing requirements pertaining to services to persons with co-occurring disorders should coexist with the new rule, or whether the new rule should displace them. The department determined that it is too soon to mandate that all treatment provided to dually-diagnosed persons conform to the new rule. Consequently, certification of an integrated treatment program under the new rule is voluntary, rather than mandated. When a program is IDDT-certified, then the new rule provides that the new rule requirements supersede any previously-existing department rule requirements. Thus, there are no cumulative effects of the proposed rule with other departmental requirements.

PERFORMANCE-BASED RULES THAT MAXIMIZE FLEXIBILITY

Minnesota Statutes, sections 14.002 and 14.131, require that the Statement of Need and Reasonableness describe how the department, in developing the rules, considered and implemented performance-based standards that emphasize superior achievement in meeting the department's regulatory objectives, and maximum flexibility for the regulated party and the department in meeting those goals.

The proposed rule will result in better outcomes across a range of societal and health care measures because the rule standards adopt evidence-based practices and prescribe a model of treatment proven to be successful with the target population. The target population is persons with an acute or chronic mental illness and a substance-related disorder, who are experiencing problems due to these disorders. Research supports that integrated treatment for these

individuals not only improves treatment outcomes for both disorders, but also leads to better housing, employment, educational, and social outcomes.[4]

As certified programs are implemented across the state, the department will obtain valuable treatment outcomes data from these programs. The department will analyze the data to identify patterns and seek to further improve health care outcomes for the individuals served in these programs.

The proposed treatment rule is designed to offer maximum flexibility to providers in designing integrated treatment programs and providing integrated services. For example, the rule permits flexibility about the makeup of the multidisciplinary team that implements IDDT, and permits providers to select from among a variety of treatment interventions based on clinical assessments.

ADDITIONAL NOTICE PLAN and NOTICE PLAN

Request for Comments. In accordance with Minnesota Statutes, section 14.101, the department published a Request for Comments in the State Register on August 29, 2011, at 36 S.R. at 194 (2011). The department sent the Request for Comments to all persons registered to receive department rulemaking notices. In addition, the department sent the Request for Comments to mental health service providers and their Minnesota provider associations; chemical dependency treatment providers and related provider associations; children's mental health providers; advocates for persons with dual disorders; the council for health insurance companies; the Minnesota Medical Association; all persons who participated in the rule advisory committee or attended rule hearing before an administrative law judge in 2011 concerning amendments to rules governing payment standards for outpatient mental health care under medical assistance; and the co-chair of the Rules Committee of the Minnesota Association of County Social Service Administrators.

Notice of Hearing: Required Notices. As required by Minnesota Statutes, sections 14.131, 14.14, 14.22, and 14.23, the Department will publish the Notice of Hearing in the State Register in December 2012, and send the Notice to all persons who have registered with the Department to receive rulemaking notices. As required by Minnesota Statutes, section 14.116, the Department will send copies of the Notice of Hearing, the proposed rules, and the Statement of Need and Reasonableness to the chairs and ranking minority party members of the legislative policy and budget committees with jurisdiction over human services matters. In the Notice, the Department states that a free copy of the proposed rules will be sent to anyone who contacts the Department and requests one.

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[4] Mueser, et. al., 2003. See also Treatment Improvement Protocol 42 ("TIP 42"), which addresses the rationale for and core components of integrated treatment for co-occurring disorders. It was published by the Center for Substance Abuse Treatment at SAMHSA in 2005 and is available at http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073 (National Center for Biotechnology Information, health care research).

Notice of Hearing: Additional Notice Plan. Minnesota Statutes, sections 14.131 and 14.23, require that this statement contain a description of the Department's efforts to provide additional notice of the rules hearing to persons who may be affected by the proposed rules. The Honorable James E. LaFave approved the additional notice plan relating to the plan described below on December 7, 2012.

In addition to the persons that the department is expressly required to notify by law, the Department will send Notice to all persons who attended any of the six public stakeholder advisory group meetings during informal development of the proposed rule. Notice will also be sent to anyone who has submitted a comment at any time to date related to this rulemaking or draft rules.[5] Notice will be sent to all of the above-described recipients of the Request for Comments. The Department will publish the Notice of Hearing, the proposed rules, and the Statement of Need and Reasonableness on the public portion of the Department's web site soon after the notice is signed.

In addition, the department will mail the notice to:

- Minnesota Medical Association;
- Minnesota Psychological Association;
- Minnesota Psychiatric Association;
- Minnesota Association of County Social Service Administrators;
- County Board Chairs;
- Minnesota Association of Community Mental Health Programs;
- Minnesota Association of Residential Treatment Facilities;
- National Alliance on Mental Illness, Minnesota (NAMI-MN);
- Pacer Center;
- Mental Health Consumer/Survivor Network of Minnesota;
- Mental Health Association of Minnesota;
- Minnesota Joint Council of Health Plans;
- Association for Children's Mental Health;
- Minnesota Council of Child Caring Agencies;
- Minnesota Association of Resources for Recovery and Chemical Health;
- Advocates for persons with dual disorders;
- Minnesota Hospital Association; and
- Providers eligible for certification under the proposed rule, including:
    - mental health centers and clinics approved under Minnesota rule part 9520.0750, et. seq.;
    - residential and non-residential chemical dependency treatment providers licensed under Minnesota Rules, chapter 9530;
    - assertive community treatment providers certified under Minnesota Statutes, section 256B.0623;

[5] There are a few advisory group meeting participants or commenters who provided the Department only with an electronic mailing address, and no postal address, and for whom the Department could not readily find a postal address. Those persons were provided notice via electronic mail. All others in this group were notified via both postal addresses to the organization represented, and electronic mail.

- adult rehabilitative mental health services providers certified under Minnesota Statutes, section 256B.0623;
- adult intensive rehabilitative services providers certified under Minnesota Statutes, section 256.0622;
- childrens' residential services providers licensed under Minnesota Rules, chapter 2960, in which the license includes providing either mental health or chemical dependency treatment services; and
- tribal social services contacts.

CONSULT WITH MINNESOTA MANAGEMENT AND BUDGET ON LOCAL GOVERNMENT IMPACT

As required by Minnesota Statutes, section 14.131, the Department has consulted with Minnesota Management and Budget (MMB). The department sent MMB copies of the documents sent to the Governor's Office for approval before publishing the Notice of Hearing. These documents included: the Governor's Office Proposed Rule and SONAR Form; a copy of the draft rule; and a copy of the draft SONAR. The documents were sent on November 15, 2012 to the Governor's Office, and on November 21, 2012 to MMB. The Department will submit a copy of the cover correspondence and any response received from MMB to the administrative law judge at the hearing or with the documents it submits for the judge's review.

COST OF COMPLYING FOR SMALL BUSINESS OR CITY

As required by Minnesota Statutes, section 14.127, the Department has considered whether the cost of complying with the proposed rules in the first year after the rules take effect will exceed $25,000 for any small business or small city. The rule does not impact cities. Furthermore, the rule will impact a small business only if the business chooses to seek certification of an integrated dual diagnosis treatment program. Certification is voluntary, not mandatory, so no small business will be impacted unless it chooses to be.

LIST OF WITNESSES

The Department does not intend to call any non-agency witnesses.

RULE-BY-RULE ANALYSIS: PROPOSED NEW RULES.

Part 9533.0010 **APPLICABILITY.**

Subpart 1. **Purpose and applicability.** This provision is needed to clarify who is governed by the provisions in the proposed rules. It is reasonable to specify that the proposed rules apply to certified integrated dual diagnosis treatment (IDDT) services because this is consistent with the legislative directive to create a certification system for such programs. It is reasonable to add the last phrase indicating that the rules apply to the licensed program when the provider seeks licensure, because the certification of the program is voluntary, rather than mandatory. The department's authorization of the program is designed for programs that wish to hold themselves out as having a well-developed program capable of treating clients with all levels of needs

intensity among those with dual diagnosis disorders. In other words, clients with high intensity mental health needs, coupled with high-intensity substance-related disorder needs, would be assured that their needs could be met at a certified program. A certified program will also be capable of serving clients with less intensive needs if the provider elects to do so.

Subpart 2. **Certification option.** Requirements about specialized, integrated treatment for persons with co-occurring disorders began to appear in the department's statutes and rules and rules long before the legislature directed the adoption of these rules in 2011. Indeed, various programs licensed or certified by the department contain requirements to provide dual diagnosis treatment according to best practices and commonly-accepted principles. As is often true with legal developments, the sets of requirements for various programs are not a model of consistency; each was initiated at a different time and sometimes had a slightly different emphasis or focus. All of these other sets of requirements fall far short of those presented in this rule, which, for the first time in Minnesota, constitute the comprehensive regulation needed to ensure effective and successful integrated dual diagnosis treatment programs. This is one reason that the present, proposed rule will enhance the department's regulatory structure: it establishes consistent standards for top-tier, integrated dual diagnosis treatment, regardless of which program the provider operates.

At the same time, however, many providers have been offering elements of a dual diagnosis treatment program for some time, according to the program-specific statutory or rule requirements. This is true for licensed chemical dependency providers (informally referred to as "Rule 31 providers"), which abide by the dual diagnosis requirements in Minnesota Rules, part 9530.6495; and intensive residential rehabilitative mental health services, which abide by specific programmatic requirements imposed in connection with Minnesota Statutes, section 256B.0622, and part 9520.0500 et. seq. The statutes governing assertive community treatment teams for both adults and children also include a requirement that integrated dual disorders treatment be provided as a required service component. Minnesota Statutes, sections 256B.0622, subd. 6 (adults); and 256B.0947, subd. 3a, paragraph (b)(13)(children). The phrase "assertive community treatment" refers to an intensive treatment approach that includes rigorous outreach efforts ("assertive") to engage severely mentally ill persons who usually slip through the proverbial "cracks" in the system.

The department made a deliberate decision to propose rules for a program that would be capable of serving the highest-needs persons among those with dual disorders. Although the department believes that it is successfully making inroads toward the development of systems and qualified professionals in Minnesota that are well-suited to provide IDDT, much work remains to be done. It is too soon to require all providers who offer services modeled more or less along the lines of integrated services to establish such a highly-capable, evidence-based program. Consequently, IDDT certification is voluntary, not mandatory. It is an option for

sophisticated providers, such as participants in the COSIG project, to obtain a stamp of approval indicating they have the organizational and clinical elements needed to provide IDDT effectively. While some mainstream chemical dependency treatment providers might not be philosophically ready to organize treatment programming for persons who would benefit from IDDT, the demand for this programming is already present. Consumers and their families have contacted the Department to request a list of state-recognized IDDT providers, and the department will be able to meet that demand as soon as programs become certified.

Subpart 3. **Requirements supersede.** IDDT is a term of art that refers to a treatment model, which includes certain principles and evidence-based practices, designed to serve persons who have both highly acute and chronic mental disorders, and highly acute and chronic chemical dependency disorders. This is a population that requires intensive, high level of care services, and the rule requirements establish a program that is specifically designed to meet its needs. It follows that the proposed new rule requirements generally establish a higher standard of care than other rules. It is therefore necessary to override all other, less rigorous standards in other rules that may apply to a particular program, so that certified IDDT programs are operated consistently with the evidence-based practices on which the rules are based, and can therefore expect improved treatment outcomes. In a couple instances, however, because the proposed new rule sets a standard across several program types, a particular program type may be governed by a pre-existing rule requirement that establishes a higher standard than that set forth in the proposed rule. In this case, the pre-existing requirement governs, so that the more rigorous standard of care that already applies to the particular provider setting is preserved.

The impact of this provision will not be as great for this rule as it might in other rules. This is because, as explained further in connection with part 9533.0030, subpart 1, "Eligibility," this rule supplements existing rules and statutory certification standards that already apply to providers based on their provider type (e.g., a chemical dependency treatment provider, or a mental health treatment provider). Providers in a number of different licensed or certified classes are eligible for IDDT certification. The proposed rule is a supplement to the pre-existing requirements that govern the provider classification. This approach is informally referred to within the department as an "add-on rule." The proposed rule thus relies heavily on the foundational requirements of the pre-existing, program-specific law, which takes care of basic requirements such as records management, client rights, personnel administration, etc... The supercision provision therefore applies more narrowly here, than it might elsewhere, because the new rule does not encompass a broad swath of operational requirements. Rather, providers will continue to comply with the familiar, pre-existing basic programmatic requirements applicable to their program type, which are unimpacted by the new rule.

9533.0020 **DEFINITIONS.**

Subpart 1. **Scope.** It is necessary to limit the applicability of the definitions to Chapter 7200. It is reasonable to describe this as an aid to the rule reader.

Subpart 2. **Alcohol and drug counselor.** The phrase "alcohol and drug counselor" has a specific meaning in Minnesota law. It is necessary to define the phrase to show the phrase is a particular licensed profession under Minnesota law. It is reasonable to use the statutory definition of the phrase in the rule because this ensures consistency across departmental law.

Subpart 3. **Care coordination.**

A. The definition of "care coordination," for an adult, is necessary because it describes the criteria for and scope of activities that qualify as "care coordination" in an IDDT program. For adults the definition of "care coordination" is necessary because it differentiates the focus of the service between what is appropriate for adults and what is appropriate for children, both of whom are addressed in this rule. The definition is reasonable and necessary because it directs and limits activities to those that have been presented in peer-reviewed journals and have been shown to be effective components of an IDDT program.

B. "Care coordination," for children, requires a definition to state which criteria must be present for an activity to qualify as care coordination in an IDDT program. This definition is necessary because it differentiates the focus of the service between what is appropriate for adults and what is appropriate for children. The definition is reasonable and necessary because it directs and limits activities to those that have been presented in peer-reviewed journals and have been shown to be effective components of an IDDT program.

Subpart 4. **Certificate holder**. It is reasonable and necessary to define certificate holder in terms of legal responsibility for the operation of the IDDT program. The definition provided in these rules is reasonable because it ensures consistency throughout this rule chapter when referring to the legally responsible authority for the licensed or certified program. Stating that the certificate holder is a controlling individual is necessary so that one legally responsible person can be identified for accountability.

Subpart 5. **Certification.** It is reasonable and necessary to define this term so that eligible programs are on notice that the program must conform to the applicable rule requirements to become certified.

Subpart 6. **Certified integrated dual diagnosis treatment program.** For the same reasons that it is necessary to define "certification," it is also necessary to define the phrase "certified

integrated dual diagnosis treatment program." It is reasonable to define the term in a manner that comports with the definition of certification so that the rule is internally consistent.

Subpart 7. **Certified peer specialist or peer specialist.** The definition of the term "certified peer specialist, or peer specialist" is necessary to clarify who is eligible, by training, experience, and state certification, to fulfill this role in the IDDT multidisciplinary team. It is reasonable to refer to Minnesota Statutes, section 256B.0615, subdivision 5, for services provided to adults, or section 256B.0947, subdivision 2, paragraph (h), for services provided to children, because these sections state the qualifications and duties of a "certified peer specialist or peer specialist," and reflect how the requirements differ based on the age group of the population being served.

Subpart 8. **Chemical dependency**. Throughout the rule, the phrase "substance-related disorder" is the preferred phrase for the concept of addiction because it is consistent with the most current industry terminology, and the terminology that will be used in the imminent, upcoming release of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The phrase "chemical dependency" had been the favored phrase in the past, however; as a result, Minnesota statutes refer in many instances to chemical dependency, as do the names of many treatment programs. It is therefore reasonable to use the older phrase where the SONAR context refers to an older statute or program, and to define it to eliminate confusion about whether the phrase means something other than "substance-related disorder."

Subpart 9. **Chemical dependency treatment**. The same rationale for the necessity and reasonableness of defining "chemical dependency" applies to the definition of "chemical dependency treatment."

Subpart 10. **Child with a severe emotional disturbance**. It is reasonable and necessary to define the phrase based on the Minnesota Comprehensive Children's Mental Health Act statute because this ensures consistency of laws and meaning.

Subpart 11. **Client.** The definition of the term "client" is necessary because it is important to identify an individual accepted by an IDDT program for assessment or treatment of dual disorders. The definition is reasonable because it clarifies both the inception and termination of services that create a client relationship. The definition is reasonable because it is analogous to the definition of a client under part 9530.6405, subpart 8, which governs chemical dependency treatment programs. It is reasonable to adopt department rules that are consistent because this consistency facilitates compliance for programs governed by more than one rule.

Subpart 12. **Cognitive behavioral approaches, techniques and strategies.** It is necessary to define "cognitive-behavioral approaches, techniques and strategies" because the department's use of the phrase refers to specific kinds of approaches that are described in the definition. It is

reasonable to define the phrase because it is has been traditionally used in both the addiction treatment field, and in the treatment of mental illness. The department is cognizant of these uses and believes this is an approach that is therefore also of value in the delivery of integrated treatment.

Subpart 13. **Collateral sources.** It is necessary to define "collateral sources" because the phrase does not have a commonly understood meaning, and has a very specific meaning in the treatment field. It is reasonable to define the term by providing examples of persons who can serve as collateral sources because this is the best way to convey persons that program staff may find helpful in acquiring an additional set of information to better understand the consequences of the client's dual disorders in his or her life.

