NATIONAL POLICY ACADEMY
ON
CO-OCCURRING DISORDERS

“CONNECTICUT CHAMPIONS RECOVERY
WHAT EVER IT TAKES
WHEN EVER IT’S NEEDED
REBUILDING LIVES TOGETHER”

State of Connecticut
State Action Plan
July, 2004

REVISED March, 2006

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National Policy Academy on Co-Occurring Disorders
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Connecticut is one of ten states nationwide to participate in the National Policy Academy on Co-Occurring Mental Health and Substance Use Disorders. As part of that effort, a Connecticut team of public and private stakeholders has developed this statewide plan to address co-occurring disorders in Connecticut, building upon existing strengths and infrastructure.

The Connecticut *Statewide Action Plan On Co-Occurring Disorders* contains action strategies in two domains: 1) WORKFORCE and 2) SERVICE DELIVERY. Those strategies are outlined below.

WORKFORCE

Priority 1: ***Connecticut will develop and implement a co-occurring disorder core curriculum that is applicable to all behavioral health service providers, and has measurable outcomes to assess its effectiveness over time. Specialized curriculum will be developed for advocacy organizations (i.e. Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU)) and for people who are in recovery.***

Strategies:

- Review existing workforce competencies and develop a COD core curriculum.
- Establish adequate training systems and web-based training opportunities.
- Re-tool existing state education and training departments and develop new means of technology transfer.
- Develop culturally appropriate and recovery-oriented training modules for each identified core area.

Finance Strategy: National Academy TA funding is requested to support these strategies.

Outcomes:

- A COD competent workforce will "work smarter," provide better care and reduce costs to the state.
- Improved treatment matching.
- Reduced hospital and emergency room admissions, critical incidents and incarcerations.
- Competitive employment, housing stability and community involvement improved for persons with COD.

Timeframe: <u>*Year One*</u>

- A statewide COD steering committee will be established.
- A survey of current COD workforce competencies will be conducted.

- A survey of clinical supervision knowledge and skills will be conducted.
- Dialogue will take place with professional and educational institutions about the need for a COD competent workforce and their role in developing COD knowledge and skills.

Year Two

- A COD core curriculum with a post-test applicable across disciplines and across agencies will be adopted and implemented.
- A COD clinical supervision core curriculum that is applicable across disciplines and across agencies will be adopted.
- COD competency based job descriptions for all disciplines across agencies will be developed.
- Positions to attract peer specialists will be created.
- Initiatives and incentives to attract culturally diverse individuals to the workforce will be developed.
- Competency-based job descriptions for clinical supervisors will be developed.
- The feasibility of mandating COD credentialing for certain identified job classifications will be determined and appropriate job descriptions will be developed.

Year Three

- A COD-trained workforce will be fully achieved.
- Performance reviews for measuring COD competency will be conducted.
- Trained clinical supervisors with a defined clinical supervision structure across disciplines and agencies will be fully achieved.

TA Needed:

- TA from Minkoff and Cline to review current workforce COD competencies and assist in the development of COD core competency curriculum and training that can be introduced across disciplines and agencies. This will require the use of a COD survey tool (i.e. COD Basic Competence Evaluation Tool developed by Minkoff and Cline), which will need to be purchased, and training to administer this will need to occur.
- TA to develop a curriculum, training and supervision module for peers or persons in recovery.
- TA in developing technology transfer (i.e. teleconferencing, videoconferencing) in the delivery of training.

Progress (As of 3/2006):

- An extensive COD curriculum has been developed and is in place through the DMHAS Training and Education Division. The courses offered are based on 18 core areas within 5 domains and is directly applicable to the certification process for COD credentialing offered by the Connecticut Certification Board (CCB). Future COD course development can be created within the guidelines of the current curriculum insuring it meets credentialing requirements. The curriculum framework is available in the DMAHS Training and Education offices for review by current and future trainers. (Post training assessment is still being looked at).
- The current COD curriculum is careful to take into consideration cultural differences that exist within the population served and is woven throughout the curriculum. There is also one entire module within the COD curriculum devoted to development of cultural competency.
- The DMHAS Training and Education Division will "repackage" current and future COD training opportunities under the newly developed Co-occurring

Disorders Academy. A listing of these offerings will be available in the Fall 2006 DMHAS Training and Education course catalogue.

Under consideration at this time to enhance COD training and education:

- Emphasis placed on DMAHS facilities to strongly encourage skilled COD practitioners to commit to providing one day of COD training through the newly established COD Academy (Goal is to develop a larger pool of trainers and offer more training throughout the year).
- Reallocation of existing funding for DMHAS Training and Educating to COD specific courses to be offered through the COD Academy, placing a clear emphasis on the importance of educating a workforce in the area of COD while also minimizing the waiting list for individuals leading to COD competency and credentialing.
- The development of a COD listserve, a COD information video and a COD Initiative link on the DMHAS home page.

Updated TA Request (As of 3/2006):

- TA would be needed to develop on-line COD training modules with built in assessments that could be delivered on-site to reach a larger audience, potentially minimize the interruption to client care and could be accomplished on off shifts.

Priority 2: ***A clinical supervision structure must be designed that fosters and continually assesses the skills of the workforce.***

Strategies:

- Identify core competencies for clinical supervisors and create a clinical supervision structure in which supervisors will be required to demonstrate COD core competency and skills necessary to provide clinical supervision.
- Establish a training module for clinical supervisors.
- Conduct supervision on a prescribed basis and make available to all direct care staff.
- Adopt Policies and procedures to outline the requirements for both the supervisor and supervisee.
- Implement a tracking system to ensure that clinical supervision is occurring as designed.
- Develop a competency-based job description for supervisors and require that they be assessed per the description as part of an annual review.

Finance Strategy: A core curriculum must be purchased or developed that can be provided to all levels of care providers, across the state and private non-profit service provider systems. The recommendation is to obtain the basic COD competency training developed by Minkoff and Cline. It appears that the Systems Development workgroup has identified Minkoff for some of their components, so it might be advantageous to allocate initial monies to contract with Minkoff and have him conduct a systems analysis that would include COD workforce competency and workforce training needs. National Academy TA funding is requested to support the purchase and/or development of the curriculum.

Outcomes: Clinical supervision will help to sustain competent COD practice over time.

Timeframe: <u>Year One:</u>

- A review of clinical supervision knowledge and skills will be conducted within 6-9 months.

Year Two:

- A core clinical supervision curriculum across disciplines and agencies to be in place and ready for implementation at 12-18 months.
- Competency based job descriptions for clinical supervisors will coincide with clinical supervision training and will be in place across disciplines and agencies at 18-24 months.

Year Three:

- Trained clinical supervisors with a defined clinical supervision structure across disciplines and agencies at 24-36 months.

TA Needed:

- TA in developing and implementing COD clinical supervision, assessment, and training curriculum.
- TA from Minkoff to conduct a systems analysis that would include COD workforce competency and workforce training needs.

Progress (As of 3/2006):

- A survey will be designed with 3 months that requests in writing the current clinical supervision that is occurring at all DMHAS and DMHAS funded agencies. In addition, the survey will request agencies put forth any plans to develop a clinical supervision process. The survey will also ask agencies to list the barriers to providing supervision. A final report outlining the findings with recommendations will be rendered in 5 months.
- DMHAS Training and Education has in place a well-defined training for clinical supervisors as well as implementation guidelines. Standards are outlined and include a minimum of 2 hours of clinical supervision per month for direct care staff. Also, within this training/implementation module a mechanism to capture and track supervision exists.
- Under consideration at this time to develop clinical supervision are:
  - Giving priority to agencies that have clinical supervision in place access to COD trainings that are offered by DMHAS Training and Education (Having the supervision mechanism in place will likely increase the development of newly acquired skills, provide on going assessment and sustain the practice over time).
  - Potential on-site training to agencies to develop and implement clinical supervision.
  - Potential development of creating co-op arrangements within networks and the brokering of clinical supervision.
  - The reallocation of current resources at the agency level to create clinical supervision structures.
  - Conducting focus groups to better understand the barriers of developing clinical supervision as well as solutions.

Updated TA Request (As of 3/2006):

- TA to assist in creative ways of developing clinical supervision to minimize the need for additional resources and time away from direct care service, which also has a financial impact on agencies.

Priority 3: ***The credentialing of co-occurring disorder practitioners will be addressed.***

Strategies:

- Review and update the current Connecticut Certification Board's (CCB) COD curriculum for consistency with current best practices.
- Develop criteria for the CCB credential to make it more accessible.
- Develop self-learning modules and web-based training.
- Determine the feasibility of a state (DPH) COD credential, state certification of COD agencies, and network credentialing.
- Adopt incentives for individuals, agencies and networks to pursue this credential.
- Consider making COD credentialing a requirement for staff positions.

Finance Strategy: Supervision training must be provided to insure proficiency in this area for supervisors. DMHAS currently has a supervision-training module that could be implemented across systems. Here the cost would be the time required by staff outside of their current role needed to develop proficiency in COD competent supervision. Time will have to be allocated to provide this supervision, for both the supervisor and supervisee. Also a tracking system will need to be developed to ensure that supervision is occurring. Supervision will need to be one of the conditions for credentialing, the cost of which may be supported by a tiered fee schedule and/or reallocation of state agency's federal block grant and state grant funding.

Timeframe: Year 1:

- Review making credentialing a requirement for some job classifications
- Should this become a requirement, facilitate revisions of job descriptions.

TA Needed:

- TA in developing job descriptions which reflect COD competencies, credentialing, recruitment and retention of underrepresented groups and of the overall workforce, and in addressing staff burnout issues and strategies for how to best negotiate these changes with organized labor unions.
- TA in developing system-wide incentives for service providers and clinicians to become COD credentialed and/or hire COD credentialed staff.
- TA in supervision training to insure proficiency for supervisors.
- TA in developing a tracking system to ensure that ongoing COD supervision is occurring.

Progress (As of 3/2006):

- A well-defined COD credentialing process is in place and offered through the CCB. The requirements are in line with other states offering the credential minus the written exam (Connecticut was the first state to offer the COD credential).
- Active collaboration between the CCB and DMHAS is in process to adopt a written exam. At this time we are considering the adoption of the Pennsylvania Certification Board COD exam. This exam is available now, requires no up front expense and is line with the current Connecticut COD best practices curriculum. The Connecticut Director of the CCB is scheduled to meet with the Pennsylvania Certification Board Director on March 27, 2006 to discuss this approach. Also the CCB Director will attend the National IC/RC Board meeting in early April and it is likely that we will adopt the PCB exam shortly after.
- Active discussions are underway to identify a grand fathering period of one year (exam exempt) for individuals who meet the current COD credentialing requirements.

- Discussions are underway to develop a collaborative (DMHAS/CCB) educational blitz to "get the word out" to behavioral health care providers once the written exam has been adopted. There would be a one-year grand fathering period before the exam would be required. We are projecting that as many as 500 individuals would receive this credential during this grand fathering period.
- We are also projecting that work with Human Resource Divisions to re-work job descriptions will coincide with the above process to include the requirement of this newly introduced credential.

Updated TA Request (As of 3/2006):

- TA could assist in the development of on-line training and assessment making it more accessible to individuals.
- TA to develop a DMHAS/CCB website allowing for online COD information in addition to information on certification and registration for the exam.
- TA to re-work job descriptions within heavily unionized environments.

Priority 4: ***CT will develop a mechanism to recruit and retain culturally diverse individuals and individuals in recovery to enhance the workforce.***

Strategies:

- Develop and implement incentives within COD service structures to attract and retain culturally diverse and recovery/re-entry people into the workforce.
- Create positions to attract candidates from the community who are culturally diverse and/or in recovery.
- Establish a well-defined professional development path that will provide the opportunity for professional growth within organizations.

Finance Strategy: State agency Human Resource Departments will need to retool existing job specifications and competency based job descriptions to reflect the expected requirements of staff. Factoring in the cost of developing possible implementation of technology transfer (i.e., teleconferencing, videoconferencing, self-training modules), state agencies should cover the cost of the survey and training for their respective workforces. Each agency's training and education budget will need to be reviewed to determine what is spent on training annually and determine what percentage of training dollars can be directed to support this initiative. The agencies will need to factor in the percentage of the workforce that will require COD competency training and the percentage of time outside of direct service that will be needed to accomplish this. The costs of surveying and training the workforce and supervisors of private non-profit service providers will be covered by the requested National Academy TA funding.

Outcomes:

- A well-defined professional development path that will provide the opportunity for professional growth within organizations.
- This will assist greatly in retaining these individuals.

Timeframe: Year One

- Positions to attract peer specialists (recovering/reentry individuals) to be created within 18 months.
- Initiatives and incentives to attract culturally diverse individuals to be developed within 18 months.

TA Needed: TA in creating incentives for engaging and retaining a diverse workforce that includes persons from various cultural and ethnic backgrounds and persons in recovery.

Progress (As of 3/2006):

- The initial approach to this area remains the same. Within the near future talks with State Human Resource Departments will be scheduled to look at how re-tooling existing job descriptions and aggressive recruitment can be constructed to attract culturally diverse individuals and individuals from the recovery community. Dialogue in the area will include minimally members from the Connecticut Community for Addiction Recovery (CCAR), Advocacy Unlimited and Directors from Departments of Cultural Affairs.

Updated TA Request (As of 3/2006):

- TA in creating incentives for engaging and retaining a diverse workforce that includes persons from various cultural and ethnic backgrounds and persons in recovery.

Priority 5: ***A statewide committee comprised of key individuals across agencies will be established to stand as a Co-Occurring Disorder Practice Steering Committee.***

Strategies: Provide oversight to drive the COD initiative through this steering committee, which will be comprised of key individuals from all regions of the state who have the ability and necessary authority in their respective regions.

Finance Strategy: Establish opportunities and/or incentives for service providers that hire individuals with COD certification.

Outcomes: A statewide COD steering committee will ensure consistency, accountability and sustainability for the initiative.

Timeframe: A dedicated statewide COD steering committee will be established within 6 months. It is important that this be in place prior to other points mentioned above.

TA Needed: None identified at this time.

Progress (As of 3/2006):

- There is a COSIG Steering Committee currently in place tasked with development and implementation of key COD components and to drive the COD initiative.

Updated TA Request (As of 3/2006)

- TA is not required at this time.

Priority 6: ***Dialogue with the State Universities, Community Colleges and other professional training institutions will be initiated regarding the need for a co-occurring disorder competent workforce in the behavioral health field.***

Strategies: Dialogue to take place between the steering committee and higher education and professional training institutions regarding the need for COD competent practitioners for CT's workforce.

Financial Strategies: None identified at this time.

Outcomes:

- Ongoing relationship with institutions of higher education and professional organizations.
- A college curriculum that prepares students to be COD competent .
- Cultivation of a new pool of COD competent professionals.

Timeframe: Achieving this objective may be a longer-term goal but the dialogue should begin as soon as possible.

TA Needs: TA in developing and implementing university and college curriculum that prepares a new pool of competent COD professionals.

Progress (As of 3/2006):

- Dialogue has occurred with the State Community Colleges targeting the Directors of the Drug and Alcohol Rehabilitation Counselor (DARC) programs. One of the colleges is currently creating a course specific to COD and one has created a proposal for a multi-course certification in COD.
- Within the next 60 days meetings with the two State University Schools of Social Work will take place to discuss the development of COD curriculum.

Updated TA Request (As of 3/2006):

- TA in developing and implementing university and college curriculum that prepares a new pool of competent COD professionals.

SERVICE DELIVERY

Priority 1: ***Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.***

Strategy:

- Develop and implement training in welcoming and recovery-oriented engagement techniques. Provide customer service training (non-clinical) that is person-centered, supports CT's "no wrong door" and Recovery Initiative philosophy, and includes protocols for greeting, engagement, managing difficult situations, and crisis response.

Progress (As of 3/2006):

- The Connecticut Co-Occurring Steering Committee's Service Delivery Workgroup has recommended that the DDCAT and the modified version of the DDCAT by Missouri for use in mental health agencies be the tools used to assess dual diagnosis capability across the system. One of the seven domains in this index is

"program milieu" and has two criteria that speak to this issue of welcoming and engagement. Mark McGovern, Dartmouth College, is under contract by DMHAS to create a toolkit by August 2006, which will provide specific strategies agencies can use to become a dual diagnosis capable or enhanced program. The toolkit will include strategies to create a more welcoming environment and increase engagement.

Strategy:

- Assess and improve physical program sites to provide a welcoming and safe environment.

Progress (As of 3/2006):

- Connecticut is in the process of completing DDCAT assessments at 65 of our substance abuse programs around the state. This covers almost half of all our substance abuse treatment programs. We will analyze scores on the two program milieu items across these programs to complete this assessment and make specific plans to improve program sites on welcoming and engagement.

Strategy:

- Implement cultural competency plans to address language, art, and staff competency.