Subpart 14. **Commissioner**. It is reasonable to define the term "commissioner" because the term is used repeatedly in the rule, and the definition permits a short reference to the commissioner without requiring a reference to the human services agency in each instance. It is reasonable to state in the definition that the term may also refer to a designated staff person who carries out a given responsibility because, in the complex social services world that the commissioner operates in, she could not fulfill all of the commissioner's duties herself and therefore designates responsibilities to others within the agency.

Subpart 15. **Competency**. It is necessary to define competency to clarify the scope of the department's discretion to interpret this term. The use of the term has worked well in other department rules (see, e.g., parts 2960.0460 and 2960.0660) and is also in use by the Minnesota Department of Health (see, e.g., parts 4655.1200, 4655.1300, and 4658.0105) and other agencies. The definition affords the agency a small measure of discretion, circumscribed by the specific references to "requisite abilities" and "work obligations." The term competency is also generally understood to include providing services that are based on current professional standards.

Subpart 16. **Co-occurring substance-related disorder and mental illness, or co-occurring disorders**. Defining the phrase is necessary because the definition provides clarity about what disorders constitute co-occurring disorders. The definition is reasonable because it includes the alternative, simpler reference to "co-occurring disorders," to avoid any potential ambiguity in the use of the shorter phrase.

Subpart 17. **Counseling.** It is necessary to define the word counseling because counseling can be used to describe many activities. It is reasonable to describe the term to eliminate ambiguity about what services the term is referencing.

Subpart 18. **Department.** It is reasonable to define the term department because the rule refers to the department of human services many times, and rule definition permits the use of one word for simplicity.

Subpart 19. **Diagnostic assessment**. The definition of the term "diagnostic assessment" is necessary to describe what is required in an assessment of mental health conditions. The diagnostic assessment provides information about the client that will be used to design and implement the client's treatment. It is important to list the essential elements so that providers will have enough information about a client to provide effective mental health treatment. It is reasonable to refer to incorporate by reference the requirements under part 9505.0372, subpart 1, the same requirements that apply to a diagnostic assessment for purposes of medical assistance reimbursement, because this ensures consistency across department rules and facilitates compliance.

Subpart 20. **Dual diagnosis or dual disorder**. It is reasonable to define dually-diagnosed because the description is used in various places throughout the rule as a shorter reference to co-occurring disorders. It is necessary to define the phrase to remove any potential ambiguity about whether it means something different than co-occurring disorders.

Subpart 21. **Emotional disturbance.** It is necessary to define emotional disturbance because the phrase has a specific meaning under Minnesota law and is generally used to refer to the mental condition of a child. It is reasonable to adopt the definition from the Minnesota Comprehensive Children's Mental Health Act because consistency of the law facilitates understanding and compliance. It is also reasonable to use this definition because, in practice, it is used to refer to mild to moderate mental health needs, as distinguished from more severe mental health needs.

Subpart 22. **Evidence-based practices.** It is necessary and reasonable to define evidence-based practices because the phrase has a commonly understood usage in the field of mental health and substance use treatment. Defining the phrase ensures that providers understand that evidence-based practices must be supported by research and shown to be effective, which limits the approaches that fall within the definition.

Subpart 23. **Illness management and recovery, or "IMR**." It is necessary and reasonable to define the phrase because it references a specific practice and set of related principles and has a commonly understood use.

Subpart 24. **Integrated assessment.** It is reasonable and necessary to define integrated assessment because it is a significant component in the sequence of steps needed to provide integrated dual diagnosis treatment. It is reasonable to describe the assessment by including

examples of resources used to assemble the assessment information because this facilitates compliance.

Subpart 25. **Integrated dual diagnosis treatment.** It is reasonable and necessary to define integrated dual diagnosis treatment because the term encompasses the type of treatment being provided by a certified program and establishes a uniform reference for those services.

Subpart 26. **Integrated treatment plan.** It is necessary and reasonable to define integrated treatment plan to ensure consistency across providers in the use of the integrated treatment plan, and to facilitate compliance.

Subpart 27. **Level of care.** It is reasonable and necessary to define the phrase because it has specific meaning in both the mental health and chemical dependency communities. Defining the phrase is reasonable to ensure a common understanding by providers of the need to assess a client's resource intensity needs and determine the appropriate treatment setting (e.g., inpatient or outpatient).

Subp. 28. **Mental illness.** It is necessary and reasonable to use the definition of the term "mental illness, for an adult" that is consistent with Minnesota Statutes, section 245.462, subdivision 20, used in determining eligibility and reimbursement for services in existing adult mental health programs. It is also reasonable and necessary to define mental illness for a child because the term is used differently with children. It is reasonable to define the term for children consistently with the language used in the Minnesota Comprehensive Children's Mental Health Act for consistency across laws.

Subpart 29. **Program of origin.** It is reasonable to select the phrase "program of origin" to refer to the underlying program previously authorized by the department, or other regulatory body, which makes the provider eligible for certification under part 9533.0030, subpart 1. The phrase permits a simpler reference to the pre-existing, foundational program, where the SONAR refers to more than one provider type.

Subpart 30. **Protocol.** It is necessary to define "protocol" because it is a term that may not be familiar to all rule readers, and it is important to establish that a protocol provides a specific and concrete manner to implement research findings regarding effective treatment and clinical practice in a consistent manner.

Subpart 31. **Psychoeducation.** It is necessary to define the term "psychoeducation" because it is not a commonly-used term outside of the mental health and addiction treatment fields. The concept has come into acceptance as both a useful and necessary element of most treatment programs. It is reasonable to define a relatively newer type of service that may not be familiar to all rule readers.

Subpart 32. **Recovery coach. "Recovery coach"** is not a generally-used phrase with a widely-accepted meaning because it refers to a newly-emerging focus, so it is reasonable to define the phrase.

Subpart 33. **Recovery philosophy.** It is necessary to define "recovery philosophy" because this is not a generally-used phrase with a widely-accepted meaning, outside of the addiction or mental health fields. It is necessary to define the term to provide a common understanding that the recovery-oriented model of care involves a philosophy of personal change and improvement over time.

Subpart 34. **Screening.** It is reasonable to define "screening" because the term has more than one meaning, depending on the context in which it is used. In the rule, the term is used to describe the process of identifying persons with co-occurring disorders. It is necessary to describe this to ensure a common understanding the term for interpreting the rule requirements.

Subpart 35. **Staff or staff member.** It is reasonable to define the term to show that the term is not limited solely to employees. The term includes volunteers because required policies and practices in the rule are intended to govern both employees and IDDT volunteers.

Subpart 36. **Stage of change.** It is necessary to define stage of change because it does not have a commonly understood meaning outside of the mental health field. It is reasonable to define the phrase because this is a relatively recently-emerging concept and focus.

Subpart 37. **Stage of treatment.** It is necessary to define the phrase to ensure a common understanding that the phrase includes specific, identifiable phases of treatment. It is reasonable to list the stages to facilitate uniformity across providers and facilitate compliance.

Subpart 38. **Stage-wise treatment**. It is necessary to define stage-wise treatment because the phrase is not generally-used with a widely-accepted meaning outside of the addiction or mental health fields. It is necessary to define the phrase to ensure consistent understanding by providers because research has shown that interventions appropriate at one stage may be ineffective or contra-indicated at another stage.

Subpart 39. **Substance-related disorder**. The department has chosen the term "substance-related disorder" rather than "chemical abuse" and "chemical dependency" because substance-related disorder is the most current terminology and will be used in the upcoming, fifth edition of the DSM. It is reasonable to rely on the definition of the term in the DSM because the Manual is the most widely recognized reference for standardizing the definitions of mental and behavioral disorders. It is also necessary and reasonable to define the phrase because the presence or absence of a substance-related disorder is essential to making the determination of whether the person has co-occurring mental illness and substance-related disorder.

Subpart 40. **Telehealth.** It is necessary to define the term telehealth to clarify the specific types of services referenced in the rule. It is reasonable to define the term to distinguish it from telemedicine because telemedicine is a more narrow term used to denote only clinical services, so that the definition prevents confusion about the two similar terms.

Subpart 41. **Treatment for a substance-related disorder.** It is reasonable to define this phrase to confirm that it has the same meaning as treatment for a chemical dependency because both phrases are used in the rule.

Part 9533.0030 **ELIGIBILITY FOR CERTIFICATION.**

Subpart 1. **Eligibility.** The proposed IDDT certification requirements are not the only governing law pertaining to a program. Rather, as described briefly for part 9533.0010, subpart 2, the proposed new rule is a supplemental or "add-on rule." This means the certification is supplemental to a pre-existing authorization by the department (or other governing body), to operate a previously-existing mental health or chemical dependency service. Thus, the new rule adds a supplemental layer of specialized requirements focused solely on the provider's IDDT program.

The previously-authorized, foundational program (or hospital license) makes the provider eligible for IDDT certification under subpart 1. The rule refers to the foundational program as the "program of origin." The body of law governing the program of origin contains basic operational requirements, such as those about infrastructure, maintenance of records, policy and procedures manuals, and the like. Because the proposed rule applies in tandem with the previously-applicable regulation, it does not contain a comprehensive set of programmatic requirements that can apply independently.

Subpart 1 identifies the programs of origin that are eligible to obtain IDDT certification. It is reasonable and necessary to list these programs, to inform providers who operate them and the public whether the program is eligible for IDDT certification.

Item A states that community mental health centers and clinics (collectively referred to as centers or CMHCs) are eligible to obtain IDDT certification. There are 72 non-profit centers across the state that are certified by the department's licensing division to provide outpatient mental health services. Minnesota rules, parts 9520.0750 to 9520.0870, govern the certification of CMHCs. Minnesota Statutes, section 256B.0625, subdivision 5, paragraph (a), requires certification in order to bill Minnesota's Medicaid program, known as Medical Assistance.

Although not mandated to do so, many centers provide some measure of dual disorder programming including screening and assessment for the presence of a dual disorder. Fourteen centers are dually-licensed to provide not only outpatient mental health services, but also chemical dependency treatment. As explained above, these dually-licensed providers were a

primary focus of Minnesota's COSIG project, in which federal grants were provided to programs to begin to build an infrastructure in Minnesota of the types of core services needed to develop IDDT programming.

The CMHCs, particularly those that participated in the COSIG project, but others as well, are essential to implementation of the proposed rule. Based on their experience, these entities possess a good deal of the state's expertise about the development of an IDDT program. This is important to the department's continuing efforts to create broader availability of IDDT programs and trained professionals.

The existing rules governing CMHCs establish a strong foundational base of program operations from which to provide community-based outpatient mental health services. CMHCs are present throughout the state and presently serve a significant proportion of the population receiving mental health treatment in Minnesota. As evidenced by the statistics, one can expect that many of these individuals have a substance-related disorder. It is therefore reasonable to permit CMHCs to obtain IDDT certification.

Item B permits licensed chemical dependency treatment programs to obtain IDDT certification. The department's licensing division licenses both residential and non-residential chemical dependency treatment programs under parts 9530.6405 to 9530.6505. With the exception of programs licensed by an American Indian tribe, no Minnesota program can offer chemical dependency treatment without a license. See Minnesota Statutes, section 245A.03. There are roughly 250 licensed chemical dependency treatment providers in the state, which are providing services to virtually all Minnesotans currently receiving substance use treatment. Based on the statistics, about one in five of these individuals can be expected to have a co-occurring mental illness, representing many of the individuals who would benefit from IDDT programming. It is necessary and reasonable to permit licensed chemical dependency treatment providers to obtain IDDT certification because they are so well-positioned to offer these services to existing client bases in communities throughout the state.

Moreover, the state's expertise about substance use treatment resides largely with these providers. This is critical to the development of IDDT programs and trained professionals in the state, particularly because the philosophy of IDDT is that both the substance-related disorder and mental illness are viewed as primary conditions.

Item C permits a tribally-licensed substance use or mental health treatment provider to seek IDDT certification, if it desires to do so. Minnesota has the thirteenth largest population of American Indians in the country, with eleven reservations. American Indians in Minnesota can choose to access mental health and substance use services through state, county, tribal government, or American Indian Health Boards. Consistent with federal law and funding encouraging this development, tribal governments are increasingly interested in becoming providers of mental health services. Both federal and state public policy favor increased

American Indian participation in the delivery of their own health care, including Medicaid-funded care. See Indian Self-Determination and Education Assistance Act (P.L. 96-638)(giving tribes the authority to administer and operate their own health services and programs within their communities); Indian Health Care Improvement Act (P.L. 94-437)(encouraging tribes' fullest participation in planning and managing their health services). See also Minnesota Statutes, section 254B.05 (American Indian programs tribally-licensed for chemical dependency treatment eligible for reimbursement from the state Consolidated Chemical Dependency Treatment Fund). It is necessary and reasonable to permit tribally-licensed chemical dependency or mental health treatment programs to seek IDDT certification.

Item D makes certain statutory programs authorized by the commissioner eligible for IDDT certification. Minnesota Statutes, section 256B.0622 authorizes intensive residential treatment settings to provide short-term, transitional mental health services for persons who are leaving, or being diverted from, inpatient psychiatric hospital care. There are thirty-three such settings across the state, which are regulated by the department's licensing division according to parts 9520.0500 to 9520.0690, and related variances. Recipients are at risk of significant functional deterioration if they do not receive these services. The treatment settings are designed to develop psychiatric stability, personal and emotional adjustment, and skills to live in a more independent setting.

Existing state standards require these treatment settings to provide some of the elements of IDDT to persons with co-occurring disorders. In the fall of 2005, over 120 direct service staff from these facilities received department-sponsored, intensive training in IDDT, provided by an IDDT expert from the Dartmouth Evidence Based Practices Center. Providers then collaborated with specialists at the center to implement some measure of integrated treatment services. The resulting knowledge base and experience providing IDDT to a particularly vulnerable population is a valuable part of the core infrastructure needed to develop widely-accessible IDDT programs in Minnesota. It is necessary and reasonable to allow intensive residential treatment providers to obtain IDDT certification.

Minnesota Statutes, section 256B.0622, as well as 256B.0623, govern two other types of specialty mental health programs: Assertive Community Treatment (ACT), and Adult Rehabilitative Mental Health Services (ARMHS), respectively. Both programs are authorized by department certification.

The Minnesota Legislature established ARMHS programs in 2001. ARMHS is a community-based, non-residential service. Today, over 250 providers furnish ARMHS services statewide to individuals whose psychosocial functioning is impaired due to mental illness. The service array offered by these providers is comprised of psychosocial rehabilitative services, which includes specialized services designed to develop psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills.

In 2006, the department sponsored an informational workshop for ARMHS providers to provide a broad overview of IDDT consistent with widely-accepted and SAMHSA-endorsed practices. The program was led by a national expert in IDDT evidence-based practices from Dartmouth. It is reasonable and necessary to continue the development of IDDT expertise and services in these programs by allowing for ARMHS providers to obtain IDDT certification.

There are twenty-six Assertive Community Treatment teams for adults throughout the state. ACT services are similar to those of ARMHS, except that ACT services are directed to recipients with a serious mental illness who require more intensive services. These services are offered on a time-unlimited basis, and are available to recipients 24 hours per day, 7 days per week, 365 days per year. An ACT team must be able to promptly and appropriately respond to emergent needs and ensure the health and safety of recipients.

ACT teams are multidisciplinary, which is a feature they share with IDDT programming. ACT teams share another feature of IDDT programming, and that is the use of peer recovery specialists, an evidence-based practice. Roughly 180 ACT team members have received department-sponsored, intensive training in IDDT. This training was provided by specialists from Dartmouth. It is necessary and reasonable to build upon this base of knowledge by permitting ACT teams to voluntarily seek IDDT certification.

Item E makes another statutory programs authorized by the commissioner eligible for certification. The rule refers to a statute informally known as the "Youth Assertive Community Treatment Act," or "Youth ACT." The Youth ACT seeks to establish teams available to youths age 16 to 21 who have a serious mental illness, or co-occurring mental illness and substance use disorder, and require intensive services to prevent hospitalizations or residential treatment. It is tailored for youth who have a history of not succeeding in the community, school, and home, and who will soon enter adult mental health services. Similar to the makeup of adult ACT teams, Youth ACT teams are required to include a multi-disciplinary set of professionals. They are required to be capable of offering a broad array of services, which may include therapy, skills training, crisis assistance and stabilization services, education about medication and mental health care management, and care coordination. Sadly, at present the state does not have a certified youth ACT team; but the department is taking measures to encourage inception of these programs.

Youth Act teams are required by the statute to provide "integrated dual disorders treatment." The Youth Act, however, uses the phrase differently than it is used in the proposed rule. The Youth Act defines the phrase as simply:

> "a team of cross-trained clinicians within the same program, ... characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment."
>
> Minnesota Statutes, section 256B.0947, subdivision 2, paragraph (f).

In addition, the statute requires each Youth ACT core team to include "a licensed alcohol and drug counselor who is also trained in mental health interventions." Minnesota Statutes, section 256B.0947, subdivision 5, paragraph (b)(1)(iii). This represents an important step toward the availability of integrated treatment services for youth in the future. Importantly, at least one professional on each ACT team will be uniquely qualified to provide integrated treatment services for dually-diagnosed youth. With these building blocks in place toward the development of IDDT programming for youth among ACT providers, it is necessary and reasonable to allow youth ACT teams to seek voluntary IDDT certification.