Progress (As of 3/2006):

- In 1999-2002, DMHAS, through its Capitol Region Mental Health Center and other stakeholders, conducted the Dame La Mano Project, a federal Center for Mental Health Services funded Community Action Grant. Through consensus building and implementation phases, the stakeholders successfully modified the IDDT model linguistically and culturally for Latinos/as with co-occurring disorders. Through our COSIG project we are replicating this model at the Hispanic Clinic at CMHC in New Haven. The COSIG has contracted with Yale to complete a process and outcomes evaluation. Through the outcomes evaluation we will be able to formally assess the effectiveness this modified model for this population. Plans for statewide implementation of the culturally specific model will be included in the COSIG statewide plans. We are also currently arranging training at the Hispanic Clinic on TREM groups (trauma-specific groups) using the culturally adapted version for Latinas. The Morris Foundation has already implemented TARGET trauma groups. A Spanish version of the groups is available and we will work over time to implement those at this site because 20% of their population served are Latino/a.

Strategy:

- Use person- and family-first language in all communication forms.

Progress (As of 3/2006):

- Connecticut will complete a formal assessment of all documents used at the two COSIG pilot sites to inform us of common errors currently being made relative to person- and

family-first language. Based on this assessment, documents will be revised and training will be provided at these sites, and become part of the statewide implementation plan.

Finance Strategy:

- Review existing training and human resource funds within each respective state agency (DMHAS, DOC, DCF, and the Judicial Branch) to support welcoming and recovery-oriented training programs.
- Support service providers in creating more welcoming environments through encouraging their application for capital financing/bond funds.

Outcomes:

- Employees across the system who have patient contact will be trained to create an environment that recognizes and warmly assists persons with CODs towards engagement and sustained recovery.
- Environments will be safe and sensitive to people with COD.
- Programs will have cultural competency plans that address COD.
- Materials on CODs that assist the persons served (including family and support persons) will be available in a variety of languages.
- Person- and family-first language will be in use throughout the system of care.
- Persons with CODs will be able to enter any mental health and/or substance use program in the system and experience welcoming environments where staff members ensure that they receive appropriate assistance in addressing their presenting concerns.

Timeframe: Year One

- Customer Service Training will be developed/purchased and initiated.
- Service providers will be presented with opportunities to participate in trainings.
- Current training on "Managing Difficult Situations" will be revised
- Protocols for greeting and engagement for support and other "front door" staff will be developed.
- Criteria and self-administered survey for a welcoming physical environment, especially access points and safety areas, will be developed
- Existing documentation will be reviewed and forms and paperwork will be revised or developed in diverse languages using person- and family-first language and recognizing COD needs/issues.
- Data collection systems will be assessed for ability to collect COD data and will be revised and updated, as needed.

Year Two

- All service providers will have 25% of identified staff trained.
- An intact training module will be developed for future use.
- All service providers will implement protocols.
- All service providers will implement survey and identify any needs.
- Culturally sensitive signage, art and literature will be distributed and utilized throughout the service system.
- A mechanism will be developed and implemented to get feedback from various service levels to identify needs and issues as they arise.
- All state contracts will include requirements for welcoming training, as appropriate, and as a definable service.
- State departments will support requests for bond funds for this priority.

Year Three

- All service providers will have 50% of identified staff trained.
- All service providers will develop a comprehensive plan so that new staff will be trained in a timely manner.

- A system that annually measures how well protocols are being followed will be developed and implemented with a feedback loop for improvements.
- On-going review of needs and competencies to be addressed via Cultural Competency Plans.
- Capacity for expedited form sharing between state departments and between service provider networks will be developed.
- By the end of Year 3, all service providers will have approximately 75% of identified staff trained. Ongoing training opportunities will help to ensure reaching the goal of having 100% of identified staff trained.

TA Needed:

- TA to develop and implement a customer-service training program, using experts outside the behavioral health field, that includes a communication plan for person-first and family-first language and approaches.
- TA from Dr. Minkoff to consult with customer service team, conduct workshops for service providers, and develop standards for safe and welcoming environments.

Updated TA Request (As of 3/2006):

- TA to develop and implement a customer-service training program, using experts outside the behavioral health field, that includes a communication plan for person-first and family-first language and approaches.

Priority 2: ***All service providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools, regardless of where the individual initially presents for care.***

Strategy:

- Build and maintain competent person- and family-centered screening and assessment tools for children and adults.

Progress (As of 3/2006):

- The Co-occurring Screening workgroup has recommended that DMHAS not create new tools, but adopt existing standardized screening tools available in the public domain. DMHAS will connect with the Department of Children and Families' co-occurring grant, funded by the federal Center for Substance Abuse Treatment (CSAT), to understand which screening and assessment tools they have chosen to implement for children and adolescents.
- Adopt standard screening and assessment tools for statewide use that are appropriate to populations served and comply with the regulatory and accreditation requirements.
- The Screening Workgroup, after a comprehensive review, has recommended that we pilot the following instruments in our two COSIG pilot sites, as well as other agencies that would like to pilot them: MHSF-III, MINI Screen, SSI-AOD, CAGE, and RAGS. In a recent survey of our providers, 70% of programs report using some kind of screening instrument. We anticipate that several screening instruments will be used and that we will implement standards about what kind of instruments are acceptable, and ultimately have a relatively short list of screening tools being used around the state.
- Provide statewide trainings and a quality assurance program on use of tools.
- We have collected some information from the other COSIG states that are using the same screening tools we are going to pilot what

kind of training they have implemented. We will be using the resources of the DMHAS Training and Education Division to assist with this task through the new COD Training Academy. We will be collecting hard copies of the completed screens at our pilot sites to ensure they are being completed correctly and the data being entered into the MIS is correct. Ultimately, our statewide monitoring protocol will include review of the screening tools.

Strategy:

- Develop and implement standards to assess service provider competence in screening and assessment.

Progress (As of 3/2006):

- The service delivery workgroup has proposed definitions of DDC and DDE programs and will be working on standards next, including standards.

Strategy:

- Create systems that allow recovery information that has been approved for release by the person served to be easily shared among service providers and adopt standard "authorization to release information" forms to be distributed to all service providers and individual practitioners through the Internet.

Strategy:

- Examine web-based information sharing systems, identify key health information that would facilitate quality care and assess electronic sharing capabilities and create a long-term plan for information sharing.

Progress (As of 3/2006):

- We have recently extended an offer of employment to someone for the systems developer II position funded by the COSIG project. This person will work for the DMHAS Director of Quality Management and Improvement and be a key resource for creating and implementing a long-term plan for information sharing. We are also recruiting for a research analyst funded by the COSIG project to assist in this work.

Strategy:

- Build statewide, centralized access and referral service to offer objective information to callers, facilitating access to appropriate levels and types of care and facilitate information gathering.

Progress (As of 3/2006):

- Ultimately, we want to be able to have sufficient DDC and DDE programs throughout the state and be able to easily identify which programs those are and refer people to them as needed.

Finance Strategy:

- Plan to create systems that allow recovery information to be released with patient consent and shared among service providers may require financing beyond existing departmental resources. Sources of health information related grant opportunities will be pursued. Review existing funding for possible reallocation and, if necessary, seek new resources.
- Develop a statewide, centralized access and referral service 18-month pilot with National Academy TA funds. The state would also pursue existing private and federal grants to supplement those funds. Pending favorable outcomes, participating state agencies will collaborate in identifying resources needed to support continuation of the program.

- Review existing options and resources for achieving centralized access and referral, including the use of Connecticut Infoline, which may be able to enhance its directory of mental health and substance abuse service providers to include whether the provider is COD credentialed. State agencies will review existing funding for possible reallocation and, if necessary, seek new resources.
- Assess program costs associated with expanding the capacity for standardized screening and assessment for co-occurring disorders. If there are increased costs, the state agencies will review federal block grants and other existing resource expenditures to determine whether allocation can be modified to support adoption of standardized assessment. If necessary, the state will seek new resources. State agencies will review existing funding for possible reallocation and, if necessary, seek new resources.
- Consider the costs associated with standardized assessment in the development of tiered fee schedules under the General Assistance Behavioral Health Program (GABHP) for service providers that are either COD capable or COD enhanced.
- Require that Connecticut's behavioral health contractors, under the HUSKY program, use level of care/medical necessity criteria that are co-occurring capable.

Outcomes:

- Service providers use common screening and assessment tools in their work with persons with COD and their families. The effective use of these tools is regularly monitored ensuring consistency throughout the system of care and reducing the number of times people with COD need to go through a full assessment.
- A standardized release of information form that satisfies all regulatory and ethical requirements is in use throughout the system enabling all state departments and private service providers to release information within 48 hours of receipt of the request.
- Service providers and persons with mental health and substance use needs utilize a centralized access and referral system to identify appropriate and available resources, reduce waiting time to enter services, improve utilization of treatment capacity, and match persons to needed level of service.
- A plan for improved information sharing among service providers is created maximizing the potential of electronic data transmission in real time.
- Development of data, within a quality improvement framework, accessible by providers and state decision makers that describes program-, service-, and system-level aggregate information for use in understanding and adjusting the program, service, or system to be responsive to individuals with CODs.
- Clinical care planning for people with COD disorders and their families will be improved.

Timeframe: Year One

- The capacity for service providers to identify COD needs at any level/place in the service system will be developed.
- Standardized screening tools for children/youth and adults will be adopted.
- A standardized "authorization to release information" form will be developed and distributed.
- A pilot program for a Central Access and Referral Service will be designed and implemented.

Year Two

- Opportunities and incentives for service providers to identify COD needs will be developed.
- Service providers will receive training in the use of screening tools and the screening tools will be implemented statewide.

- The feasibility of using web-based information sharing systems will be examined.
- All state and private service providers will release information, as authorized, within 48 hours.
- The pilot Central Access and Referral Service will be assessed, modified as needed, and reviewed for applicability to other areas of the state.
- Data collected from the Central Access and Referral Service will be used to develop clinical profiles and measure demand and capacity to meet demand.

Year Three

- Use of standardized screening and assessment tool(s) will be evaluated for needed modifications and appropriate action will be taken.

TA Needed:

- TA to examine JCAHO compliant standardized screening and assessment practices in other states and use that information to develop Connecticut instruments.
- TA to support modifications to Connecticut's web-based information system that facilitate information sharing and ensure compliance with all privacy standards.

Updated TA Request (As of 3/2006):

- Although we have decided to use standardized instruments already in the public domain, TA is requested to ensure that the selected tools are consistent with JCAHO requirements.

Priority 3: ***Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.***

Strategy:

- Establish local planning partnerships to annually assess COD needs and system capacity to meet needs, and create child/family and adult services plans for coordination of behavioral health, peer advocacy and support services. These local planning partnerships shall develop and implement local, integrated service delivery plans, including practical strategies for quality, continuity of care, and leveraging of resources to sustain COD services.

Progress (As of 3/2006):

- The Service Delivery Workgroup is developing recommendations for developing co-occurring collaboratives in each of the five regions.

Strategy:

- Build system capacity and infrastructure that ensures continuity of timely and appropriate COD services based on annual recommendations from local planning groups regarding coordination, expansion, and creation of new services to meet local needs. Local plans to be integrated with statewide plans. State agencies to actively seek grant opportunities that increase or enhance co-occurring capacity and provide TA to local groups.

Progress (As of 3/2006):

- The COSIG was awarded to CT in 2005 and its resources are critical to building sustainable system capacity and infrastructure for COD services.

Strategy:

- Create a task force with participating state agencies to expand service provider system capacity for medication evaluation, prescribing, monitoring, and dispensing.

Progress (As of 3/2006):

- A specific task force has not been created yet. There is a small regional effort in the New Haven area to collaborate with the Schools of Psychiatry to have residents/fellow provide psychiatric coverage at local SA agencies on a rotating basis.

Strategy:

- Identify major transportation obstacles and develop innovative solutions for bringing people to service providers and for bringing services to people.

Strategy:

- Encourage service providers to become Dual Diagnosis Capable or Enhanced (ASAM PPC-2R), i.e., outpatient addiction treatment providers to be licensed for mental health, DCF licensed psychiatric clinics, residential group homes for children and youth to be licensed for addictions treatment. Incorporate language into service contracts to assure Dual Diagnosis Capable/Enhanced.

Progress (As of 3/2006):

- The Service Delivery Workgroup has recommended to the Steering Committee program definitions for DDC and DDE programs and those definitions rely on the use of the DDCAT and its modified version for mental health agencies.

Strategy:

- Increase number of COD-certified clinicians by expanding the COD clinician certification program and providing local and web-based training.

Progress (As of 3/2006):

- We are actively engaged with the new CCB Director, Marshall Rosier, about increasing the number of COD-certified clinicians. It is likely that the CCB will add Pennsylvania's COD exam to our COD credential. The Workforce Development Workgroup and DMHAS' Training and Education Division are exploring ways to provide web-based training. Rick Fisher is also a member of the multi-state agency workgroup designed to collaboratively purchase/develop such a system.

Strategy:

- Develop and implement plans for utilization of evidence-based practice models and measurement of quality care for persons with COD.

Progress (As of 3/2006):

- The Service Delivery Workgroup is planning to recommend increased rates for sites that are designated as DDE. A key factor in attaining a DDE designation will be the use of evidence-based practices (EBPs), such as IDDT. DMHAS currently contracts with Dartmouth/Rusty Foster to provide training and consultation of the IDDT model throughout the state.

Strategy:

- Develop and implement prevention and early intervention programs that target people at risk for co-occurring disorders.

Strategy:

- Develop and implement a full array of effective and culturally responsive COD clinical and recovery support services for individuals with CODs across the state.

Progress (As of 3/2006):

- The results of the Hispanic Clinic's implementation of the culturally adapted version of IDDT will inform these plans.

Strategy:

- Conduct ongoing evaluations of process and outcomes pertaining to the areas of the COD implementation across the state that allow state agencies and service providers to utilize data to inform quality improvement.

Progress (As of 3/2006):

- Yale (Larry Davidson, PI) has been contracted with our COSIG dollars to conduct a comprehensive process and outcome evaluation of the two COSIG pilot sites. In addition, DMHAS' quality management and improvement division will be conducting other statewide evaluation activities relative to CODs and providing feedback to all stakeholders in order to make data-based decision making a reality.

Strategy:

- Translate the implementation evaluations of COD services into lessons learned for communities attempting to implement evidence-based practices for CODs in their own community.

Progress (As of 3/2006):

- DMHAS, Dartmouth, and Yale plan to collaboratively work on products for dissemination regarding lessons learned in CT's successful statewide implementation of integrated screening and treatment.

Finance Strategy:

- Review block grant and existing state resource expenditures to determine whether allocations can be modified to support the adoption of comprehensive COD treatment and recovery support services. The state will seek additional new resources, if necessary. In addition, DMHAS will consider the costs associated with the provision of COD capable services in the development of tiered fee schedules under the General Assistance Behavioral Health Program (GABHP) for service providers that are either COD capable or COD enhanced.
- Review whether non-covered COD treatment and support services should be covered under the General Assistance Behavioral Health Program. If expansions are warranted, review existing funding for such services for possible reallocation or, if necessary, seek new resources.

Outcomes:

- Local/regional planning partnerships exist statewide to improve COD care through processes that include: coordination of integrated systems of services; fostering of collaborations and peer advocacy; assessment of local needs and capacity; and recommendations for system changes to state agencies.

- State agencies will review local recommendations and collaboratively improve the system of care for persons with COD.
- The system will improve its capacity to provide psychopharmacological care to persons with COD in their local community.
- State and private service providers will participate in research and develop protocols to measure treatment outcomes for persons with COD.
- The state will address licensure issues and create incentive so that service providers will pursue COD appropriate licensing and/or credentialing and regions will have sufficient number of providers who are co-occurring capable or enhanced.
- Prevention and early intervention programs will include specific foci on co-occurring disorders.

Timeframe: Year One

- A joint MH/SA committee will be created to review existing initiatives and implement common contract language that ensures all service providers report on people with COD needs. (Builds on TA from RWJF and the IDDT Initiative.)
- Joint committee to assess existing planning, collaboration and treatment delivery capacity within local communities and peer advocacy groups and expand to encompass COD needs and issues, develop linkages and engage community resources to build wrap-around supports, including housing and transportation.
- Opportunities, including provider incentives, will be established for service providers who pursue COD licensing or credentialing.

Year Two

- Joint Committee to identify COD Champions to provide on-going leadership, facilitate working through systemic roadblocks, and reconvene an ad hoc committee as needed.
- Recommendations will be implemented across state departments to contractually define and measure "dual diagnosis capable" and "dual diagnosis enhanced" service providers (mental health and substance use programs) and attach incentives, as appropriate.
- State departments to integrate recommendations regarding system capacity and needs into contracts and RFPs.
- People with COD will be actively solicited to serve on advisory boards and in communities to strengthen relationships and improve communications between the service sector and the community.
- All persons with COD seeking medications will be able to access prescribing services in their local community.