Item F makes some certified residential programs for children eligible for IDDT certification, namely, group residential settings that have departmental authorization to provide substance use or mental health treatment services. See Minnesota Rules, parts 2960.0430 to 2960.0500 (standards for residential programs choosing to obtain authorization to operate chemical dependency program). These programs have staff already experienced in addressing the mental health and chemical dependency needs unique to children and youth. The needs of this population are distinct from those of adults. In order to develop a continuum of IDDT services capable of meeting the needs of the state's youths, it is necessary and reasonable to permit these providers to obtain IDDT certification.

Item G states that hospitals licensed by the Department of Health are eligible to obtain IDDT certification. Hospitals that contain psychiatric units provide intensive, inpatient mental health services for acutely ill individuals. In addition, hospitals may elect to obtain department licensure as a chemical dependency treatment program. Hospitals are the only such treatment program (other than a tribally-licensed program) for which such licensure is not mandatory. A department license is required, however, if the hospital wishes to obtain program funding from the state Consolidated Chemical Dependency Treatment Fund.

Hospitals are the state's repositories of knowledge and experience in treating the acutely mentally ill, and, for several of these providers, for providing substance use treatment to this population. Department staff have been working with the psychiatric units in several metropolitan hospitals to develop a program for integrated treatment services. It is necessary and reasonable to allow for hospitals with a psychiatric care unit to seek voluntary IDDT certification.

Subpart 2. **Compliance with preexisting requirements.** With the exception of tribal licensure, the programs eligible to seek IDDT certification are licensed by the department, or, in the case of hospitals, by the department of health. It is necessary and reasonable to require the provider to be in compliance with the regulatory requirements governing the program of origin. Because the proposed rule operates in tandem with regulation governing the program of origin, and not as a stand-alone rule, being out of compliance with the foundational requirements could compromise a program's ability to competently operate without impairing the best interests of the clients served. It is therefore necessary to deem violations of foundational program requirements to be a violation of the IDDT license.

Part 9533.0040 **TARGET POPULATION.**

When the legislature directed the department to adopt the proposed rules, it instructed the department to establish "a system through which individuals [with co-occurring disorders] receive integrated dual diagnosis treatment." Consistent with this directive, the department's ultimate goal is the development of a comprehensive system in Minnesota capable of serving persons with co-occurring disorders in a manner suited to their individual needs. When fully developed, the system will offer a continuum of IDDT services, so that providers are able to match each individual with the integrated treatment service level and setting appropriate for the severity of his or her symptoms.

A national consensus has formed around a four-quadrant model for describing the system distribution for persons with co-occurring disorders. See Attacmnent 2, *Quadrant Model for Co-Occurring Disorders.* In the model, persons with co-occurring disorders fall into one of four major categories. The four categories are referred to as quadrants, which are defined based on the severity of an individual's mental illness and substance abuse. Individuals may move between the quadrants during the various stages of their recovery. The first quadrant is comprised of persons who do not have high severity symptoms for either mental illness or a substance-related use disorder. The second and third quadrants include persons having either mental illness, or a substance use disorder, at a high level of severity, without the other disorder also being at a high level of severity. The fourth quadrant is the highest needs category: persons with high-severity mental illness, and a high-severity substance use disorder.

The four-quadrant conceptual framework is a guide for systems integration and resource allocation in treating individuals with co-occurring disorders. Each quadrant corresponds with a locus of care. The quadrant one has a locus of care in primary care settings, quadrant two in the outpatient mental health system, quadrant three in the substance use treatment system, and quadrant four in jails/prisons, inpatient psychiatric hospitals, emergency rooms, and Assertive Community Treatment (ACT) teams.

When determining the standards of care for this rule, the department determined that the proposed rule could not initially encompass all settings of care that would encompass the entire continuum of severity levels of persons with both mental illness and substance use disorders. Rather, the department determined that the new rule should ensure development of an enhanced level of coordinated services capable of treating persons whose severity level placed them within quadrant IV. The department affirmatively selected the phrase "integrated dual diagnosis treatment" to connote that the rule governs programs capable of addressing the service needs of persons with the highest severity level of mental illness and substance use disorder. In much of the literature, this phrase equates with enhanced care designed to serve even those in quadrant IV.

The department believes this approach is optimal as an initial step toward building the system capacity for dual disorder treatment among Minnesota providers. The department is simultaneously taking other steps to develop a more comprehensive system that will be specifically targeted at various levels of care. Indeed, at the same time the department is proposing these rules, it is in the process of developing amendments to its rules pertaining to

community mental health centers and clinics (CMHCs), so that, in the future, all CMHCs will be required to be capable, at a minimum, of serving persons in quadrants II and III. Thus, the department deliberately directed the proposed rule to meet one particular system gap in the service continuum, while undertaking other steps as part of a broader plan.

Accordingly, the target population for the proposed rule as stated in part 9533.0040, subpart 1, is persons with "relatively intensive needs" (that is, persons in quadrant IV). This is a reasonable first step because it would be a formidable task for the department to define standards to meet the differing needs of persons in all four quadrants at the outset. During the initial five topical advisory group meetings, department staff presented this concept to the advisory group and weighed the response.

Importantly, a program capable of serving persons at the highest level of severity for both disorders is also capable of serving persons with less intensive needs. So a program that meets the rule certification standards is able to address the needs of persons in quadrant IV and also the needs of individuals in quadrants II and III. (The locus of care which can meet the needs for quadrant I is any standard primary care clinic.) This is in keeping with the philosophy that the needs of all dually diagnosed persons should be met by the rule; no one should be denied access to dual diagnosis treatment because their symptoms are not severe enough. The rule therefore spells out that certificate holders can elect to serve any patient population they choose based on the needs of their client base. That includes a person in any quadrant who would benefit from IDDT services.

Rule part 9533.0040, subpart 1, item A describes a set of diagnoses that represent a relatively high level of severity on the continuum of mental illness. Consistent with the rationale described above, it is reasonable to describe the target population as persons with one of these listed mental illness and a substance-related disorder. Some comments on the rules wonder why borderline personality disorder is not listed among the described diagnoses, perhaps because it also is a major illness consistent with the severity level of the other diagnoses and therefore often seen in a grouping among the major illnesses in that category. The department deliberately omitted borderline personality disorder because the evidence-based practices that the rule is based on are not necessarily indicated for the particular needs of individuals diagnosed with this illness. Other practices may better address their dual diagnosis.

Item B takes a different approach to defining the target population. Item B identifies persons who have both a substance-related disorder, and significant functional limitations. Impaired role functioning may be used as an indicator of the presence of a high-severity disorder. It is therefore reasonable to list potential indicators of impaired role functioning as factors that may describe persons in the target population. It is hoped that this alternate set of descriptors will assist providers in applying the rule at a grass-roots level.

Part 9533.0050. **POLICIES, PROCEDURES AND PROTOCOLS.**

Subpart 1. **Policies, procedures, and protocols.** It is reasonable and necessary to require the certificate holder to develop procedures to maintain compliance with the rule requirements

because it enables the department to carry out its responsibilities to evaluate whether or not certificate holders are doing so. The documentation allows the department to verify that compliance measures are being taken. It is also reasonable to require that the procedures are available to staff persons, and contain an index. This ensures staff know the procedures are both readily available in a given physical location, and readily accessible by topic.

Subpart 2. **Medication and drug management requirements**. It is necessary and reasonable to regulate the certificate holder's administration of medications when services offered include this service. Part 9530.6435, subparts 3 and 4, are the pertinent medication management requirements that govern licensed chemical dependency programs in the rule that governs that provider type. It is reasonable to incorporate these requirements by reference because the reasonableness and necessity of the existing requirements has previously been established when the department adopted the requirements in chapter 9530 for providers handling medicine for a chemically dependent population, and the rule has worked well for licensees in that context. It is necessary to ensure that medications are stored, distributed and recorded in a manner that protects clients from the possibility of obtaining unauthorized medications, and ensures that improper use of medications can be detected.

It is reasonable to limit the application of the subpart to certificate holders whose medication program is not already governed by other law. Because the programs of origin are governed by existing law about medication management, it would not be efficient to add an additional layer of requirements where previously existing requirement adequately address the topic. Indeed, there is only one provider type eligible for certification that does not have such preexisting requirements, namely, community mental health centers or clinics. The rule that governs them, informally referred to as Rule 29 (Minnesota Rules, part 9520.0750 to 9520.0870), is outdated and therefore lacks such standards. As noted, the department is in the process of updating the rule.

Subpart 3. **Behavioral emergency procedures**. It is reasonable and necessary to require that procedures are in place in the event of a behavioral emergency because behavioral emergencies may arise in the population treated by the certificate holder. It is necessary to have procedures in place for this circumstance so that people know immediately how to respond and can therefore perform their role quickly. The described procedures are in accordance with existing law and serve to ensure that the well-being of clients is protected.

Subpart 4. **Training and implementation**. It is necessary to require training about the program policies and procedures to ensure that staff both understand and abide by the procedures. It is reasonable to require documentation to this effect so the department can verify both are true.

Part 9533.0060. **PROGRAM STRUCTURE AND PRACTICE PRINCIPLES.**

Subpart 1. **Program structure.** Organizational guidelines and structures are needed to launch and support a dual-diagnosis treatment program. Item A requires the certificate holder's management to endorse a program mission that the provider is able to provide and offers integrated services. To maximize the potential for a program, the certificate holder needs to embrace the mission of integration and set a resulting tone for change.

Some in the advisory group advised the department that they belong to traditional organizations that have been around for decades, and are proud to have maintained a consistent mission statement throughout their existence. The rule is reasonable because it therefore permits the certificate holder to adopt a more specific "program mission statement" to define the program, as a subset of the entity, without requiring a change to the overarching mission statement.

Item B requires a treatment structure that facilitates the integration of substance abuse and mental health treatment services. The requirement is necessary because particular organizational factors have been shown to best support the full development of an integrated program to treat persons with co-occurring disorders. The DDCAT and DDCMHT measure the degree of formalized, written collaboration and coordination between professionals having a primary focus on mental health treatment and substance abuse treatment. Structural factors include as a protocol for formal and documented collaboration between these fields, or having of an array of professionals with in-depth expertise in particular areas. The requirement is reasonable because it leaves the particular elements of the structure up to the certificate holder's management team.

Item C requires the certificate holder to provide IDDT services through a multi-disciplinary team. This is necessary and reasonable because persons with dual disorders, and those with chronic and acute mental illness, typically have a wide range of treatment and living needs that cannot be met by a single clinician. The need for and reasonableness of the multidisciplinary team is further established in the SONAR supporting the rule requirements pertaining to the multidisciplinary team, namely, part 9533.0130.

Item D requires a billing structure amenable to reimbursement at some point in the future for integrated treatment services. The DDCAT and the DDCMHT assess whether an organization's billing structure provides for reimbursement of IDDT services. Programs that are able to merge funding for the treatment of substance-related disorders with funding for the treatment of mental health disorders have a greater capacity to provide integrated services. The practice reflects greater organizational realignment, including from a financial standpoint. The rule provision does not require the billing structure to be currently capable of reimbursement for IDDT because the department has not yet established a source of funding that applies specifically to IDDT services, billed as such. As indicated, the department is exploring how to better fund IDDT in the future. If and when such funding is established, providers will need to be in a position to receive reimbursement for IDDT services. So the rule merely requires removal of any foreseeable obstacles to future reimbursements for combined services.

Subpart 2. **Practice principles.** It is reasonable and necessary to require the certificate holder to establish its integrated dual diagnosis treatment program based on a set of core practice principles. These core principles reflect the philosophy of the integrated care model and show current thinking about how best to provide integrated services. It is reasonable to require adoption of these principles to guide program decisions and operations in a manner most likely to result in the positive treatment outcomes associated with IDDT. Some of these principles are embodied in more specific requirements elsewhere in the rule, but it facilitates program conceptualization and development to also organize them in one place.

It is reasonable and necessary to require a client to be able to fully participate in treatment. Treatment will have a significant focus on personal empowerment and self-management recovery skills, which are critical to successful treatment outcomes and ongoing recovery from co-occurring disorders.

It is reasonable and necessary to require that a client be able to share in treatment decisions because research into the effectiveness of treatment and therapy shows that formation of a therapeutic alliance, and collaborative goal setting, are significant factors that contribute to the success of therapies.

It is reasonable and necessary to require clients to be able to offer expertise about their own lives to ensure that the treatment team members are informed of the unique aspects of a client's life that may have a positive or detrimental impact on the treatment process and outcome. The principle also recognizes the broad fund of knowledge a client brings to the treatment context about his or her recovery.

It is reasonable and necessary to require that stage-wise treatment be provided. This type of treatment has been validated through research as an effective component of integrated dual diagnosis treatment. Treatment planning must be matched to the various stages of change for each condition. Because recovery is know to occur over time and progresses through phases, working together with this dynamic optimizes the use of the different treatment components.

It is reasonable and necessary to require strengths-based treatment. Strengths-based approaches are reasonable because they achieve outcomes through a focus on efforts to increase a client's resilience and natural abilities. This fosters client empowerment and fully utilizes a valuable treatment resource. Strengths-based approaches are necessary because they are already a foundation of social work theory and practice, and are a familiar concept in many other disciplines.

It is reasonable and necessary to require that mental illness and substance-related disorder treatment be provided within the same episode of care because this approach has been validated in integrated treatment research. The principle ensures that the multiple interactive variables of the two conditions are simultaneously addressed, and that this is done in a consistent manner with a unified message.

It is reasonable and necessary to require the use of a single integrated treatment plan because this approach is also evidence-based, as reflected in the integrated treatment research. The approach replaces parallel treatment plans, and is superior because it can address each condition as it relates to or affects the others. The approach may also involve collaboration with licensed providers in other disciplines.

It is reasonable and necessary to require the certificate holder to adopt the principle that treatment address the complexity of client needs and support recovery in other major life areas, because when these areas are not addressed, the client's chances of successful, ongoing recovery are greatly diminished. The principle enhances prospects for better treatment outcomes because it adopts particular approaches that will work best in the client's life. A primary objective of integrated treatment is to enable the client to meet the challenges of one's life, with a sense of purpose and positive identity. Specifically focusing on major life areas builds the client's ability to do so across situations.

It is reasonable and necessary to require the certificate holder to adopt the principle that family, guardians, or other support figures should be involved in the treatment process, except when counter-therapeutic or when such figures are unable or unwilling. Family and important others represent a natural support that can provide significant emotional and social support for the client. This support has the capacity to continue after the episode of treatment, and may therefore contribute to better, more consistent longer-term treatment outcomes.

It is reasonable and necessary to require psychoeducation to the individual being treated and family members about the interaction of mental health and substance-related disorders because these interactions are generally poorly understood. A client and family may not have the knowledge of how symptoms of each disorder affect the other. Educating the client and family about possible interactions and impacts enables better recognition of these factors when they arise, and therefore an increased ability to understand and address them.

It is reasonable and necessary to require that the treatment be tailored to the individual's developmental and cognitive level because interventions that are beyond the clients developmental or cognitive level are likely to be poorly understood, poorly applied, or seen as irrelevant by client. These conditions would lead to a poorer treatment experience and would likely hinder a client's successful recovery.

Item J identifies the principle of incorporating evidence-based treatment practices shown to be effective in treating mental health, substance-related disorders, and co-occurring disorders. This is reasonable and necessary because treatments that have been validated and shown to be effective for each condition have a strong likelihood of providing those proven benefits to the client.

Item K identifies the principle of focusing on ongoing engagement throughout treatment services based not on an episode of care, but on continual assessment of progress and recovery. This is a reasonable and necessary requirement because ongoing engagement is likely to increase a client's acceptance of treatment, which, in turn, leads to a greater beneficial impact from the services. Additionally, progress and recovery may fluctuate over time, so that continual

assessment is needed to identify larger patterns over time and recognize the sources of these patterns.

Item L identifies the principle of endorsing a recovery philosophy reflected in a formal mechanism for follow-up care in both areas, with equal focus on both. A recovery-oriented system of care focuses on recovery and the activities that support it, and provides multiple ways of supporting individual recovery in the community. Transition and discharge planning is needed to occur at appropriate times to make arrangements for continuing recovery-management interventions and activities, including crisis plans and recovery management plans. Requiring this recovery focus is necessary because it increases the likelihood that a client is able to sustain progress made through treatment. The requirement to adopt the principle is reasonable because it leaves up to certificate holder management the details of how to provide for a recovery philosophy combined with follow-up care.

It is reasonable and necessary to require a program to accept the principle that full recovery from substance-related and mental disorders is an ideal goal, but further interventions may be needed. This requirement is stated in item M. Requiring the certificate holder to endorse this principle is necessary because the complexity and difficulty inherent in treating this population requires modified expectations for what constitutes treatment success. Harm reduction is an appropriate outcome for some clients. Engagement in continuous, ongoing treatment might be needed to achieve acceptable outcomes for much of the client base.

Item N identifies the principle of recognizing and remaining sensitive to issues related to culture. It is reasonable and necessary to require the adoption of this principle because a program must be competent to welcome and engage clients in ways that convey respect for diversity. It is also important for certificate holders to know how to access information and resources about diversity, and how to provide services in a culturally and linguistically appropriate way. Attention to the importance of diversity is critical to begin to address and reduce the cultural disparities found in health care outcomes generally.