TA Needed:

- TA to define COD capability in level of care/medical necessity criteria, including the development of guidelines for reviewing and determining that such criteria are COD capable.
- TA in the development of clinical care criteria for level of care and length of treatment that supports a person-centered, no-wrong-door, and recovery-oriented approach.
- TA in re-directing existing resources and re-designing all substance abuse and mental health programs to meet the needs of individuals with CODs. This is based on the understanding that system-wide dual diagnosis capability can be created most efficiently within the context of existing resources.
- TA in applying Hawkins and Catalano's Community Mobilization Model in Connecticut's regions to strengthen coalitions and enhance systems' coordination.
- TA on expanding prevention interventions to include COD and increase awareness among service providers, educators, and the public.

- TA to develop outcome-based approaches for person- and family-centered care.
- TA for local communities in methods of grant seeking and writing.
- TA to identify innovative ways to address transportation needs.
- TA to develop a tiered fee schedule option, including the policies and procedures under which such a fee schedule would operate.
- TA in identifying non-covered COD services and recovery supports that should be added to the State's General Assistance Behavioral Health Program benefit package.
- TA in maximizing the use of the federal Substance Abuse Prevention and Treatment and Mental Health Block Grant funds for COD services.
- TA for implementation of Rehabilitation Options for COD services, including assistance with defining COD services.
- TA regarding opportunities for extending Rehabilitation Option coverage for COD services and supports, including assistance with defining COD services.
- TA in conducting a cost-analysis study on the cost-effectiveness of integrated CODs services vs. non-integrated mental health or substance abuse treatment services.
- TA to enhance the utilization review criteria for the General Assistance Behavioral Health Program.
- TA to develop and implement effective and culturally responsive clinical and recovery support dual diagnosis enhanced care for individuals with CODs across the state.
- TA in conducting ongoing evaluations of process and outcomes pertaining to the areas of the COD implementation across the state that allows providers to utilize data to inform quality improvement.
- TA in translating the implementation evaluations of COD services into lessons learned for communities attempting to implement evidence-based practices for CODs in their own community.

Updated TA Request (As of 3/2006):

- TA in maximizing the use of the federal Substance Abuse Prevention and Treatment and Mental Health Block Grant funds for COD services.
- TA for implementation of Rehabilitation Options for COD services, including assistance with defining COD services.
- TA regarding opportunities for extending Rehabilitation Option coverage for COD services and supports, including assistance with defining COD services.
- TA in conducting a cost-analysis study on the cost-effectiveness of integrated CODs services vs. non-integrated mental health or substance abuse treatment services.
- TA to enhance the utilization review criteria for the General Assistance Behavioral Health Program.
- TA to identify innovative ways to address transportation needs.
- TA on expanding prevention interventions to include COD and increase awareness among service providers, educators, and the public.
- TA in applying Hawkins and Catalano's Community Mobilization Model in Connecticut's regions to strengthen coalitions and enhance systems' coordination.

COMPILED LIST OF TECHNICAL ASSISTANCE REQUESTS

WORKFORCE TA

1. TA from Minkoff and Cline to review current workforce COD competencies and assist in the development of COD core competency curriculum and training that can be introduced across disciplines and agencies. This will require the use of a COD survey tool (i.e. COD Basic Competence Evaluation Tool developed by Minkoff and Cline), which will need to be purchased, and training to administer this will need to occur.
2. TA to develop a curriculum, training and supervision module for peers or persons in recovery.
3. TA in developing technology transfer (i.e. teleconferencing, videoconferencing) in the delivery of training.
4. TA in developing and implementing COD clinical supervision, assessment, and training curriculum.
5. TA from Minkoff to conduct a systems analysis that would include COD workforce competency and workforce training needs.
6. TA in developing job descriptions which reflect COD competencies, credentialing, recruitment and retention of underrepresented groups and of the overall workforce, and in addressing staff burnout issues and strategies for how to best negotiate these changes with organized labor unions.
7. TA in developing system-wide incentives for service providers and clinicians to become COD credentialed and/or hire COD credentialed staff.
8. TA in supervision training to insure proficiency for supervisors.
9. TA in developing a tracking system to ensure that ongoing COD supervision is occurring.
10. TA in creating incentives for engaging and retaining a diverse workforce that includes persons from various cultural and ethnic backgrounds and persons in recovery.
11. TA in developing and implementing university and college curriculum that
12. prepares a new pool of competent COD professionals.

SERVICE DELIVERY TA

13. TA to develop and implement a customer-service training program, using experts outside the behavioral health field, that includes a communication plan for person-first and family-first language and approaches.
14. TA from Dr. Minkoff to consult with customer service team, conduct workshops for service providers, and develop standards for safe and welcoming environments.
15. TA to examine JCAHO compliant standardized screening and assessment practices in other states and use that information to develop Connecticut instruments.
16. TA to support modifications to Connecticut's web-based information system that facilitate information sharing and ensure compliance with all privacy standards.
17. TA to define COD capability in level of care/medical necessity criteria, including the development of guidelines for reviewing and determining that such criteria are COD capable.
18. TA in the development of clinical care criteria for level of care and length of treatment that supports a person-centered, no-wrong-door, and recovery-oriented approach.
19. TA in re-directing existing resources and re-designing all substance abuse and mental health programs to meet the needs of individuals with CODs. This is based on the understanding that system-wide dual diagnosis capability can be created most efficiently within the context of existing resources.
20. TA in applying Hawkins and Catalano's Community Mobilization Model in Connecticut's regions to strengthen coalitions and enhance systems' coordination.

21. TA on expanding prevention interventions to include COD and increase awareness among service providers, educators, and the public.
22. TA to develop outcome-based approaches for person- and family-centered care.
23. TA for local communities in methods of grant seeking and writing.
24. TA to identify innovative ways to address transportation needs.
25. TA to develop a tiered fee schedule option, including the policies and procedures under which such a fee schedule would operate.
26. TA in identifying non-covered COD services and recovery supports that should be added to the State's General Assistance Behavioral Health Program benefit package.
27. TA in maximizing the use of the federal Substance Abuse Prevention and Treatment and Mental Health Block Grant funds for COD services.
28. TA regarding opportunities for extending Rehabilitation Option coverage for COD services and supports, including assistance with defining COD services.
29. TA in conducting a cost-analysis study on the cost-effectiveness of integrated CODs services vs. non-integrated mental health or substance abuse treatment services.
30. TA to enhance the utilization review criteria for the General Assistance Behavioral Health Program.
31. TA to develop and implement effective and culturally responsive clinical and recovery support dual diagnosis enhanced care for individuals with CODs across the state.
32. TA in conducting ongoing evaluations of process and outcomes pertaining to the areas of the COD implementation across the state that allows providers to utilize data to inform quality improvement.
33. TA in translating the implementation evaluations of COD services into lessons learned for communities attempting to implement evidence-based practices for CODs in their own community.

GUIDING FRAMEWORK

A. CHAPTER I – INTRODUCTION

The National Policy Academy on Co-Occurring Mental Health and Substance Use Disorders

In its November 2002 *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) documented the human, social, and economic costs of co-occurring disorders and the toll they take on individuals, families, schools, workplaces, communities, States, and ultimately, the Nation as a whole. The National Policy Academy on Co-Occurring Mental Health and Substance Use Disorders, as an outgrowth of one of the major recommendations under the Report's Blueprint for Action, set forth National policy and agenda efforts to ensure accountability, capacity, and effectiveness in the prevention, diagnosis, and treatment of co-occurring substance use and mental health disorders. Additionally, the National Policy Academy offered an unprecedented opportunity to join Federal, State and local partners to improve services for persons with co-occurring disorders.