Part 9533.0070. **SCREENING REQUIREMENTS.**

Subpart 1. **Screening required.** The legislation that directed the adoption of this certification rule also directed the commissioner to "require individuals who perform chemical dependency assessments or mental health diagnostic assessments to use screening tools approved by the commissioner" to identify persons with dual disorders. Minnesota Statutes, section 245.4863. The rule requirement carries out this mandate.

In medical care settings, screening is used as a low-cost way to determine whether more costly and invasive diagnostic assessment needs to occur. In the mental health and addiction treatment fields, many standardized instruments are available to help providers establish the need for in-depth assessment for substance use, trauma, depression, victimization, etc... Clients who have mental illness are significantly more likely to have a substance use disorder than individuals

who do not have mental illness. Similarly, clients with substance use disorders are much more likely to have a mental illness than people without substance use disorders. It is important to screen for substance use disorders in mental health settings and for mental illness in substance use treatment settings because the two disorders frequently co-exist for individuals within these treatment settings. Because mental illness and substance use disorders often begin in adolescence, screening for co-occurring disorders is important in this age group.

The screening process for co-occurring disorders seeks to answer a "yes" or "no" question: Does the substance abuse (or mental health) client show signs of a possible mental health (or substance abuse) problem? The answer serves a limited purpose: to determine whether further assessment is warranted. The answer does not identify what kind of problem the person might have, or how serious it might be. Rather, screening with brief, well-validated measures for co-occurring disorders, like screening for any other health problem, is an efficient and cost-effective way to detect the need for further diagnostic assessment.

Subp. 2. **Protocol.** Item A requires the certificate holder to screen clients who are age 12 and older. Most screening measures extend down to age twelve and upwards through adulthood. It is reasonable to require this age range to be screened so that the potential for dual disorders are detected as early as is feasible and throughout the lifespan. Because mental illness and substance use disorder often begin in adolescence, screening for co-occurring disorders is important even in an age group extending to age 12.

Item B requires screening at least annually for each client. It is reasonable to require annual screening unless the exemption conditions are present because this ensures regular monitoring for the presence and development of co-occurring disorders. Unless these co-occurring disorders are identified expeditiously, the possibility exists that ineffective treatment will be provided to a client when a better integrated treatment approach would be more beneficial. It is also reasonable to require annual, repeated screenings because a new disorder may develop at any time in a client's life, so that a client who had not previously been dually-diagnosed may, at any time, manifest dual disorders.

It is reasonable to require that the certificate holder set out in the protocol the screening process it uses because the statute requires the use of a tool that is approved by the commissioner. Minnesota Statutes, section 245.4863. The requirement enables the department to verify that an approved tool is being used that is a valid and reliable process to screen for co-occurring disorders. This is important to ensure that the screening process accurately identifies those with an increased likelihood of co-occurring disorders. It is also reasonable to ask that the screening tool is identified so that the commissioner is aware of which tools are being widely used. This enables the department to disseminate information to the mental health community if there are important changes, updates, or alterations related to the use and nature of a particular tool. In addition,

It is reasonable to require that the certificate holder be prepared to address to address whether or not acute intoxication is an issue, and if so, how it will be addressed. The target population by definition includes persons who have a substance-related use disorder. This group of persons can be expected to include some individuals who are acutely intoxicated. This

possibility must be addressed in advance so that professionals know how to handle this circumstance promptly when it arises. Indeed, due to the fact that some individuals become volatile or hostile when intoxicated or under the influence of drugs, having appropriate plans in place to address it is a matter of health and safety for staff, other program participants, and the client.

It is reasonable to require a protocol stating other specifics about the use of the tool because it is important to know how the instrument is being used in certain settings. The department seeks through these requirements to ensure that the screening tool is used in accordance with its manual and purpose, and that the procedures used are documented by the provider. It is reasonable to require documentation of the information because having a written protocol regarding the use of a tool is believed to increase fidelity and adherence to the intended use of the tool. It is also important to have this information documented so that if future anomalies begin to appear with regularity from a particular site or in a certain population, the protocol is known and can be produced and examined for causes.

It is reasonable to require a protocol to describe how the certificate holder documents screening results, actions taken in response to results, and whether assessments are performed because this information is important to ensure that appropriate and consistent procedures are being followed, and that subsequent assessment occurs when warranted. It also ensures that accurate and consistent records are kept about the routine, day-to-day implementation of those procedures. The requirement also serves the purpose of ensuring data collection about screen results in the aggregate. The department will use this information to derive statistics, generate reports, and collect data for correctly- identified factors. Such information is valuable to help evaluate how well the state is performing in its approach to co-occurring disorders.

Part 9533.0080 **DIAGNOSES.**

This part requires the certificate holder to make a preliminary determination and document whether the client has a co-occurring mental illness and substance-related disorder. It is necessary and reasonable to require this preliminary determination because only if an individual is identified as a person with co-occurring disorders is it necessary to continue with further assessment of the client's treatment needs, and to evaluate whether an IDDT program is best-suited to meet those needs.

The rule requirement is reasonable because it permits the certificate holder to obtain the client's diagnoses in one of two ways. One method is to simply perform a diagnostic assessment according to the requirements of part 9505.0372, subpart 1. That part sets forth the requirements that a diagnostic assessment must meet in order to be eligible for reimbursement under the Medical Assistance program. It is reasonable to incorporate provisions of other departmental rules by reference because consistency between rules promotes understanding of requirements and compliance. It is necessary to require that the diagnostic assessment meet a set of minimum requirements to ensure an accurate diagnosis that is consistent with current professional standards in the field of mental health. The Minnesota Comprehensive Adult Mental Health Act requires the department to ensure a system of mental health that provides quality of service

consistent with current professional standards. Minnesota Statutes, section 245.461, subdivision 2, paragraph 6.

The rule also permits the certificate holder to obtain the client's diagnoses based on a previous diagnosis, when the previous diagnoses were made by the referral source, according to the DSM, and within the past six months, and no significant changes in condition have occurred. This alternative is meant to address the situation in which one treatment setting determines that an individual has co-occurring disorders, and therefore refers the individual for treatment to a certified IDDT program. When this is the case, and the individual has current diagnoses, it would not be a good use of resources to complete another diagnostic assessment. The Adult Mental Health Act also requires the department to ensure mental health services that are effective and efficient. Minnesota Statutes, section 245.461, subdivision 2, paragraph 6.

It is reasonable to include requirements that ensure the previously-made diagnosis remains accurate and current. The rule requires that the diagnostic assessment be completed within the previous six months, and that no significant changes have occurred. These requirements seek to avoid the use of a diagnosis that has become outdated, or is no longer accurate due to a change in the client's status.

Part 9533.0090 **INTEGRATED ASSESSMENT.**

Subpart 1. **Integrated assessment required.** Subpart 1 requires that staff prepare an integrated assessment if a preliminary determination has been made that the client has co-occurring disorders. It is reasonable and necessary to require an integrated assessment because an integrated assessment is part of the protocol for evidence-based integrated treatment services. Integrated assessment is critical to understanding the interactions between mental illness and substance abuse. Substance abuse worsens the outcomes of severe mental illness; yet clients often continue using substances for other reasons related to their mental illness, such as coping with symptoms, or increasing social contact or acceptance. Identifying how substance abuse and mental illness interact can lead to treatment plans that specifically address these areas. The integrated assessment may be the first time that such a broad review of the factors in the individual's life, including the interaction of the two disorders, has been done.

The integrated assessment must include, first, the elements of a diagnostic assessment under part 9505.0372, subpart 1; and second, the elements of a comprehensive assessment under part 9530.6422, subpart 1. Part 9505.0372, subpart 1 sets forth the requirements for reimbursement of a mental health diagnostic assessment by a public Minnesota health care plan. The diagnostic assessment requires that a mental health diagnosis be identified, and mental health services recommended. In a traditional, "service as usual" setting, this assessment provides the factual basis to develop the client's mental health services and treatment plan. Part 9505.0372, subpart 1, item A.

The key underpinnings of integrated treatment are a thorough evaluation of both the mental health and substance use disorders, to arrive at how the two interact. Because the diagnostic assessment lays the foundation for mental health treatment services, it is necessary to require that it be a component of the integrated assessment. The requirement is reasonable

because it leaves up to the clinical judgment of the mental health professional whether the standard diagnostic assessment, extended diagnostic assessment, or brief diagnostic assessment is most appropriate for the client.

Rule 31 sets forth the requirements for a chemical dependency treatment program to perform a comprehensive assessment of a client's substance use disorder at the outset of treatment. The assessment thoroughly addresses "information about the client's problems that relate to chemical use and personal strengths that support recovery." Part 9530.6422, subpart 1. This includes details of the chemical use history, including frequency and duration of chemical use, amounts and types of chemicals used, periods of abstinence, and circumstances of relapse. For the same reason that a thorough evaluation of the mental health disorder is required, it is also necessary to require a thorough evaluation of the substance use disorder. It comprises a major part of the complete picture for a dually-diagnosed individual.

The department considered, but rejected, relying solely on the diagnostic assessment requirement that information about the history of alcohol and drug use, and treatment, be included. Part 9505.0372, subpart 1, item B, subitem (2), unit (f). This information is not comprehensive enough to gain a complete picture of the client's substance use disorder for persons who are dually-diagnosed. Further, such an approach would perpetuate the traditional paradigm that mental health issues are the primary focus, and substance use issues are secondary. In integrated treatment, the focus is on both, and the interactions between the disorders.

The department planfully selected the word "information" in the rule requirement, and not domains or elements. By this word choice, the rule conveys that, when information required in the diagnostic assessment overlaps with the same information required in the comprehensive assessment, the information need not be obtained twice (i.e., once in the course of each assessment).

Subpart 2. **Timing.** Subpart 2 creates two standards for the timing of the integrated assessment. For residential programs, the integrated assessment must be completed no more than 10 days after admission. For outpatient programs, the integrated assessment must be completed within the first three client sessions. There is an inherent tension between desiring that an assessment be done quickly enough so that value can be derived early in the process, and providing staff with sufficient time to do a thorough and complete assessment. The department considered its experience with various timeframes required in other residential and outpatient programs, as well as input from stakeholders about these timeframes. In a chemical dependency treatment program, for example, the comprehensive assessment is required in 3 days for a residential program, and 3 sessions for an outpatient program.

The department views the integrated assessment as a high priority because the information collected is used to identify the client's needs and issues. The goal is to evaluate numerous factors, including not only problem areas for the client, but also cultural, strengths-based factors, life experience factors, and other information. The assessment may represent the first time such a broad analysis of the client's overall circumstances has been performed. As a result, the department struck a balance between having adequate time to perform a broad and meaningful assessment and analysis, and the conflicting need to have the assessment completed

quickly so that it can be of value early in the process. The department believes the appropriate balance is to permit ten days to complete the integrated assessment in a residential setting (i.e., seven days longer than is the case for a standard assessment), and three sessions for an outpatient program.

This subpart also requires that a new integrated assessment be completed for a child client every six months. This is to ensure that the integrated assessment reflects the client's current mental health status and service needs even as changes occur. Children tend to change more rapidly than adults due to their development toward becoming an adult. This explains the duration of only six months between assessments. The counterpart to this requirement, for adults, is that adult integrated assessments be *updated* annually, according to subpart 6. Rather than merely requiring that a child's integrated assessment be updated every six months, the Department chose to require a new assessment for children every six months. Again, this is due to the dynamic nature of a child's mental health and service needs over time. It makes sense to comprehensively address all the information in the integrated assessment every six months. A new assessment is the best way to achieve this comprehensive review. In addition, the requirement comports with the payment scheme under Medical Assistance. MA does not cover updates to a diagnostic assessment for children, as it does for adults. See Minnesota Rules, part 9505.0372, subpart 1, item E (covered services include an adult diagnostic assessment update). Because the diagnostic assessment in traditional treatment corresponds most closely with the integrated assessment in IDDT, one can probably anticipate that the payment structures will match.

Subpart 3. **Supplemental information.** Subpart 3 states the supplemental information that must be included in the integrated assessment, in addition to the information obtained through the diagnostic assessment and the comprehensive assessment of the substance use disorder required under subpart 1.

It is necessary to require a level of care assessment because the assessment matches the client's needs and symptom acuity with the appropriate intensity of resources. For example, IDDT services are available in both inpatient and outpatient settings, and the level of care assessment shows which of these settings is more appropriate to address the client's immediate needs. The rule requirement is reasonable because it requires an assessment only if the assessment has not been performed in the previous thirty days. This permits the provider the flexibility to use professional judgment about whether a new assessment is needed when an existing assessment might be entirely consistent with the client's current needs.

Item B requires a longitudinal review of the interaction between the client's substance use and psychiatric symptoms, and its consequences for the client in three specific areas: health, relationships, and emotional functioning. A longitudinal review establishes the development and course of the disorders. It shows the client's functioning across a lifespan, which can reveal both the chronicity of the disorders as well as whether treatment is successful. Furthermore, research has shown that treatment outcomes for dual disorders are gradual, so that the benefits of integrated treatment are not dramatic over short periods of time. Rather, the benefits tend to show up through a long-term perspective. Because the longitudinal review can provide insight

that is only gained through a long-term view, it is necessary and reasonable to require this review.

It is necessary and reasonable to require the longitudinal review to include the consequences of the intertwined disorders and effects on the client's health, relationships, and emotional functioning because these are three primary and distinct spheres of the client's life that can be dramatically impacted. Addressing the impact on these three spheres with the client gives both the mental health professional and the client a deeper appreciation for the long-term consequences of the interaction of the disorders, as it relates to different and critical aspects of one's life.

Item C requires an assessment of a client's stage of treatment and motivation for change. It is necessary to require an assessment of both factors because current research shows that treatment procedures and techniques matched to a client's stage of treatment and stage of change are more likely to be beneficial and help a client make progress than interventions that are not matched. As explained below, these two assessments yield valuable information about the client's stage that informs and guides the client's treatment. It is reasonable and necessary to require these assessments because it enhances the likelihood that treatment will be effective and result in positive outcomes for the client.

Research shows that when the treatment professional identifies which of four specific, identifiable phases of treatment the client is in, the professional can better address the client's particular needs at that phase. The most important feature of a stage of treatment assessment is that the stage of treatment provides a model for clinicians to identify appropriate goals and strategies at different points throughout the recovery process. For example, during the engagement phase, the clinician needs to focus on building a trusting working alliance between the clinician and the client. At the persuasion phase, the treatment professional helps to engage the client to develop the motivation to participate in recovery-oriented interventions.

Assessment of the client's motivation for change is closely related to the stage of treatment assessment. Attending to each client's motivation for change ensures that interventions are appropriate to the client's current motivational state, and avoids the negative effects of prematurely attempting to change behavior before the client is ready. For example, if the clinician skips to the persuasion phase before a therapeutic alliance has been built, the client may be inadvertently driven away from treatment.

Item D requires documentation of a client's relevant strengths and indication of how these may be useful during treatment. It is necessary to require an evaluation of a client's strengths because the individual strengths of the client are an additional resource on which to draw during treatment to enhance the likelihood of client progress and reaping the benefits of treatment. It is necessary to require the provider to document consideration of the client's strengths so the commissioner can verify compliance with the requirement.

Item E requires the certificate holder to obtain information from collateral sources about the client when these are available. Collateral sources can provide valuable information that would otherwise be overlooked. It may be that a client does not have adequate self-knowledge to be aware of the information; or it may be that the client is reluctant to disclose the information. These sources of information provide an avenue for the treatment professional to evaluate the accuracy, veracity, and completeness of information supplied by the client, which helps the professional tailor treatment to the client's individual needs. Such sources of information could be family members, a landlord, a probation officer, or hospital staff. Accessing these additional sources of information is a widely-accepted practice in the field and is consistent with current norms.

Subpart 4. **Integrated assessment summary**. Subpart 4 requires the certificate holder to use the comprehensive information gathered during the assessment to culminate in an integrated assessment summary. Collection of data about the client and the various analyses performed in the integrated assessment does not yield its maximum value unless the information is viewed as a whole and complete picture. One of the core principles of integrated treatment is the importance of examining all factors relating to a client's symptoms and treatment wholistically. This is the optimal approach to identify the interaction between the two disorders. For these reasons, it is reasonable to require that the certificate holder prepare an integrated assessment summary. It is necessary to require the summary because the summary provides a concise snapshot of client information to facilitate the creation of a single integrated treatment plan that addresses both disorders.

Items A and B both require information about the interaction of the co-occurring disorders in the integrated treatment summary. Item A requires a case conceptualization that identifies antecedents, responses toward, and consequences of symptoms and maladaptive behaviors of both disorders, and their interaction across key areas of a client's life functions. Item B requires a description of how the client's symptoms and behaviors associated with one disorder affect or impact the expression of symptoms and severity of the other disorder. These rule requirements are necessary because it is the analyses of the interaction between the two disorders that makes integrated treatment unique, and enables more finely-tuned treatment planning and interventions. It is reasonable and necessary to require this information in the integrated assessment summary to facilitate verification that the certificate holder considered these factors.

The case conceptualization requirement provides a framework for combining information obtained in the assessment into a format that is useful in treatment planning. The requirement that the case conceptualization describe the interplay between symptoms and maladaptive behaviors of the two disorders ensures that the case conceptualization is comprehensive and based on the client's specific comorbidities, and how these play out in the client's life. These detailed analyses facilitate treatment planning and a later ability to judge the success of treatment interventions.