Connecticut is one of the ten states selected to participate in the National Policy Academy's intensive policy-building forum to develop a State action plan for improving access to services for persons with co-occurring disorders. The Connecticut Team is composed of key stakeholders in Connecticut's substance abuse and mental health system, including representatives from the Governor's Office, state agencies, service providers, and recovery and advocacy groups. Indicative of Connecticut's focus on the involvement of persons in recovery, Connecticut's team is co-chaired by a leader in the recovery community. The Connecticut Team Members are listed below:

- Thomas A. Kirk, Jr., Ph.D., Department of Mental Health and Addiction Services (Team Co-Leader)
- Phillip Valentine, Connecticut Community for Addiction Recovery (State Team Co-Lead)
- Brenda Sisco, Governor's Office
- Leslie Woods, Advocacy Unlimited
- Mark Schaefer, Ph.D., Department of Social Services
- John F. Chapman, Psy.D., Judicial Branch, Court Support Services Division
- Dan Bannish, Psy.D., Department of Correction
- Peter Panzarella, LADC, LPC, Department of Children and Families
- Joan M. Pesce, M.Div., Morris Foundation (Community Provider)
- Heather Gates, MBA, Community Health Resources (Community Provider)
- Arturo Morales, M.D., Independent Service Provider
- Susan Niemitz, LCSW, Hartford Behavioral Health (Community Provider)
- Edward Spauster, Ph.D., Liberation Meridian Group (Community Provider)
- Samuel R. Segal, LPC, LADC, Department of Mental Health and Addiction Services
- Rick Callahan, LADC, LPC, Department of Mental Health and Addiction Services/Southeastern Mental Health Authority
- Sabrina Trocchi, MPA, Department of Mental Health and Addiction Services

Content of the Connecticut Plan on Co-Occurring Disorders
The Connecticut State Plan on Co-Occurring Disorders areas of focus include: 1) Service Delivery; 2) Workforce Development; and 3) Financing Strategies. Summary priority recommendations under each of the areas of focus, include:

1) Developing an *integrated system of care* which is welcoming and accessible and comprehensively assesses and treats individuals with CODs;

2) Developing and sustaining a *competent and skilled workforce* that will effectively provide integrated care, through accessibility to ongoing training, clinical supervision, reimbursement for COD credentialed practitioners, providers' incentive to pursue COD credentialing, and recruitment/retention of culturally diverse individuals and individuals in recovery; and

3) Strategic *reinvestment of existing substance abuse and mental health funding* into COD training, services, and supports.

Coordination with the Connecticut Co-Occurring State Incentive Grant (COSIG) for Adults
The proposed Connecticut COSIG application is consistent with the Connecticut COD Plan's priority recommendations. Connecticut proposes to use COSIG funds to better serve individuals with co-occurring disorders (CODs) through the following infrastructure enhancements:

1. Standardized Screening & Assessment will be established to identify individuals with CODs and their treatment needs, regardless of where the individual initially presents for care. The ultimate goal is that all substance abuse providers will be required to implement a brief screening tool for mental health concerns. In turn, all mental health providers will be required to implement a brief screening tool for substance abuse concerns.

2. Service Coordination and Network Building are essential to enhance the quality of services by removing barriers that impede access, retention, and favorable treatment outcomes, leading to a cohesive, coordinated, and integrated delivery of services and programs for individuals with CODs, thus, reducing the burden on the individual to negotiate services and maximizing use of limited resources within both treatment "silos".

3. Develop infrastructure that allows information sharing to all stakeholders and promotes the use of data in a quality improvement framework.

Additionally, Connecticut proposes to provide sufficient testing ground for these infrastructure enhancements through two service pilots, one in Quadrant II and one in Quadrant III. The Enhancing Psychiatric Services Pilot seeks to develop and implement effective, integrated, and culturally responsive clinical and administrative dual diagnosis enhanced care for Latinos/as with CODs. The Addiction Services Pilot will design and implement an integrated system of services for individuals with CODs, which includes use of system change technology with clinical practice technology at the system, program, and clinician

competency levels to create comprehensive system change. These pilots will establish an integrated system of care for persons with CODs and will implement a coordinated outreach, intake, and screening process to ensure that individuals who present in either system with CODs are engaged in appropriate care.

Coordination with the Connecticut Co-Occurring State Incentive Grant (COSIG) for Adolescents

Connecticut proposes to use COSIG for Adolescent funds to build a statewide infrastructure designed to support and sustain effective interventions for youth with CODs. Specifically, Connecticut will develop and initiate a three-tier strategy for infrastructure development:

1. Establish state leadership dedicated to planning, implementing, monitoring and sustaining the enhanced infrastructure;

2. Support communities to develop and implement their own action plans that will address the unique needs of co-occurring youth in their particular area; and

3. Improve the quality of services for co-occurring youth.

CHAPTER II – EVOLUTION OF CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES IN CONNECTICUT

Connecticut's Strengths and Existing Infrastructure and Capacity

Connecticut has in place two public/private stakeholders' policy-making bodies: the Alcohol and Drug Policy Council (ADPC) and the Mental Health Policy Council (MHPC). The ADPC has statutory responsibility to review practices of agencies concerning substance abuse or co-occurring treatment services and develop a statewide, integrated plan for such programs. The ADPC is composed of key stakeholders in Connecticut's substance abuse system including state agencies, legislators, academic experts, law enforcement agencies, service providers, persons in recovery, and advocacy groups. Recognizing the need for a more responsive mental health system, Governor Rowland also established a Blue Ribbon Commission on Mental Health in 2000 to recommend strategies for improving the quality of care across the state. The result was establishment of the MHPC, an advisory body that has placed particular emphasis on exploring ways to improve the range of mental health and co-occurring services needed by CT residents. *Both Councils are Co-Chaired by the DMHAS Commissioner, with current efforts to establish a joint steering committee on Co-Occurring Disorders.*

Recognizing that individuals with co-occurring disorders present themselves at different venues, (i.e., criminal justice, child welfare, healthcare, etc.), Connecticut has diligently moved forward in bringing together relevant state agencies, including the Departments of Mental Health and Addiction Services (DMHAS), Child and Families (DCF), Correction (DOC), Social Services (DSS), and the Judicial Branch, in order to capitalize on the most efficient use of agency resources and eliminate service redundancy. These existing partnerships provide a solid foundation for the development and implementation of the Connecticut

Co-Occurring Plan to increase capacity to provide accessible, effective, comprehensive, integrated, and evidence-based service for persons with co-occurring disorders. Relevant state agencies and their existing strengths, infrastructure, and capacity for co-occurring services are described below.

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

In 1995, the CT General Assembly created legislation that merged substance abuse and mental health administrative functions and service delivery structures into a new integrated department. Since the merger of the two agencies, the newly renamed Department of Mental Health and Addiction Services (DMHAS), as the Single State Agency (SSA) for substance abuse treatment services *and* the State Mental Health Authority (SMHA) for adult populations (18 and over).

1. One of the first initiatives undertaken by the newly integrated DMHAS was the formation of a Dual Diagnosis Task Force that issued recommendations (all 4 of which were adopted) in 1997. The implementation of one of the Task Force recommendations led to development of a comprehensive CODs training curriculum as a basis for cross-training providers and educating people in recovery in both Mental Health and Addiction Treatment Systems. Regional representatives from mental health and substance abuse treatment and the recovering community participated in an 8-month educational train-the-trainer series.

2. Following a decade of supporting research on CODs conducted in CT by Dr. Drake and his colleagues from the Dartmouth Psychiatric Research Center (PRC), DMHAS has obtained funding to support provision of consultation by PRC for all of CT's Local Mental Health Authorities (LMHAs). This consultation focuses on bringing the entire system in line with best practices within the context of the national model, which calls for integrated treatment for the most severely affected of the dually diagnosed population. At the same time, this project is developing protocols for consultation and collaboration between the mental health and substance abuse treatment systems, where clinically appropriate, in order to address the needs of less severely affected individuals in this heterogeneous population. A particular emphasis of this technology transfer project is application of Fidelity Measures and ongoing support of sustaining these practice changes through selection of agency "Champions", development of peer supervision groups, and Integrated Treatment Steering Committees.

3. DMHAS, through Stage I of its Assessment/Treatment of Persons w/Psychiatric Co-Morbidity in Substance Abuse Treatment Initiative, assessed the current practices of treatment programs with respect to CODs. Prevalence estimates, typical assessment & treatment practices, attitudes, resources, perceived training & staffing needs, and program and provider characteristics were obtained from 48 substance abuse agencies, with a total of 456 providers composing the sample. Using the NASADAD-NASMHPD Quadrant model, these providers estimate that 50% of clients with CODs are high substance use severity and low psychiatric severity. Using the ASAM-PPC-2R definitions, providers identified their programs as *Addiction Only*

Services (13%), *Dual Diagnosis Capable* (60%), or *Dual Diagnosis Enhanced* (27%). This information will form an evidence- and consensus-basis for system improvements.

4. The CT Integrated Dual Disorder Treatment (CT-IDDT) Initiative, a partnership between DMHAS and Dartmouth, seeks to integrate IDDT into the day-to-day practice of CT's 16 Local Mental Health Authorities (LMHAs). Each LMHA has identified an agency "champion" to successfully integrate the IDDT practice into agency culture, involving 3 stages of action: 1) Motivation & Consensus; 2) Implementation; and 3) Sustaining. Through this initiative, approximately 13,000 hours of COD training has occurred with approximately 6,500 hours of this training occurring for private non-profits agency employees and 6,500 hours for DMHAS staff. Approximately 500 individuals have received in depth COD training, monthly consultation, supervision, and case conferencing with Dartmouth staff. This initiative has set the stage for implementation of a screening tool for psychiatric disorders in addiction treatment settings, to be followed by provision of mental health care in an integrated fashion.