Item C requires the treating professional to describe the situational factors in which the client's substance use behavior does and does not occur. This is an important part of dual-disorder treatment because, in addition to the client's internal state, it is critical to also address the external conditions that lead to poorer outcomes for the client. The information aids in identifying modalities of treatment that may be most effective. For example, if the individual slips into substance-using behavior when he or she is with their ordinary network of social contacts, then this information points toward treatment interventions that assist the client in developing skills and information needed to develop new social networks, such as group skills work.

Item D requires a description of the client's domains of behavior and symptoms that have been most challenging to recovery, or have led to crises. This requirement is reasonable because studies have shown treatment participation is better when crises and challenging behaviors are reduced. Another reason to identify these variables is to increase the client's awareness of risk factors, which helps the client begin to identify and use measures to counteract behaviors that have previously led to crises.

Item E requires a description of the factors that contribute to the client's stability and relapse for both disorders, and how the interaction of the disorders affects stability and ability to benefit from treatment. It is necessary to require this description so the treatment program can address the client's experience of unpredictability in his or her life. By identifying and addressing the variables most likely to be in play at times of relapse, the treatment professional can help the client better anticipate risk factors for relapse, and build or restore a sense of predictability and control for the client.

It is reasonable to require an analysis of how the interaction of the disorders affects stability and treatment outcomes because the interaction often complicates treatment, and treatment outcomes. Documenting information about how the effects of one of the client's disorders may worsen the symptoms of the other disorder, or interfere with beneficial treatment outcomes, requires an in-depth analysis that later helps the treatment professional select optimal treatment options during treatment planning.

Item F requires consideration of referral for pharmacological treatment. The certificate holder is required to have a prescribing provider as part of the multidisciplinary treatment team, and it is reasonable to draw upon the expertise of this individual. Abundant research shows that psychotropic medications are beneficial to reduce both symptom severity and relapse in clients with severe mental illness. The use of antipsychotic, antidepressant, and mood-stabilizing medications continue to be primary modes of treating severe mental illness, and, for some conditions or symptoms, remain the best alternative available. Clients with dual disorders, including those with active substance abuse, therefore need to have access to pharmacological treatments for their mental illness. In addition, clients with dual disorders may benefit from trials or use of medications that have been shown to decrease substance abuse.

Item G requires a preliminary treatment plan in the integrated assessment summary. It is reasonable and necessary to require a preliminary treatment plan because the initial treatment plan sets the stage for treatment, at an earlier stage than might otherwise occur absent this requirement. By providing an early analysis of treatment options, more finely-tuned treatment planning can occur in the next step.

Research has shown that treatment plans that match a client's stage of treatment, motivation for change, and strengths are more likely to be productive when treating a client with dual-disorders. To treat co-occurring disorders most effectively, interventions must be motivation-based – that is, adapted to meet a clients' motivation for change. Motivation for change is described as a set of stages, namely: precontemplation, contemplation, preparation, action and maintenance. Stages of treatment describe a series of four stages that clients who recover from co-occurring disorders typically progress through: engagement, persuasion, active treatment and relapse prevention. The concepts of stages of treatment correspond closely to the client's motivational states. Assessing motivational state and stage of treatment facilitate the treatment professional's ability to understand the client's goals, and, in turn, identify appropriate treatment interventions to achieve those goals.

Subpart 5. Post-assessment determination about program suitability. It is reasonable and necessary to require the certificate holder to determine through an analysis of the assessment results and conclusions whether the treatment and resources available from IDDT services are likely to benefit the individual presenting for assessment and treatment. The assessment places much information in the hands of the provider, who is in the best position to confirm the suitability of IDDT services for the individual at this step. Although a preliminary determination that the individual has co-occurring disorders has been made prior to this stage, this is the point at which the provider consolidates knowledge of the client's needs in light of the resources and practices available in IDDT to decide if IDDT services are appropriate for the client.

The provider's determination of whether IDDT services are best suited to the client's needs is an important evaluation for another reason. Both public and private health care payors base reimbursement decisions on whether the care is medically necessary. The provider's determination about the suitability of IDDT services for the person has a bearing on the payor's decision in this regard. It is reasonable to require the provider to make this determination because if the services will not benefit the client, then the services will not be cost-effective. It is reasonable to require documentation of this determination so that the commissioner can verify compliance.

If IDDT services are not appropriate, then it is reasonable to require the certificate holder to refer the individual to another program more suited to his or her needs. Ultimately, the provider is responsible for understanding alternative treatment options for persons needing a different level of care, or an alternative treatment approach. It is therefore reasonable to require the provider to help the client connect with an appropriate program, resource, or treatment option, rather than leaving it solely up to the client. The client does not have the same breadth of knowledge as the provider; and, in light of the population being served, some clients might be at risk of being in a vulnerable stage and therefore require assistance. This is also a population that

has a higher likelihood of some clients not engaging easily with the health care system, further reinforcing the need to help the client appropriately maneuver through the system.

Subpart 6. Integrated assessment updates. It is reasonable and necessary to require updates to the adult integrated assessment annually to ensure that the document reflects current mental health status and service needs. It is similarly reasonable to require that the document be updated when a significant change occurs so that the document remains current and correctly influences treatment to meet the client's current needs. This requirement is also contained in the Minnesota Comprehensive Adult Mental Health Act for the diagnostic assessment, which is the closest counterpart in traditional mental health treatment to the integrated assessment in IDDT. See Minnesota Statutes, section 245.467, subdivision 2. It is reasonable to require that the certificate holder document a written update where changes have occurred, and document the fact that no changes have occurred when that is the case. This ensures that all areas were addressed for potential changes by the mental health professional, and enables the commissioner to verify that fact based on the documentation.

Part 9533.0100 **INTEGRATED TREATMENT PLAN.**

Item A requires the certificate holder to adopt a protocol that requires completion of an integrated treatment plan 14 days after completion of the integrated assessment for residential treatment, and 30 days afterward for outpatient treatment. It is reasonable to require prompt completion of an integrated treatment plan because the plan directs and guides treatment based on the client's needs identified in the integrated assessment. Its completion is needed for planful treatment to proceed. It is reasonable to have separate standards for inpatient and outpatient programs because the intensity of services in an inpatient program requires that action be taken more quickly.

Item B requires the creation of a treatment plan based on information obtained during assessment that contains a set of actions to be followed by the treatment team. The integration of treatment for a substance-related disorder and mental illness is a foundational element of integrated services. The IDDT research demonstrates that individuals benefit from both disorders being addressed at the same time, within one treatment plan, with one or more qualified persons delivering the treatment for both disorders simultaneously. It is necessary and reasonable to require an integrated treatment plan to maintain fidelity to these evidence-based practices and achieve better outcomes for persons with co-occurring disorders.

Item C requires the certificate holder to adopt a protocol, which requires updates to the integrated treatment plan every 30 days to reflect the client's individual needs. It is necessary for the certified program to have procedures in place that address the frequency of client progress reviews. A treatment plan cannot be implemented without regular, periodic review, with revisions made based on the success or failure of various treatment components. Thirty days is a reasonable period of time because the client's individual needs and focus can change from month to month, so monthly review enhances the likelihood that important changes will be promptly noted.

It is reasonable to require that the treatment professional's review and updates be based on the client's stage of treatment and stage of change. These stages are reflective of the client's subjective state, so that treatment goals and interventions can be designed to address the client's current state. The stage of treatment influences the choice of treatment modalities. For example, a social skills group can help the client if the current goal is to develop new social outlets with non-substance-using peers, whereas cognitive-behavioral therapy can help the client if a primary concern is to manage cravings in high-risk situations. Review of the stage of change and stage of treatment facilitates a thorough analysis of the treatment plan in light of the client's evolving needs to keep the treatment plan current.

Part 9533.0110 **STAFFING REQUIREMENTS.**

Subpart 1. **Multidisciplinary team.** Clients with dual disorders, and likewise those with severe mental illness, typically have a wide range of different treatment and living needs. A single or even a very small group of clinicians typically cannot meet all of these needs. A team-based approach has been found to be the best approach to meet all of these needs, and has therefore become the recommended organizational model for treating those with dual disorders, and the dominant model for treating those with severe mental illness. Research has shown that dual disorder treatment teams are most effective when they directly provide as many clinical services as possible, and avoid brokering services to other providers who are not team members. For these reasons, it is necessary and reasonable to require a multidisciplinary team, particularly in light of the target population of those with acute and chronic mental illness.

It is necessary and reasonable to require individuals to be employed by the provider, as a protection for those being served. This requirement gives limited assurance to clients that the agency has followed general employer responsibility in confirming the mental health professionals' educational credentials and work history, and completing necessary background checks. It also serves as a monitoring responsibility for the certificate holder because the certificate holder is legally responsible and liable for the actions of these professionals.

Item A requires a prescribing provider. Psychopharmacological treatment plays an important role in the treatment of clients with dual disorders. Treatment with medicine remains a primary mode of treatment for the severe mental illness, such as schizophrenia, bipolar disorder, and major depression. The use of medicine is also gaining ground and support in the literature based on having beneficial effects for substance users. For these reasons, it is important to have a prescribing provider on the multi-disciplinary team. The prescribing provider's work needs to be in integrated with that of the team, rather than provided separately and independently from the client's IDDT treatment. As addressed previously, the presence of dual disorders presents additional challenges to psychopharmacological treatment. The prescribing physician who is part of an IDDT multi-disciplinary team gains and applies expertise in dealing with these challenges.

A licensed psychiatrist is the traditional model to prescribe psychotropic medications for persons with mental illness. As licensed medical doctors, psychiatrists have authority to prescribe medicine typically used in the treatment of substance-related disorders. The requirement that the physician be licensed in Minnesota ensures oversight of the physician's medical practice by a responsible regulatory body. This requirement is necessary and reasonable for the protection of clients.

The rule requires the psychiatrist to be certified by the American Board of Psychiatry and Neurology (ABPN), or eligible for certification. The ABPN is a member board of the American Board of Medical Specialties; it evaluates a physician's competencies in psychiatry through board examination. Certification demonstrates that the individual possesses current scientific knowledge and clinical expertise. Although the ABPN, in accordance with policy of the American Medical Board of Specialties, does not issue statements about whether an individual is eligible for certification, "[t]he Board informs an applicant of admissibility to examination only when the applicant has an active, approved application on file in the Board office." (ABPN web site, Frequently Asked Questions.) Proof of admissibility to examination amounts to eligibility for certification because it demonstrates that the experiential and credential prerequisites have been met.

The requirement for certification in psychiatry or eligibility for same is consistent with Minnesota policy. Both the Adult and Children's Minnesota Comprehensive Mental Health Acts require a psychiatrist to be board certified or eligible for certification in psychiatry to fulfill the role of a mental health professional. Minnesota Statutes, sections 245.462, subdivision 18 (adult act), and 245.4871, subdivision 27 (children's act). It is reasonable and necessary to establish consistency between applicable statutes and rule.

There are efforts underway in Minnesota to improve the capabilities of primary care physicians in treating adults who have a mental illness, and to explore funding strategies to enhance greater collaboration and consultation between mental health and primary care providers. Specifically, due in large part to the current and future shortage of psychiatrists in the state, and the data (both national and Minnesota) that indicate that many persons who have a mental illness seek treatment from their primary care physicians (U.S. Department of Health and Human Services, 2004 Report to Secretary), the Integrated Behavioral Health Care Coalition was formed. This group is comprised of primary care physicians, psychiatrists,, health plan representatives, the University of Minnesota School of Medicine, Minnesota Department of Health and the department to expand the competencies of primary physicians to treat mental illness.

In keeping with this state-wide effort and the funding for it, the rule permits a primary care physician to meet the requirement of a prescribing provider on the multidisciplinary team if

the provider acts in consultation with a psychiatrist. The requirement is reasonable because it permits greater flexibility in light of the shortage of psychiatrists to fulfill the role of prescriber of psychotropic medicines. The requirement is a cost-effective approach.

It is necessary to require consultation with a psychiatrist because a psychiatrist has the specialized knowledge about appropriate medication options for person who are dually-diagnosed, and can guide the decisions of a primary care physician. In persons with dual disorders, this is especially important. There may be impacts from the use of a habitual drug of choice on psychotropic medication. In addition, a psychiatrist has the knowledge to be able to prescribe medicine that will not be habit-forming. A psychiatrist has a broader knowledge base to prescribe medicine that is best-suited to a client's needs, which may therefore result in more successful treatment outcomes. This approach protects clients served by the primary care physician because it ensures that the element of psychiatric expertise is present in the prescription of drugs.

The rule permits a psychiatric nurse with prescribing authority to meet the requirement for a prescribing provider on the multidisciplinary team. This, too, is a reasonable and cost-effective measure, particularly in light of the shortage of psychiatrists. It is necessary to require the nurse to meet the statutory requirements under the Adult Mental Health Act because the ability to meet these requirements, including licensure, serves as a protection to clients.

Item B requires the team to include an integrated treatment team leader who meets either of two possible sets of professional credentials. The first set is comprised of selected elements from part 9505.0371, subpart 5, item D, which establishes the requirements that pertain to a clinical supervisor for the purpose of Medical Assistance reimbursement for mental health clinical supervision. The second possible set of professional credentials come from part 9530.6450, subpart 4, which sets forth the requirements to serve as a supervisor of addiction counselors in a chemical dependency treatment program. Thus, the Department seeks to draw from existing supervisors in either the mental health treatment or chemical dependency treatment setting – and make either set of credentials equally amenable to qualifying the person as the integrated treatement team leader.

The rule requirement is reasonable because it leaves up to the provider a determination of which set of requirements is best suited to the particular treatment setting. The requirement generally reflects comments from the rule advisory group members who are chemical dependency providers that they wish to be an equal partner in bringing about the transformation of services and systems needed to deliver effective integrated treatment. Thus, a decision was made that supervisor from either discipline should be able to serve as the integrated treatment team supervisor.

The Department deliberately used the word "leader," rather than "supervisor." This is to avoid confusion between the role of the integrated treatment team leader, and mental health clinical supervision. The distinction is important because an integrated treatment team leader is not necessarily qualified to provide mental health clinical supervision. He or she would not be able to do so if the integrated treatment team leader qualifies for the role on the basis of the leader's background supervising licensed alcohol and drug counselors. Nothing prohibits an individual who is a mental health clinical supervisor, of course, from fulfilling both the clinical supervision functions and the role of the integrated treatment team leader.

For purposes of identifying team leadership requirements, the Department relied on the DDCAT and DDCMHT. The Department believes that the scoring benchmark to meet in these instruments is the one that reflects the most advanced level of integration of services. Each program element of the DDCAT and DDCMHT is rated on a one to five scale. A score of 1 means that the program is not integrated; in other words, the program is focused on providing services to persons in one, or the other, of the two treatment fields, depending on whether the organizational setting is one for chemical dependency, or mental health (the "foundational field"). A score of 3 indicates a program that is capable of providing services to some individuals with co-occurring substance use and mental health disorders, but has greater capacity to serve individuals in the foundational field. This level is referred to as being Dual Diagnosis Capable. A score of 5 designates a program that is capable of providing services to any individual with co-occurring substance use and mental health disorders, and the program can address both types of disorders fully and equally. This level is referred to as being Dual Diagnosis Enhanced. Scores of 2 and 4 are reflective of intermediary levels between these standards.

To establish rule standards, the Department relied the practice that the DDCAT and DDCMHT associate with a score of level 5, Dual Diagnosis Enhanced. The Department's rationale is that the target population requires this level of capability. As set forth in part 9533.0040, the target population is persons with a substance-related disorder, and any of a specified major mental illness, including schizophrenia, schizoaffective disorder, or a major mood disorder, including major depressive disorder and bipolar disorder; or, for a child, an emotional disturbance or severe emotional disturbance. Alternatively, a person with co-occurring disorders and consequent impaired role functioning are in the target population. These are serious disorders that significantly complicate treatment. Only a program rated as Dual Diagnosis Enhanced could meet the relatively intensive demands of this population.

With respect to integrated treatment team leadership, the DDCAT and the DDCMHT measure an organization's ability to provide access to formal supervision in mental health (for substance abuse programs) or access to formal supervision in substance use (for mental health programs). The Dual Diagnosis Enhanced benchmark requires that the organization provides

routine, on-site supervision in the non-foundational field, which demonstrates a focus on in-depth learning. When the Department chose to require an integrated treatment team leader, it was with these benchmarks in mind. Having a treatment team leader on the multidisciplinary team provides the championing of integrated treatment philosophies and day-to-day practices that is needed at a grass-roots level to effectively implement IDDT, and train staff appropriately. The requirement captures access to supervisory expertise in the non-foundational field that is reflected in the DDCAT and DDCMHT measures.

The other requirement for the integrated treatment team supervisor is either a credential from a nationally recognized certification body approved by the commissioner, or approval by the commissioner's designated representative based on knowledge of both disorders and the complexity of interactions between them, as well as skills found to be effective in treating persons with dual diagnoses. It is reasonable to require the professional who has the greatest knowledge about IDDT services to supervise those who are still learning about this treatment model. The qualified integrated treatment supervisor has developed expertise in IDDT and can supervise and train other professionals in day-to-day practice, and promote collaboration between the two treatment fields to promote integrated treatment. The individual can develop core competencies among staff; and can share the philosophical dimensions of integrated treatment, such as harm reduction to reduce harmful effects of substance abuse without judging or imposing moral values on recipients.