5. CT has made a concerted effort, through both workforce training and system development, to prepare its workforce for treatment of clients who have a more severe psychiatric disorder and less severe addiction (Quadrant II). These efforts still need to be taken further in terms of their appropriateness for clients from ethnic minority backgrounds.

6. DMHAS, in collaboration with Yale University and the University of CT, has undertaken an ambitious Preferred Practices Initiative. This Initiative has as its primary aim identifying the most effective and/or promising practices in all areas of behavioral healthcare, including CODs. Particular attention is being paid to sustaining fidelity to evidence-based practice models over time through the use of fidelity measures and ongoing expert consultation.

7. DMHAS' overarching goal is to promote a value-driven, recovery-oriented system of care. DMHAS has initiated a major initiative, which has focused on system design, consensus building, training, and technology transfer. As a core component of the Recovery Initiative, DMHAS in collaboration with Yale has established the Recovery Training Institute. Since 2003, over 3,000 individuals have received training to provide specific recovery-oriented skills. DMHAS has also established a "Center of Excellence" for the treatment of individuals with co-occurring disorders to foster service innovation that can then be transferred throughout the system. Directions for the coming year include increased focus on person-centered planning, performance measures, and finalizing recovery-oriented standards.

8. DMHAS, through academic partnerships with Yale, the University of CT, and Dartmouth College, has a history of participation in research, including research relative to use of Integrated Dual Disorders Treatment within Assertive Community Treatment (ACT) Teams. This work has culminated in multi-year CODs projects, taking place within both the mental health and substance abuse treatment systems.

9. CT Treatment Outcomes/Performance Study, funded through CSAT, developed a set of instruments to identify clients with co-occurring psychiatric disorders in addiction treatment settings. The study showed that more than 37% of men and more than 53% of women in substance abuse treatment met diagnostic criteria for depression, anxiety, or post-traumatic stress disorder.

Areas for COD Infrastructure Development	**Table 1. Existing Infrastructure**
Standardized Screening and Assessment	-Recommendations made by the DMHAS Standing Committee on CODs, composed of members from both MH and SA, as well as a mix of public and PNP agencies, led DMHAS to adopt the NASADAD/NASMHPD Model for categorizing CODs by severity of symptoms. Having drafted Standards of Care for COD Capable programs (under ASAM PPC-2R model), the Standing Committee oversees a project to develop a fidelity measure for monitoring program compliance with the draft standards. -DMHAS over the past 4 years has funded projects to implement screening and integrated treatment for CODs within CT Opioid Agonist Treatment Programs.
Complementary Licensure and Credentialing Requirements	-The CT Certification Board developed a certification process for COD Practitioners. -CT General Statues allow DMHAS to grant/recommend an exemption from the Certificate of Need process for new or expanded substance abuse or mental health services. As part of this authority, DMHAS has strongly promoted the expansion of CODs services by approving requests for integrated services.
Service Coordination & Network Building	-The Alcohol and Drug and the Mental Health Policy Councils and the integrated State MH/SA Board have made effective treatment of CODs a high priority. -Integrated SSA/SMHA (DMHAS), including 1 Commissioner and integrated operations.
Financial Planning	-Developing rate structure for COD Enhanced services in selected care levels as an incentive for providers to implement staffing patterns necessary to effectively treat persons w/CODs. -Developing capacity for Medicaid reimbursement for Targeted Case Management within SA programs in order to enhance engagement & coordination of care for individuals w/CODs.
Information Sharing	-The DMHAS Integrated Information system contains data on all clients receiving SA & MH services within the DMHAS system of care including state operated & non-profit facilities. -Data Sharing Project: 7 state agencies & Judicial Branch are participating in estimating the individuals treated for SA within criminal justice and health and human services populations and sharing administrative data for measuring trends of persons accessing treatment.

DEPARTMENT OF CHILDREN AND FAMILIES (DCF)

The Connecticut Department of Children and Families (DCF) is the consolidated children's agency with legislative mandates to administer fund and develop programs for Adolescent Mental Health and Substance Abuse Treatment Services, in addition to Child Welfare and Juvenile Justice matters.

DCF has a Workforce Development Committee for in-home clinical services. This group includes providers from DCF and the graduate/doctoral schools in Connecticut and surrounding states. The in-home clinical models (Multi Systemic Therapy, Multi Dimensional Family Therapy, Functional Family Therapy, In-Home Child and Adolescent Psychiatric Services) are evidenced-based and/or promising practices for youth with complex behavioral health needs including substance abuse, mental health and often involve juvenile justice or child welfare system. This group is working on various activities, externships and internships in evidenced based treatment, evidenced based curriculum, job fairs, and funding to increasing minority representation, cultural linguistically competent providers through scholarships. DCF is building a research consortium with various academic partners on behavioral health, juvenile justice and child welfare.

JUDICIAL BRANCH

The Connecticut Judicial Branch operates juvenile and adult courts, probation, detention centers, and the Court Support Services Division, which funds an array of behavioral health and community supports. The Judicial Branch holds unique capacity for weaving a co-occurring capable system into existing services, as described below.

1. For adult populations, the Judicial Branch operates a nationally recognized jail re-interview program in coordination with the Department of Mental Health and Addiction Services (Clark, 2004). The jail re-interview program holds unique opportunities for outreach and proper identification of persons with COD.

2. The Judicial Branch operates and oversees adult and juvenile probation functions, offering the opportunity for COD screening for both populations. The Judicial Branch, through its Juvenile probation services, conducts an intensive mental health and substance abuse evaluation of all children referred for non-judicial matters and adjudicated youth. Over 3,000 children were screened last year and many show evidence of both substance use and psychiatric disorders. An additional 3,000 children are screened through juvenile detention (annually).

3. Unique services in the juvenile sphere include an intermediate evaluation model designed to provide necessary forensic and psychological evaluations to the court while integrating young people into the service delivery system, and multiple community based psychiatric clinics designed to manage medication and incorporate multiple services of the community.

4. The Judicial Branch has been working with partner agencies in developing an integrated criminal justice/child welfare/service provider database

infrastructure that would allow enhanced data analysis and provide enhanced data analysis capacity for scholars and policy makers. Grant application for this project is currently underway.

5. The Judicial Branch is establishing a web-based server to integrate screening and assessment information from detention and probation offices.

6. The Judicial Branch has developed an evidence-based practices unit designed to evaluate programs for effectiveness and apply rigorous outcome measures.

7. The Judicial Branch's training academy provides pre-service and continuing education programs for all Judicial Branch employees. A COD curriculum is currently being designed and will be launched in September 2004 for all new detention and probation officers. Eventually this training program will expand to bail commissioners and jail re-interviewers in both pre-service and continuing education. With over 15,000 juvenile cases referred and 123,000 adult criminal cases between July 2002 and June 2003, the Judicial Branch is in a unique position to make appropriate determinations and referrals of persons with COD.

8. Although not a direct services provider, the Judicial Branch contracts with many private and public agencies to provide substance abuse and mental health services to its clients. Contract management provides another means of ensuring COD capability, staff education, and reporting.

DEPARTMENT OF CORRECTION (DOC)

The Department of Correction (DOC) is responsible for approximately 18,500 inmates. This includes male, female, and some juvenile offenders. It is one of only six states that combines jail and prison populations under its jurisdiction. DOC has recently taken over management responsibility for inmates on parole as well. All inmates are screened for mental health, medical and addictions issues upon entry. About 14% of inmates are receiving mental health services on a regular basis. Of those 50% require psychotropic medications. There are nearly 400 inmates who require acute services or mental health housing. Addictions Services provides programming ranging from short-term psychoeducational to long term inpatient. Eligibility for intensive and inpatient programming is determined by a formal assessment. Nearly 67% of inmates have addictions problems in the serious to severe range. There are approximately 700 inmates of those inmates being served in long-term programs usually in the final year of their incarceration. Addictions services are provided within the DOC Community enforcement offices to provide follow-up and connection to community services. DOC's holds infrastructure and capacity for a co-occurring capable system is described below.

1) Leadership-The DOC leadership team (Commissioner and staff) are committed to reentry initiatives and collaboration with other state agencies. There is strong emphasis on preparing inmates for the reentry into the community while still meeting the agency's mission.