The reference to a nationally recognized certification body approved by the commissioner is necessary and reasonable because integrated treatment is a rapidly developing field, so that new designations from professional organizations are being initiated, and existing designations are evolving. There are several certifications that could potentially demonstrate competency, including the Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders, which is available through the American Psychological Association; and the American Society of Addiction Medicine certification, which is available to physicians. Also available are the Certified Co-Occurring Disorders Professional or Certified Co-Occurring Disorders Diplomate, both available through the International Certification and Reciprocity Consortium. The department is in the process of evaluating the requirements for these certifications. The department desires sufficient rigor in training and credentialing that a certification from the body meaningfully conveys a degree of knowledge and skills in the field.

The requirement is reasonable because it also provides another avenue to receive an appropriate credential, that being through the approval of the commissioner's designee. The department has entered into a contract with a group of professionals who have expertise in IDDT, to develop a "Center of Excellence." The department has identified a set of core competencies needed to deliver IDDT in accordance with best practices. The Center will evaluate the knowledge and skills of practitioners in IDDT fundamentals. A primary objective is

to grant an avenue for approval based on knowledge gained through experience in IDDT, rather than limiting the ability to show knowledge to academic training. Thus, it is the department's hope that persons who gained experience in IDDT by participating as a pilot site in the COSIG project, or those who have been otherwise delivering IDDT services in Minnesota, can demonstrate knowledge and skills obtained to receive approval. The Center will also act as a sort of IDDT career counseling service because it will guide an individual to training to fill any gaps in knowledge, so that the person can achieve approval by taking a limited amount of focused, additional training.

Item C requires a mental health professional to be on the multidisciplinary team. It is reasonable and necessary to require a mental health professional because a mental health professional is qualified to provide clinical services in the diagnosis and treatment of mental illness. Mental health treatment is a major component of IDDT. The DDCAT Level 5 standard requires that more than half of clinical staff have either a license in a mental health profession, or substantial experience sufficient to establish competence in mental health treatment. The rule is reasonable and necessary because it permits individuals having any of several different types of licenses in the mental health field to meet the requirement. The list of acceptable licenses conforms closely to the list of licenses that qualify an individual as a mental health professional under the Adult Mental Health Act, and the Children's Mental Health Act, respectively, at sections 245.462, subdivision 18 and 245.4871, subdivision 27. The differences are: the greater latitude permitted for a psychiatrist, for the reasons explained above for item A; the addition of a tribally-approved mental health professional, for the reasons explained below; and, for the allied fields credential, limiting the applicability of this credential to rehabilitative services, as also explained below.

One might ask why the psychiatrist is again listed here as a member of the multidisciplinary team, when a psychiatrist or prescribing provider is already required under item A. This is due to subpart 2, item B, which permits one individual on the multidisciplinary team to fulfill more than one of the required functional roles if they meet the credentials for more than one role. Accordingly, because a psychiatrist can be a mental health professional, a psychiatrist could fulfill the requirements for both a prescribing provider, and a mental health professional.

The addition of a tribally-approved mental health professional to the list of qualified individuals to meet the requirement for a mental health professional is necessary as Tribal governments take on the responsibility for mental health services. Each tribal government has authority to administer and operate their own health care. See Indian Self-Determination and Education Assistance Act (P.L. 96-638)(giving tribes the authority to administer and operate their own health services and programs within their communities); Indian Health Care Improvement Act (P.L. 94-437)(encouraging tribes' fullest participation in planning and managing their health services). Increasingly, American Indian tribal governments are interested

in becoming providers of mental health services funded through federal Medicaid. This can be expected to increase the number of tribally-approved mental health professionals. With this trend, and federal and state public policy favoring Indian participation in managing their health services, it is necessary and reasonable to provide for a tribally-approved mental health professional to meet the requirements of a mental health professional. This facilitates the ability of a tribal program to obtain IDDT certification, as well as permitting greater flexibility for experienced American Indian mental health professionals to serve in a multidisciplinary IDDT team of a non-tribal provider.

Subitem 8 adds an additional class of persons who can fulfill the mental health professional requirement, but only for certified adult rehabilitative mental health services programs. Rehabilitative mental health services "enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness." Minnesota Statutes, section 256B.0623, subdivision 2, paragraph (a). The additional class of persons is described in clause (7) of the statutory definition of mental health professional under the Minnesota Comprehensive Adult Mental Health Act are added. See Minnesota Statutes, section 245.462, subdivision 18. The statute governing the rehabilitative programs permits this class of persons to fill the role of mental health professional in appropriate circumstances. It requires that individual provider staff be qualified in one of several possible ways, including the following:

> [As a] mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, *the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7),* and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

Minnesota Statutes, section 256B.0623, subdivision 5, paragraph 1. Thus, because the governing statute permits a broader class of persons to fulfill the role of mental health professional for these services, the rule also permits it.

Item D requires a care coordinator on the multidisciplinary team. This requirement is necessary and reasonable because having case managers who understand and appropriately apply the treatment principles of IDDT, such as stage-wise case management and motivational

interviewing, is a critical component of an integrated treatment system.[6] Further, it can be practical to include one or more case managers experienced in treating severe mental illness and one or more case managers experienced in treating addictions, so that these case managers' expertise in treating dual disorders will grow as a function of shared training and treatment experiences. The rule requirement is reasonable in that it only requires a minimum of one case manager, who can have expertise in treating either mental health or addiction disorders.

Item E requires a licensed alcohol and drug abuse counselor under Minnesota Statutes, chapter 148F. The LADC brings specialized training and knowledge in addiction treatment to the team. The LADC has specialized training in addiction treatment and relapse prevention. Ideally, the LADC might also have knowledge and skills gained from experience in treating addictions – but this is not required. The LADC can share his or her expertise with other members of the team whose primary area of focus has been mental health, with the expectation that the mental health workers' ability to treat dual disorders will grow as a function of acquiring knowledge and expertise from the LADC, and sharing training and treatment experiences with him or her.

The licensure requirement is necessary and reasonable because the Board of Behavioral Health ensures that such counselors are able to pass a background check, pass a substantive exam, and meet other credentialing standards. The requirement is necessary to protect a population that may be likely to include some vulnerable persons.

The requirement to have an LADC on the team is also reasonable. The rule permits the same alternative to hiring an LADC that is permitted under Rule 31 namely, a mental health professional who meets certain training, educational and experiential requirements in the substance abuse treatment field. This alternative has worked well in Rule 31, and provides an acceptable alternative because of the rigorous requirements to ensure specialized knowledge in the chemical dependency field.

Item F requires either a certified peer specialist, or a recovery coach who holds a certified credential approved by the commissioner. The effective date for this requirement is not until July 1, 2016. The requirement reflects the growing attention being focused on expanding mental health staffing patterns to include psychiatric consumers as providers. This approach reduces alienation and feelings of stigmatization that can follow a psychiatric diagnosis. It is also a less intensive use of scarce mental health resources because it does not require extended periods of time devoted by highly-trained psychologists or other highly-trained professionals. The Centers for Medicare and Medicaid Services recognize peer support providers as a distinct provider type in the delivery of support services, and considers the approach to be an evidence-based mental

[6] Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. *Integrated Treatment for Dual Disorders: A Guide to Effective Practice.* New York: Guilford Publications (2003).

health practice. It has been a growth area since the 1990s, and is now quickly gaining more widespread acceptance.

In 2007, the Minnesota legislature followed other states who had received approval for Medicaid coverage of certified peer specialists. The new law directed the department to establish a Medicaid-covered role for certified peer specialists. Minnesota has now joined 26 other states with covered peer support services. To become certified, an individual must meet certain criteria, complete departmental training, and pass a certification exam. There are presently well over a hundred certified peer specialists in Minnesota.

Another modality for providing peer support, recovery coaching, is also gaining more frequent use. In the Twin Cities area, the most active organization engaging in recovery coaching is Minnesota Connections. This organization enlists individuals who have experience with addiction recovery, either personally or through a close family member, to provide peer coaching to others recovering from substance-related disorders. Various national organizations currently have efforts underway to offer credentials to individuals who have demonstrated qualifications to serve as a recovery coach.

Because peer support in the provision of mental health services is an evidence-based practice, it is reasonable and necessary to require a certified program to have either a peer support specialist, or a recovery coach, as part of the multi-disciplinary staff. This person may be paid, or may be a volunteer.

Supbart 2. **Staffing**. It is reasonable and necessary to require that a member of the multi-disciplinary team work a minimum number of hours to ensure that no team member is present in name only, and not work sufficient hours to make a genuine contribution to the multi-disciplinary aspect of the team based on the role that he or she fulfills. The department considered many factors and other the requirements in its existing rules to determine the minimum number of hours. The department considered the setting of a small provider, as well as a larger provider. The minimum requirement of the equivalent of one full day out of a five day week is reasonable because it is just enough to ensure the individual has a meaningful presence in the team.

When part 9533.0130, subpart 1 is read in its entirety, the subpart requires a total of six functions to be fulfilled on the multidisciplinary team (namely: (1) prescribing provider; (2) integrated treatment supervisor; (3) mental health professional; (4) a care coordinator; (5) an alcohol and drug counselor; and (6) a peer specialist or recovery coach.) Stakeholders advocated for staff persons having to be able to fulfill more than one of these six distinct roles if the individual meets the requirements for more than one. In theory, then, absent a limit, one person

could conceivably cover all six of the roles, if that person met the pertinent requirements for each role.

A multi-disciplinary approach to IDDT is optimal, however, when different professionals bring different areas of expertise to bear on assessment, treatment planning, and the delivery of IDDT services. This is due to the multiple and complex needs of recipients, particularly those in the target population. To fully derive the benefit of that multidisciplinary approach, more than one or a couple of vantage points are needed to identify these needs and how best to address them. If one person has three areas of expertise, for example, the person does not bring to bear as much information and knowledge as three individuals, each commenting on one primary area of in-depth expertise and experience. For this reason, the department sought to limit the amount of overlap in fulfilling more than one team role through the same person. It is reasonable to permit at least one person to meet the requirements for more than one role, because it permits the certificate holder flexibility in staffing, yet still brings to bear two areas of expertise or services. On the other hand, the department wishes to preserve the multi-disciplinary aspect of the team by limiting the number of persons who can do this.

Item D permits team members to provide services through electronic means such as telehealth. Technology is continuing to evolve and make it easier to communicate with one another in virtual ways. At the same time, there is a shortage of health professionals in geographic areas, such as outstate Minnesota, as well as a shortage in particular areas of practice, such as a psychiatric prescribers. The requirement is necessary and reasonable because it permits technology to expand the availability of needed professionals through telehealth.

Initially, the department determined that telehealth should be permitted for psychiatric prescribers only, to help alleviate the statewide shortage of psychiatrists. Stakeholders, however, particularly those from outstate areas, asked the department to expand this opportunity to all practitioners. The department modified the requirement in response to this input.

Item E is reasonable because it permits the client to have flexibility about his or her choice of psychiatric care providers. Some clients, particularly those who enter the integrated treatment system through the substance use "door," may have a pre-existing relationship with a psychiatrist who is not on the multidisciplinary team and is instead part of a separate mental health treatment network. It is worthwhile and important to promote psychiatric continuity of care and the continued longevity of these relationships. This is particularly true for the target population, which can tend to have more persons at risk of disengagement from the mental health care system. The rule requirement safeguards this flexibility of client choice.

It is also reasonable to refer to the related care coordination requirement to reinforce the importance of care coordination when the psychiatric provider is not part of the

multidisciplinary team. It is necessary to provide care coordination in this instance to ensure to ensure services are provided in a manner that is both efficient and achieves maximum benefit for the client. Showing the links between related rule requirements enhances the clarity of and therefore compliance with rule requirements.

Subpart 3. **Competency.** Subpart 6 requires that screening, assessment, and IDDT services be required by staff having competency in their scope of practice. It is necessary to require that staff have demonstrated competency because the target population is vulnerable and relies on the certificate holder to perform treatment services through qualified individuals who are capable of delivering what is required of them. It is reasonable to limit the breadth of one's competency to their scope of practice because staff are required to be competent only to perform their assigned responsibilities, which should not be outside this scope.

Subpart 4. **Documentation of qualifications** . It is necessary and reasonable to provide notice to the certificate holder about what documents the department uses to verify staff qualifications. The commissioner is required to verify compliance with rules. See Minnesota Statutes, section 245A.65. It is reasonable to use copies of licenses and certificates to verify credentials because this is the most readily available document demonstrating one's credentials. It is reasonable to require credible evidence of successfully completing training because without this verification, it is too simple for an individual to claim that he or she received training, when the individual did not complete or did not attend the training. It is necessary and reasonable to require the certificate holder to keep these documents in one appropriate place to facilitate the department's verification of compliance during an audit.

Part 9533.0120 **STAFF RESPONSIBILITIES DURING ASSESSMENT AND TREATMENT.**

Subpart 1. **Treatment team leader.** This subpart requires that staff have routine access to the integrated treatment team leader, and that the leader be on-site or available for consultation. Routine access by staff to the leader is essential for supervision to be informed by actual day-to-day practices, interaction with staff, and close observation of the treatment setting. This is necessary and reasonable to perform the activities associated with leadership and [more: knowledge].

The rule part incorporates some of the elements of the existing rule governing the requirements for medical assistance reimbursement of mental health clinical supervision. These requirements are set forth in part 9505.0371, subpart 5, item D. These requirements have worked well to ensure quality clinical supervision of mental health treatment. It is reasonable to select those provisions that apply in the context of integrated programs.

Some of the functions of a clinical supervisor in the mental health setting, however, cannot be performed by a licensed alcohol and drug counselor because an LADC does not have the qualifications required to do so. The responsibilities described for an LADC who serves as a clinical supervisor therefore omit three responsibilities that apply in the circumstance of a mental health professional acting as the clinical supervisor. First, an LADC is not qualified to review, approve, and sign the diagnostic assessment, individual treatment plans, and treatment plan reviews of clients treated by a supervisee. Similarly, an LADC does not have the required qualifications to review and approve mental health treatment progress notes according to a supervision plan. See part 9505.0371, subpart 5, item D, subitems 9 and 10. As a result, these three requirements do not apply to the integrated treatment supervisor who is not a mental health professional. In addition, because the scope of the LADC's supervision of a mental health treatment professional does not encompass all aspects of the supervisee's work for the reasons just noted, it would not be appropriate to require an LADC to accept professional liability for the acts of a supervisee who is a mental health professional. This requirement is set forth in part 9505.0371, subpart 5, item D, subitem 7, and is also excluded from rule requirements applicable to an LADC as an integrated treatment supervisor.

Subpart 2. **Staff role in integrated assessment.** Fully integrated services cannot occur without concerted, focused efforts on the part of the treatment professionals involved. It is therefore necessary to specifically require the certificate holder to establish a protocol requiring these professionals to jointly participate in information gathering, and jointly develop an integrated assessment for the client through formal interaction. It is reasonable to state this requirement in the rule part governing staff because it underscores the importance of staff actively synthesizing the information.

Subpart 3. **Staff role in integrated treatment.** Subpart 3 requires the certificate holder to establish a protocol for the multidisciplinary team to jointly engage in treatment planning, review and modification. The objective is the development of a single treatment plan that addresses both the mental health and substance-related disorders and their interaction, and share responsibility for the implementation of the treatment plan through formal interaction and cooperation in ongoing reassessment and treatment of the client. It is reasonable for the rule to spell out these objectives to enhance staff understanding. It is necessary to require a protocol because a protocol facilitates implementation by providing specific and concrete instructions for staff to follow.

Subpart 4. **Integrated case consultation.** Subpart 4 requires that IDDT programs conduct integrated case consultation as a formal means for a multi-disciplinary staff to monitor progress and coordinate interventions in an effort to provide appropriate and effective treatment. Research supports service integration focused on both the substance use disorder and mental health disorder. Integrated case consultation ensures a formalized process for a multidisciplinary staff to develop a set of internally consistent clinical practices. Integrated case consultation ensures that

the clinical practices respond to the client's level of engagement, and appear seamless from a client's perspective. The role of the supervisor in the consultative process is to guide the process. The integrated treatment supervisor has a key role to facilitate the process, ensure accountability for participation of the entire multidisciplinary staff, provide guidance and advice, teach skills, discuss intervention strategies related to the intervention, and monitor, review, and evaluate clinical progress. It is reasonable to require that the consultation address high-risk clients so that the benefits of case consultation are used to prevent critical incidents or relapse at appropriate times.

Subpart 4 also requires that staff update the integrated treatment plan every 14 days in residential programs, and every 30 days in outpatient programs. Case consultation is the optimal time to update treatment plans because the perspective of the entire multidisciplinary team can be brought to bear on the client's circumstances and strategies for treatment. It is therefore reasonable to require treatment plan updates during case consultation.

Subpart 5. **Monitoring during treatment.** Subpart 5 supports the principle that assessment is ongoing and is done through monitoring of client progress throughout treatment. It also requires a specific section in the treatment record devoted to history and chronology of the course of both disorders and the interaction between them to ensure that the interaction is examined and documented. The certificate holder can use a specific, standardized template to address both mental health and substance use histories, which also provides historical information regarding the interactions between the two disorders. It is reasonable to require that the monitoring of the disorders during treatment be viewed from a long-term perspective because changes and progress in individual clients occurs gradually, over time, and is not be readily apparent without a longer-term view.

Subpart 6. **Care coordination.** It is necessary and reasonable for IDDT programs to provide care coordination because individuals with mental illness and substance use disorder are likely to have multiple needs and multiple service providers. Dual disorders are complex, influencing all spheres of a client's life, and affecting the lives of family and friends. IDDT requires a comprehensive array of services. There is a wide range of potential treatment options, and identifying and prioritizing treatment goals is complex. Many clients have limited ability to help themselves, due to the effects of mental illness, substance use, or their combination. It is therefore likely that persons receiving IDDT services may have difficulty navigating the healthcare, legal and social services systems. As a result, one clinician needs to take responsibility for ensuring that a client's needs are assessed, that systematic treatment planning takes place, that interventions are delivered in a coordinated manner, and that treatment either has its desired effects, or is altered. Care coordination also ensures that the client receives practical help in obtaining and maintaining social services, and follow-through on wholistic recovery strategies.

Part 9533.0130 CORE TREATMENT SERVICES.

Subpart 1 **Required services**. It is necessary to list the services provided in an IDDT program to ensure that the provider understands what is required. The array of core treatment services is reasonable because it was reviewed by the rule advisory group, and is in accord with the treatment industry standards as defined in the SAMHSA toolkit for the evidence-based practices in IDDT. It is necessary and reasonable to require the certificate holder to have formal, documented evidence that the required array of services is available either within the program or through another provider so that the department can verify compliance. The specific services that an individual receives is determined by the client's individual needs and circumstances and documented with the individualized plan of care.

Subpart 2. **Individual and group counseling**. Subpart 2 requires two primary modalities of service delivery, individual and group counseling. Based on the research for the treatment of persons with co-occurring disorders, several psychotherapeutic interventions have been found to be effective, including individual, group and family therapeutic interventions. Each intervention brings something unique to the delivery of integrated treatment. Individual interventions allows for the most attention to be focused on one person, with no distractions from others; it is especially conducive to developing close working relationships, exploring personal motives and goals, and identifying individualized targets for interventions. Group work has the advantage of introducing social support among multiple clients, providing positive role modeling for clients in the early stages of treatment and provides for a teaching environment. The group format has a long history and tradition among nonprofessional self-help groups, such as Alcoholics Anonymous, primarily in the addictions field. The group format is beneficial for an individual due to its ability to capitalize on providing mutual support, and the identification with others shared by persons with substance related disorders. It is reasonable to require formats for which there is substantial evidence-based support.

Subpart 3. **Motivational interviewing**. It is reasonable and necessary for treatment providers to utilize treatment methods which are supported by research as being effective. Protocols are necessary for programs to deliver assessment in a uniform way, including a uniform mechanism and validated tool for assessing a person's treatment stage and motivation for change. In order to treat co-occurring mental illness and substance disorders most effectively, interventions must be motivation-based – meaning that interventions must be adapted to meet a clients' motivation for change. Stages of treatment[7] describe clients who recover from co-occurring disorders by participating in treatment through a series of four stages: engagement, persuasion, active treatment and relapse prevention. The concepts of stages of treatment closely correspond to stages of change or motivational states; precontemplation, contemplation, preparation, action and

[7] Osher, F.C., & Kofoed, L.L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry, 40,* 1025-1030.

maintenance.[8] Matching an individuals' motivational state to stage of treatment is essential to the treatment of co-occurring disorders because it provides a foundation upon which to set goals, and the basis upon which to choose appropriate interventions to achieve those goals.

Motivational interviewing is delivered as an individual counseling approach designed to help clients become aware of their substance use problems through the process of articulating and pursuing their own personal goals. Motivational interviewing was originally developed for persons with substance related disorders,[9] and research has shown it to be effective also for persons with co-occurring disorders. The treatment industry standard is to use motivational interviewing when addressing positive behavior change from maladaptive behaviors. It is reasonable to require the use of a tool approved by the commissioner to ensure the use of a valid and reliable tool, yet allow for the inclusion of additional tools that may be developed and approved in the future.

Subpart 4. **Engagement and outreach techniques.** It is necessary and reasonable to address the barriers which prevent or make it difficult for individuals with co-occurring disorders to seek professional assistance, and to maintain commitment to professional help. Persons with co-occurring disorders are more likely than the general population to miss appointments, and to have difficulty establishing relationships. Therefore, it is reasonable to require engagement and outreach efforts to counteract these treatment barriers. Interventions that can be used to engage clients include basic therapeutic techniques, such as reflective listening, open-ended questions, and maintaining a nonjudgmental stance. It is also important to require engagement techniques because engagement is important to building a solid working alliance between the helping professional and the client.

Additionally, when providers work with clients in their community setting, helping professionals have an opportunity to foster engagement by providing assessment and intervention in the client's living environment. Especially for persons with severe mental illness and a substance use disorder, this provides an opportunity for the helping professional to use environmental cues as a means to collect useful information about the client.

Subpart 5 **Evidence-based procedures for delivering treatment**. Evidence-based treatments are widely accepted and utilized in the behavioral health treatment field. For example, cognitive-behavioral approaches and motivational interviewing can provide targeted interventions that are specific to the client's disorder. It is necessary to require that providers use therapies focused on specific disorders because this result in better treatment outcomes. It is reasonable to permit flexibility for the provider to use clinical judgment about what evidence-based techniques will be

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[8] Connors, G.J., Donovan, D.M., & DiClemente, C.C. (2001). *Substance Abuse Treatment and the Stages of Change.* New York: Guilford Press. See also Prochaska, J.O. (1984). *Systems of Psychotherapy: A Transtheoretical Analysis.* Homewood,IL: Dorsey Press.

[9] Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing (2nd ed.): Preparing People for Change.* New York: Guilford Press.

most effective for the particular client. This also allows for flexibility as research evolves and points toward the use of new techniques and strategies.

Cognitive-behavioral techniques or strategies involve using learning-based interventions to help clients develop more effective skills necessary to address skill deficits, and minimize or cope with thoughts and feelings. These approaches can be utilized in individual work, group work, or family interventions. They can be used in a manner that is specific to the identified mental illness, substance-related disorder, and the treatment of both disorders together.

Subpart 6 **Family-based interventions.** It is important to include family-based interventions in the required service array because families play an important role in the support of the client's treatment. Family interventions are aimed at helping the family to understand the symptoms and treatment of co-occurring disorders. Through family interventions, families can support and reinforce therapeutic interventions, and efforts of the family and the treatment team can be coordinated. Families can support the client to improve adherence to treatment interventions, helping to reduce substance use and its effect on family members. These interventions can also decrease family stress, and families can buffer the effects of other sources of stress on the client. It is necessary and reasonable to require the use of interventions that have these positive results for treatment of dually-diagnosed individuals.[10]

Subpart 7 **Psychoeducation.** Psychoeducation focuses on helping clients understand the interactions between the abused substances and their psychiatric illness, and the unique aspects of treating co-occurring mental illness and substance use disorders. Psychoeducation can be effectively delivered either individually, or to a treatment group. Particularly when a client is in the earlier stages of treatment for co-occurring disorders, psychoeducation is an important part of the service array. It is necessary and reasonable to require the certificate holder to provide this service because having a better understanding of the complex interactions between the co-occurring disorders can motivate clients to reduce substance abuse to better manage the psychiatric illness.

Subpart 8 **Dual disorder groups.** Several different types of professionally-led groups are effective for the treatment of co-occurring disorders. These include stage-specific treatment groups, social skills training groups, and education groups. It is necessary and reasonable to establish psychotherapy treatment and rehabilitative standards that are generally consistent with the applicable law and mental health treatment industry standards. Department rules establishing standards for treatment reimbursement under Medical Assistance state that "[g]roup psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting." Minnesota Rules, part 9505.0372, subpart 6, item C.

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[10] Mueser et al, 2003.

A SAMHSA-authored toolkit endorses the use of group stage-of-treatment practices for treating co-occurring disorders.[11] According to stage-of-treatment principles, clients recover from co-occurring disorders by participating in treatment through a series of four stages: engagement, persuasion, active treatment and relapse prevention. [12] Stage-specific groups help an individual progress from one stage of treatment to the next.[13] Persuasion groups focus interventions on exploring the interaction between mental illness symptoms and substance use, and help to instill motivation to address substance-related problems. Active treatment and relapse prevention groups focus on supporting the client's efforts to reduce, and abstain from, substance use. These group interventions use a combination of support and teaching strategies. It is reasonable and necessary to require certificate holders to use available tools that reflect current industry knowledge and practices.

Another type of group referenced in this item is group social skills training. Social skills training groups support the development of skills necessary to build and maintain new social supports. This builds a client's social competence, enabling the client to more easily move away from a reliance on using substances to satisfy interpersonal needs. It is reasonable and necessary to require that certificate holders provide practices that are consistent with current industry techniques and standards.

Subpart 9. **Access to peer support.** Subpart 9 requires that the certificate holder provide access to the services of a certified peer specialist. Since 2009, Minnesota has included services provided by a certified peer specialist as among those reimbursed by Medical Assistance (under its Rehabilitative State Plan Option), as authorized by Minnesota Statutes, section 256B.0615. It is reasonable and necessary to require IDDT providers to facilitate access to peer support because there is credible evidence that peer support markedly enhances treatment outcomes.

A study conducted at the Yale-New Haven Psychiatric Hospital[14] examined the feasibility and effectiveness of using peer support to reduce recurrent psychiatric hospitalization. The study's findings suggest that the use of peer mentors is a promising intervention for reducing recurrent hospitalizations. Yale is currently conducting a larger study. In a different study, the National Institute on Mental Health (NIMH)[15] worked with 278 participants who had a psychotic illness and received illness management and recovery training. In this study, participants who received peer-facilitated, person- centered care planning reported a greater sense of control in life after six months. The professional literature also suggests that persons with major mental illness who participate in peer-led community programs show reduced symptoms and improved

[11] See http://store.samhsa.gov/product/SMA08-4367 ("Resources and tools on implementing integrated COD [Co-Occurring Disorders] treatment").
[12] Osher & Kofoed (1989).
[13] Mueser, K.T., & Noordsy, D.L. (1996). Group treatment for dually diagnosed clients. In R.E. Drake & K.T. Muesner (Eds.), *New Directions for Mental Health Services: Vol 70. Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications* (pp. 33-51). San Francisco: Jossey-Bass.
[14] *Psychiatric Services,* May 2011 Vol. 62 No. 5. See also clinicaltrial.gov, identifier NCT000400166.
[15] NIMH No. ROI_MH067687.

satisfaction with life; and that peer support enhances the resources a person can bring to bear on initiating and maintaining recovery. Similarly, credible evidence shows that adding peer services decreases substance use and depression, and increases hopefulness and well-being.

Another important aspect of peer support is its cost-effectiveness and low-intensity demands on scarce mental health resources. Peer support does not require extensive time commitments from highly trained, expensive mental health professionals such as psychologists. Indeed, many peer specialists are community volunteers.

Subpart 10. **Recovery coaching.** Just as with peer-based supports, the value of recovery coaching lies in the coach's ability to share lived experiences with the client. As defined in part 9533.0020, subpart 32, a recovery coach is someone who has a mental illness, a substance-use disorder, or a dual diagnosis; or someone who has experience with with addiction or mental illness due to relationships with family or close friends that supports the individual's understanding of the complications of these disorders. Recovery coaching therefore essentially amounts to another form of peer support, although through a slightly different methodology that focuses on engaging, educating, and supporting the dually-diagnosed individual. Thus, the same research that supports the efficacy of using peer support also supports the use of recovery coaching. It is a reasonable requirement because the Twin Cities offers the availability of recovery coaches due to a couple of organizations actively using this approach. The requirement is made more reasonable by the fact that it does not take effect until July 1, 2016. This delayed effective date recognizes the current growth in availability of recovery coaches, which will make it easier to offer recovery coaching both in the Twin Cities and outstate in the future.

Subpart 11. **Psychopharmacological treatment.** Subpart 11 requires a protocol for psychopharmacological treatment, which states that the prescribing provider must collaborate with the clinical team about various aspects of medication compliance and options. The presence of dual disorders presents additional challenges to psychopharmacological treatment. Specifically, adherence to prescribed medication is worsened by the presence of substance use; the presence of substance use disorders can mask the clinical effects of medication; and the use of medications with a low abuse potential is especially critical. It is reasonable and necessary to require a protocol to ensure that the prescribing provider is aware of and considers these unique challenges. The use of a protocol provides documentation that demonstrates the provider's compliance with these requirements. The requirement to address medication compliance is necessary and reasonable due to the prevalence of nonadherence in the population being served. The requirement to address use of potentially addictive medications is also necessary and reasonable given the particular vulnerability of this population to addiction. Further, it is necessary and reasonable to require the prescribing provider to consider medicine in the treatment of substance-use issues because several medications now target substance use and have been shown to prevent relapse.

Part 9533.0140 **REQUIRED ANCILLARY SERVICES.**

Subpart 1. **Ancillary services**. The evidence-based treatment protocol provides access to comprehensive treatment practices, so that clients can receive treatment that has been shown to be the most effective to promote the optimal recovery experience. It is reasonable and necessary to require the certificate holder to have certain ancillary services available, in addition to the core treatment services. It is reasonable to require the certificate holder to have a written agreement in place to provide these services because it enables the department to verify compliance.

Subpart 2. **Family psychoeducation**. It is reasonable to require family psychoeducation because it is recommended in the current research as a beneficial and useful part of a comprehensive approach to the treatment of co-occurring disorders. It is known in the field that the use of natural support systems (family, friends, etc), when possible and appropriate, is typically considered to be beneficial in supporting long-term recovery. By providing psychoeducation to members of these natural support systems, The knowledge gained by these friends and family members through psychoeducation enables them to better assist and support the client. This knowledge includes the ability to identify and address the specific types of challenges one typically encounters in dealing with co-occurring disorders.

Subpart 3. **Illness management and recovery principles**. Subpart 3 requires illness management and recovery principles. This refers to principles arising from a specific, evidence-based practice known as Illness Management and Recovery (IMR). IMR emphasizes personal goal-setting and actionable strategies for recovery. Various experts have provided consultation to the state mental health authority on a project to establish 8 mental health center sites in Minnesota to pilot the use of IMR. Experts from the Dartmouth Psychiatric Research Center (PRC) have provided training and implementation assistance to these sites.

It is necessary to include a requirement for an evidence-based practice that has been shown through substantial research to improve outcomes for dually-diagnosed persons. For example, the above-referenced, 6-month study conducted by the NIMH with participants having a psychotic illness and receiving IMR training, [16] showed that participants reported a reduction in paranoid ideation and medical problems.

The department deliberately selected the word "principles" in relation to IMR, rather than referring solely to IMR itself, to show that it is the principles of IMR that are sought in this requirement, and not any particular standardized protocol (such as a protocol required in other department rules or embodied elsewhere). It is reasonable to permit certificate holders some latitude in the development and implementation of an IMR practice.

[16] NIMH No. ROI_MH067687.

Subpart 4. **Continuity of care**. Subpart 4 requires continuity of care through follow-up, with a focus on a long-term view of addiction recovery and mental health management. The item requires a formal protocol

The DDCAT and DDCMHT require routine documented on-site or off-site follow-up after the client's discharge, and a formal protocol to manage mental health needs indefinitely. In the case of addiction treatment programs, the requirement is to manage mental health needs indefinitely; and in the case of mental health treatment programs, to manage substance use disorder needs indefinitely. These models require that the actions occur within the same agency that provided treatment.

Consistent with the models, the department considered, but rejected, requiring indefinite follow-up with clients. Payors do not typically pay for services after discharge, and requiring indefinite follow-up would place an unreasonable and impractical burden on providers. The requirement the department selected is reasonable and necessary because it retains a small step in the direction of the models. The department believes that follow-up at six months, and one year, are finite and small-scale enough to begin to acquaint the industry with the idea of follow-up care after discharge. The department used the phrase "after completion of high-intensity services" because payors often discontinue reimbursement for services following discharge. The end of high-intensity services refers instead to treatment that is winding down but is before final discharge, to permit payment for the six-month and one-year follow-up services.

Item C, subitem (3) requires the certificate holder to document compliance with the protocol. As noted, the models require routine documentation of compliance with the follow-up care protocol to meet standards for enhanced treatment. Consistent with the model, it is reasonable and necessary to have requirements that enable the department to verify compliance with protocol. Because formal follow-up after the end of the high-intensity services is a practice the community is just beginning to adopt, it is reasonable and necessary to verify compliance with a requirement that, for some, means a change in practices.

Part 9533.0150 **ORIENTATION AND TRAINING.**

Subpart 1. **Plan for staff orientation and training**. It is necessary to require certificate holders to establish minimum training requirements for employees because the integrated treatment services provided to the clients by the employees are the responsibility of the certificate holder. Certain areas of training are essential to ensure that staff understand and implement IDDT practices effectively. Orientation is a type of training provided to staff that provides staff basic information about the certificate holder's treatment program and methods and characteristics of clients served by the program.

It is reasonable to ensure that appropriate training occurs because it is in keeping with other departmental rules that set forth training standards for both community mental health centers and clinics, and chemical dependency treatment programs. See Minnesota Rules, parts 9520.0800, subpart 5 (standards for continuing education for mental health staff); and 9530.6460, subpart 2 (training in certain topics periodically required for chemical dependency staff). See also Minnesota Statutes, section 245.69, subdivision 1, paragraph (a)(requiring the commissioner to promulgate rules that set standards for staff training and professional qualifications in mental health centers). These existing rules have helped ensure that recipients get quality services from qualified staff in keeping with the purpose of the treatment programs. It is reasonable to seek the same objective in the proposed rule about training.

Subpart 2. **Basic training for all staff.** It is necessary and reasonable to require that the certificate holder provide basic training to all staff because all staff should understand the purpose of the program and be familiar with the basic concepts used by the program for treatment, and understand general concepts about the illnesses that clients may have. The common understanding and shared purpose of staff should provide improved treatment milieu for clients.

Subpart 3. **Specialized training for treatment services staff.** The requirements of subpart 3 provide a broad guideline for the certificate holder to follow for clinical staff training that is in addition to the basic training which all program staff must have. Staff have responsibilities for care and treatment of persons who have chemical dependency conditions and mental illness. It is necessary and reasonable to establish standards for in-service training to ensure that services of adequate quality are available for all clients in the state from knowledgeable staff.

Subpart 4. **Specialized training components.** The requirements of subpart 4 provide a broad guideline for the certificate holder to follow when establishing specialized training for staff. The guidelines are intended to give the certificate holder sufficient latitude to design staff training that is appropriate. It is reasonable and necessary to identify training components to aid the certificate holder in complying with the minimum requirements of the rule.

Part 9533.0160 **QUALITY ASSURANCE AND IMPROVEMENT.**

Subpart 1. **System to collect data for commissioner.** It is reasonable and necessary to implement and maintain a quality assurance system because Minnesota Statutes, section 245.69, subdivision 2, paragraph (d) requires a community mental health center or clinic to have a mechanism for quality assurance, which includes submitting information required by rule to the commissioner. It is also reasonable for the commissioner to collect information about recipients who suffer from mental illness because the commissioner is required to establish a mental illness information management system by MS 245.721. The legislature intended that the

commissioner require a quality assurance system and obtain the data from certificate holders that is necessary to measure the effectiveness of services provided to mental health treatment recipients. Certainly, the data available from certified IDDT programs can add useful information in the effort to find effective and cost-efficient treatment models. The data generated will also provide useful information to decision makers about effective programs, which will allow decision makers to make informed decisions about prudent expenditures of public funds in the future.

Likewise, the commissioner is charged with responsibility to gather facts and information about alcoholism and other drug dependency and abuse, and about the efficiency and effectiveness of prevention, treatment, and rehabilitation from comprehensive chemical dependency treatment programs, including those in hospitals. Minnesota Statutes, section 254A.03, subdivision 1, paragraph (4). The commissioner is specifically authorized to require programs to provide treatment information to the department as necessary and reasonable to fulfill these duties. *Id.* This data collection occurs by virtue of Minnesota Rules, part 9530.6590, which requires department-licensed chemical dependency treatment providers to participate in the drug and alcohol abuse normative evaluation system by submitting information about each client admitted to the program. Requiring IDDT providers to submit information is in keeping with these broader responsibilities and efforts to collect meaningful data to inform chemical dependency treatment practices.

It is necessary and reasonable to require that the commissioner specify the process and outcome measurement tools that the certificate holder must use. The use of uniform tools will improve the likelihood of obtaining useful data from the certificate holders. Furthermore, to the extent that data collection is routinized, the process used by the provider can become more efficient.

Subpart 2. **Quality improvement plan.** It is reasonable and necessary to require the certificate holder to adopt a plan requiring the activities in part 9533.016, subpart 2, so that the department can verify that the provider has adopted these requirements; and to facilitate the provider's compliance activities by establishing any needed procedures in light of the requirements. Reviewing and responding to the data is reasonable and necessary because it ensures that the certificate holder is alerted on a timely basis to any serious issues or trends and can promptly take remedial action if warranted.

It is reasonable to require the certificate holder to get feedback about the recipient's care from the recipient's family, and others involved in the recipient's care and treatment. These individuals have a degree of independence from the certified program, and know and have access to the client, and can therefore offer an opinion about the services provided to the client and the efficacy of these services.

It is reasonable and necessary to require the certificate holder to evaluate the outcomes data and improve services and client outcomes based on that data because it would be ineffectual to collect data and not make improvements in light of the data acquired and lessons learned.

It is reasonable to request that the certificate holder monitor compliance with the rules governing the treatment program. Self-monitoring is a commonly accepted practice in many businesses and is necessary to promote rule compliance.

Subpart 3. **Quality improvement plan review**. It is reasonable and necessary to require the certificate holder to use the information about process and outcomes gathered by the certificate holder to annually review the program. The annual review will provide an opportunity for the certificate holder to make needed changes that will improve the quality of treatment and obtain better outcomes for a recipient. It is reasonable to require the certificate holder to establish goals for service delivery, and evaluate and document the status of the prior year's goal. Goal setting and subsequent accountability for those goals bring a certain rigor to the process that can spur implementation of changes needed to improve quality.

Part 9533.0170 **PRIVACY OF CLIENT INFORMATION.**

It is necessary and reasonable to require compliance with federal and state laws governing data practices and health care records. Specific provisions of law govern mental health and chemical dependency records; it is reasonable and necessary to reference these requirements and ensure the entity is in compliance. Federal law contains heightened confidentiality requirements for patient records having to do with alcohol and drug abuse under the Confidentiality of Alcohol and Drug Abuse Patient Records. There is stigma associated with substance abuse, and such use may even be illegal, so that the protection of these records from inappropriate disclosure safeguards the rights of clients and encourages their access to treatment. It is also necessary to clarify that use of electronic records does not alter an organization's compliance obligations to avoid confusion on the part of providers on this point, which the department has encountered. This requirement is reasonable because it facilitates the certificate holder's compliance.

Part 9533.0180 **STANDARDS FOR PROPOSED ADDITIONAL SCREENING TOOLS.**

Subpart 1. **Consideration by commissioner.** The same statute that requires adoption of these proposed rules, Minnesota Statutes, section 245.4863, paragraph (a), directs the commissioner to "require individuals who perform chemical dependency assessments or mental health diagnostic assessments to use screening tools approved by the commissioner." A department bulletin issued on January 5, 2012, widely disseminated the new requirement and the commissioner-approved tools. The bulletin also described the criteria for approval of a new screening tool. The requirement went into effect on January 1, 2012.

With a few exceptions noted below, the criteria in the proposed rule are identical to those identified in the bulletin. The bulletin expeditiously informed providers about the new requirement, in accordance with the rapid approach of the effective date six months after the legislation was passed. The bulletin has served as a temporary placeholder to facilitate providers' compliance until the proposed rules are adopted.

Part 9533.0070 sets forth the requirement to perform screening. Part 9533.0180, provides for approval in the future of additional screening tools. This permits flexibility as research evolves and new, credible tools are developed. Tools not yet available might be an improvement over tools now available. It is reasonable to provide for consideration and adoption of new tools.

Part 9533.0180 requires the commissioner to review any proposed new tools every six months. This requirement is a means of managing the department's responsibility to review proposed tools. The requirement permits department staff to consider all tools that have been suggested over a six month period at one time, rather than on a case by case basis. At the same time, the requirement assures the proponents of a new tool that the commissioner's review and response time will be reasonably limited to six months.

Subpart 2. **Required characteristics**. The rule part sets forth specific criteria that apply to the evaluation of new tools. It is reasonable to inform interested stakeholders in advance about the information the department will consider in evaluating whether to approve a new tool. It is necessary for the commissioner to use identified criteria because this ensures consistency in the evaluation of potential new screening tools.

Item A requires a tool compatible with the reading level of the population being served. It is reasonable and necessary to require the tool to have a reading level compatible with the population being served because if the reading level exceeds that of the population, the accuracy of the screening results could be tainted. Results from the use of a screening tool could be due to a client's inability to understand the question, rather than being based on the information being sought.

Item B requires the tool to be easily administered and scored by a non-clinician. The requirement is reasonable because it facilitates the administration of the instrument. It is common practice nationally, and specified in the administration instructions of most screening tools, that screening tools are designed to be self-administered, or administered and scored by a non-clinician. The objective of screening tools is to identify the likelihood that a disorder may exist so that, if a screen is positive, there is evidence that a client should be referred to a clinician for further assessment. This somewhat narrow objective can be accomplished through the use of a tool that is easily administered and scored.

Item C requires the tool to be tested in the general population and at the national level. This is necessary to ensure that an sufficiently large representative sample has been considered in establishing the validity, reliability, and effectiveness of the instrument. A test that lacks this type of testing could result in skewed or non-representative data and conclusions.

Item D requires the tool to have demonstrated reliability and validity. The requirement is necessary to ensure that the tool measures what is intended to measure (validity) and is consistent in its ability to measure for the symptoms of a disorder (reliability). Without verification of these psychometric properties, a test or instrument could result in erroneous data and conclusions.

Item E requires that the tool attain certain psychometric levels for accuracy. It is reasonable and necessary to require a minimum documented statistical sensitivity of .70 and overall specificity of .70 for the instrument to reasonably calibrate the instrument's predictive accuracy. The value .70 is a commonly-accepted benchmark used in psychological statistics and research because this value is generally thought to reflect an acceptable level of predictive accuracy. It is reasonable to require the tool to be within these parameters because tests with sensitivity and specificity values outside these figures have been demonstrated to lead to an unacceptable number of false-positives and/or false-negatives.

Item F addresses predictive capability. It is reasonable and necessary to require that the instrument predict of a range of diagnosable mental health conditions, or the likelihood of alcohol and drug related disorders, because these are the conditions the tool would be used to identify.

Subpart 3. **Preferred characteristics**. Subpart 3 identifies preferred characteristics that would be consistent with "best practices," or would facilitate the ease and accuracy of screening. The department deems these characteristics to be preferred, and not required. This is because the department recognizes that it may be unrealistic and overly difficult to obtain additional screening instruments that meet both the mandatory and the preferred criteria. The department could inadvertently reject tools that would otherwise have proven to be competent. At the same time, though, the preferred criteria do represent factors that present an advantage weighing in favor of the use of the tool to obtain accurate results. It is therefore necessary to balance these competing interests by creating a set of preferred criteria for evaluating proposed tools without dictating any particular outcome. It is reasonable to specify these characteristics to circumscribe the commissioner's discretion and provide notice to proponents of new tools about what the commissioner desires.

It is reasonable to favor a tool that is concise, reasonably short, and readily completed in about ten minutes or so. Given the practicalities of clinical settings, it is problematic to broadly administer a screening tool to all clients when that tool is excessively long and time-consuming. In addition, clients are more likely to complete a screening tool that is concise, which results in a larger and therefore more accurate pool of results.

It is reasonable and necessary to favor an instrument that has been widely used for adults and adolescents to ensure adequate exposure of the tool to use in a diverse array of clinical practices. Such experience with the tool is valuable for assessing its value. Further, this allows for the tool to continue to be practically evaluated by mental health professionals and their staff in the future, providing an opportunity for further research or broader ongoing dialogue about the instrument.

It is reasonable and necessary to favor a tool available for use in an interview, or self-report, to facilitate the ease with which the instrument may be administered and provide staff and clients with options for its use. Some research indicates that when screening tools are used as self-report instruments, more accurate results are obtained. It is therefore reasonable to favor a tool that can be used in this manner.

It is reasonable and necessary to favor a tool validated for more than one cultural background. This ensures that the concepts being measured are not culturally encapsulated, that is, do not measure behaviors perceived to be problematic by only one cultural group.

It is reasonable and necessary to favor a tool that is validated for linguistic strength. Linguistic validation ensures that screening items are appropriate for use with the target population.

It is reasonable and necessary to favor a tool recognized by SAMHSA. This ensures that, when available, state practice is to use tools that are in step with national research, current best practices, and new initiatives.

CONCLUSION

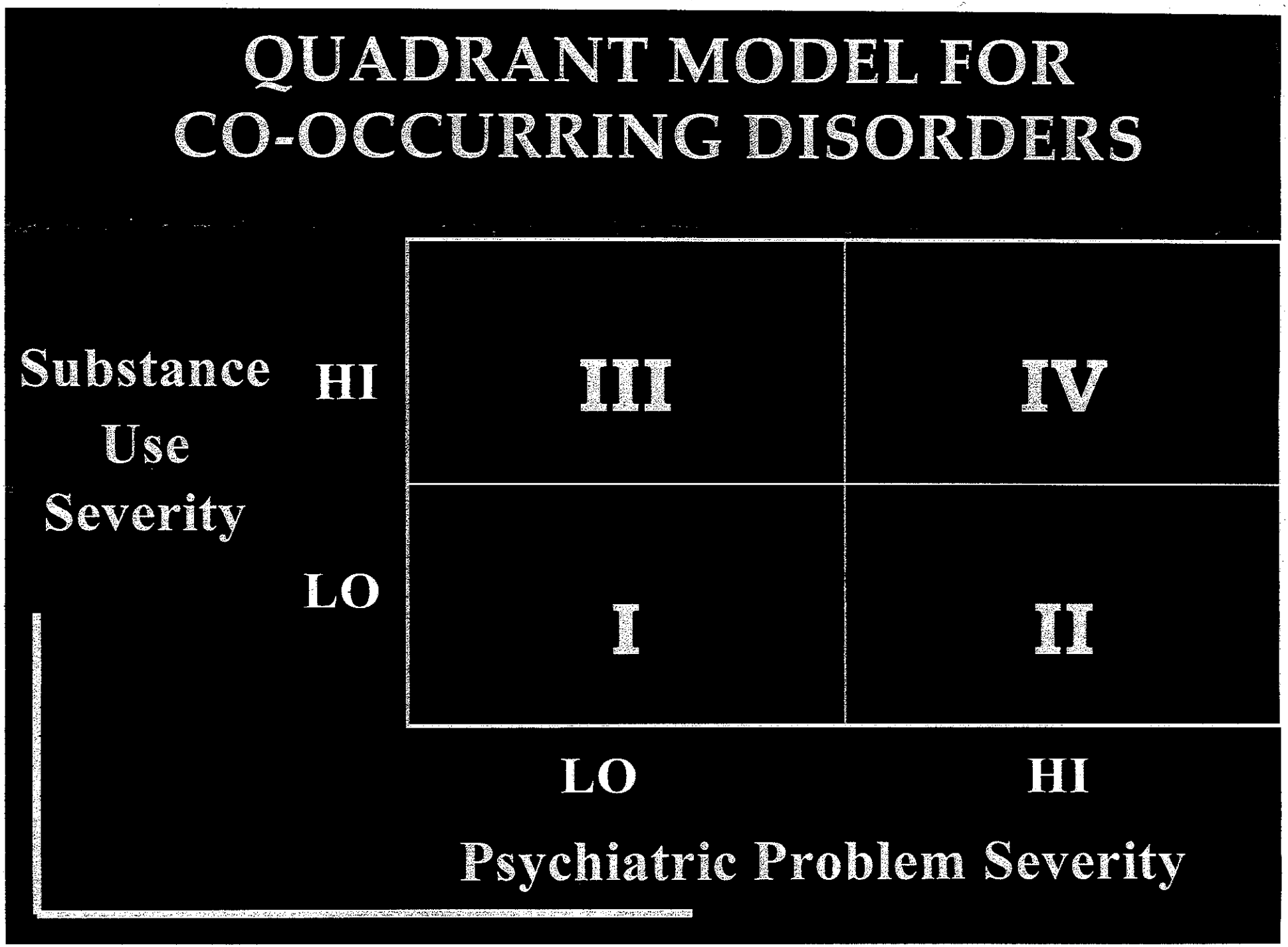
Based on the foregoing, the proposed rule is both needed and reasonable.

Date: December 9, 2012

October 5, 2012	Programs				
Rule 29	70				
Rule 31	348				
Rule 36 (ITRS)	50				
IDDT Certification - based on 10 programs	10				
		Licensor hours	Total licensor	Hourly rate	Cost
1st Year - FY13					
Unit staff - Technical assistance		20	20	$52.50	$1,050
Initial Applications	10	1	10	$52.50	$525
Application follow up (30%)	3	2	6	$52.50	$315
Application review	10	6	60	$52.50	$3,150
Due Process (denials)	1	2	2	$52.50	$105
Contested case hearings	1	8	8	$52.50	$420
Routine monitoring - 1st year all programs	10	12	120	$52.50	$6,300
Monitoring checklist development		60	60	$52.50	$3,150
Licensing complaint - investigation	2	8	16	$52.50	$840
Sanctions	1	2	2	$52.50	$105
Contested case hearings	1	8	8	$52.50	$420
Contested case attorney costs	1	8		$52.50	$420
Contested case OAH hearing costs					$3,000
Total costs					$19,800
Second year - FY14					
Unit staff - Technical assistance		10	10	$52.50	$525
Initial applications	2	1	2	$52.50	$105
Application review	2	6	12	$52.50	$630
Routine monitoring (once every 2 yrs after 1st year)	5	12	60	$52.50	$3,150
Licensing complaint	2	8	16	$52.50	$840
Correction Orders	7	2	14	$52.50	$735
Total costs					$5,985

SONAR Attachment No. 1

QUADRANT MODEL FOR CO-OCCURRING DISORDERS



SONAR Attachment No. 2