2) Expertise-DOC has contracted with the University of Connecticut Health Center (UCHC) to provide behavioral health services for inmates. This relationship assists DOC in recruiting a qualified and well-trained workforce.

3) Programming-DOC invests heavily in programs that deal with mental health and addictions problems. Facilities are identified with special units to meet needs of inmates with behavioral health disorders.

4) Alternative to Incarceration-Systemic interventions, from pre-arrest through community reentry, are being proposed and acted upon as a result of this advisory committee chaired by the DOC Commissioner. This will include recommendations for treatment of inmates with co-occurring disorders.

5) DOC uses an objective classification system that identifies behavioral health treatment needs of inmates. All male inmates receiving greater than 2 year sentenced are assessed at a reception center and are transferred to appropriate facilities based on their behavioral health treatment needs and security factors.

6) A multidiscipline team of mental health, addictions, medical and custody staff is being formed to increase observation, screening, orientation and security for inmates with behavioral health disorders upon admission to jails.

7) DOC has a six-week training academy for all staff to familiarize them with policies and procedures and health and behavioral health related issues. Each year all staff are required to have 40 hours of refresher training.

DEPARTMENT OF SOCIAL SERVICES (DSS)

The Department of Social Services (DSS) administers over 90 assistance programs. Medicaid is by far the largest DSS program; covering more than 400,000 persons monthly at an annual cost of over $2.8 billion during FFY2001. DSS operates two managed care programs. HUSKY A is a managed Medicaid program serving 300,000 Title XIX eligible adult and child enrollees monthly, including all children in the child welfare system. HUSKY B is a Title XXI State Children's Health Insurance Program (SCHIP) funded managed care model based on a commercial benefit, which enrolls more than 14,000 children. The Department also operates a Medicaid FFS program with more than 100,000 beneficiaries, many of whom have mental health, substance abuse, and co-occurring disorders.

The Department of Social Services has been developing alternative models for the administration of its behavioral health services under the above programs. Such models emphasize timely access to services, the development of a broader array of Medicaid funded community services and supports, intensive care management for persons that are not effectively served by the various systems, coordination and collaboration with primary care, early intervention in primary care settings, and the promotion of evidenced based practice.

COMMUNITY STAKEHOLDERS

Connecticut's efforts to date have been based on the premise that collaborations and partnerships with substance abuse, mental health, and co-occurring service providers and recovery communities is a fundamental component to the successful development, implementation, and evaluation of the Connecticut COD Plan. These partners will ensure the sustainability of the recommended strategies and actions.

1. Non-Profit Substance Abuse, Mental Health, and COD Service Providers

There are numerous non-profit mental health and substance abuse agencies throughout the state that have individually moved forward to create COD competency within their own agencies and/or created linkages to a variety of agencies. Many of the non-profit agencies partner closely with state agencies and have been involved in many of the initiatives mentioned above. These agencies are well positioned to move the Connecticut COD Plan forward.

2. Recovery Communities

In February 2000, Advocacy Unlimited, Inc. (AU), and the Connecticut Community for Addiction Recovery (CCAR), the state's primary substance abuse and mental health recovery and advocacy organizations, developed statewide guidelines for substance abuse and mental health recovery services, entitled ***Recovery Basic Premises and Recovery Core Values***. The ***Recovery Basic Premises and Recovery Core Values*** includes the following premises:

- All individuals are unique and have specific needs, goals, health attitudes and behaviors, and expectations for recovery.
- Persons with mental health or substance use disorders, or both, share some similarities, however, management of their own lives and mastery of their own futures may require different pathways at times.
- Regardless of the pathways, all persons shall be offered equal access and opportunity to navigate their road to recovery.
- In order to provide access to the correct road, DMHAS must establish an infrastructure that will allow for easy navigation and progress to the person's destination.
- The infrastructure should not impede the journey, instead, it should ease the travel and create safe transport to the destination.

System Barriers and Limitations

Although Connecticut offers a variety of strengths, system barriers remain, including:

- Standardized Screening and Assessment. The need for a uniform screening and assessment practice, which occurs wherever an individual with co-occurring disorders presents—is a major barrier.

- Service Coordination. Fundamental to effective linkages and network building is the collaboration between the substance abuse and mental health systems. Removing barriers that impede access, retention, and favorable treatment

outcomes, leads to a cohesive and integrated delivery of services for individuals with co-occurring disorders, thus, reducing the burden on the individual to negotiate services and maximizing use of limited resources within both treatment “silos”.

- Information Sharing. While an integrated information system is in place, there are challenges around effectively disseminating this information, using the information to make quality driven and data-based decisions, and promoting the actual use of data in a quality improvement framework that goes beyond solely using data to support a program.

- Workforce/Training Limitations. Administrators cite lack of funds for staff training and the difficulty of working across systems to cross-train providers as significant barriers (Ridgely et al., 1990). In addition, few incentives exist in the current system to motivate clinicians to become cross-trained (Drake, Essock et al., 2001).

- Budget Constraints. Providers often lack adequate resources to implement service models, administrative guidelines, quality assurance procedures, and outcome measures for a full range of needed services for people with co-occurring disorders (Drake, Essock et al., 2001).

- Stigma. The stigma still associated with substance use and mental disorders remains a significant barrier to the receipt of appropriate treatment (CSAT, 2000; U.S. DHHS, 1996b). In this respect, individuals with co-occurring disorders bear a double burden.

- Integration of MH and SA treatment, including separate funding mechanisms and administrative structures (SA vs. MH Block Grants), priority populations, treatment philosophies, clinician competencies, and eligibility criteria, are difficult and longstanding.

SERVICE DELIVERY

Service Delivery System

A. Statement of Issues

The overriding theme in the work of the service delivery system group is accessibility to high quality treatment and support services for persons with co-occurring disorders (COD). When considering the needs of persons with COD, the capacity of the current service delivery system to meet these needs and the obstacles persons with COD face in using the system, the workgroup identifies several issues to address.

The willingness and ability to welcome persons with COD is critical to quality service. Culturally competent, person-focused administrative, professional and support staff working in environments that truly invite persons with COD are a perquisite for successful engagement. The role stigma plays for persons with COD and for workers in the service delivery required consideration in all our priority areas.

Persons with COD, as well as providers of care, are part of a complex service system that is governed by numerous laws, regulations and accreditation standards that make it difficult for prompt and efficient screening, assessment and referral. Persons being served in new settings (e.g., new level of care, new provider) risk diminished quality of care due to delays in transmission of information about their behavioral health history, medications, and other key health data.

The final and most challenging issue is the provision of a continuum of care that is sufficient in size and scope, easily accessible in the home communities of persons served, and coordinated locally with such non-behavioral health services critical to recovery as safe and sober housing, vocational development, education and medical care.

B. Priority Areas

Priority One: Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.

Dr. Kenneth Minkoff's compelling COD Academy presentation and consultation with the Connecticut team emphasized the need for the system of care to focus on basic and attainable goals. Dr. Minkoff discussed the importance a welcoming environment plays in setting organizational culture and in engaging persons seeking care. Moreover, he emphasized that systems will sustain change when they provide staff with training, protocols and ongoing supervision.

The workgroup identifies the need for persons with COD to be welcomed anywhere in the service delivery system. This means that all providers—whether they are mental health or addiction focused, whether they assist adults, children or families, or whether they are in the behavioral health, child welfare, or criminal justice systems—have staffs prepared to recognize COD in persons served and assist these persons in accessing

comprehensive care. Recognizing that many people enter the system in a time of crisis, it is very important to incorporate welcoming practices into both traditional and non-traditional service systems. Those practitioners in crisis services, emergency departments, courts, jails, and probation officers are examples of the areas requiring inclusion.

Priority Two: All providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools.

The challenge of linking various systems of care to serve persons with COD is daunting. It may be impossible for providers to achieve without a common language, common tools and a common method to communicate with each other. Persons seeking assistance may do so from individuals with various degrees and credentials, including those who are not direct health care workers, as can often be found in the criminal justice system. A seamless and successful care system depends on the trust each person served and each provider has that all providers are competent to identify COD when it exists, comprehensively assess the current needs of the person, and engage that person in the care system.

When information (i.e. history) of the person served is unavailable there may be several repercussions. Persons served may be forced, once again, to go through a painstaking information-gathering process. If the person served is experiencing acute problems as a result of their COD, s/he may be unable to fully participate in a critical assessment process. In both cases, the person served experiences the care system as disjointed rather than seamless.

Staff members find themselves forced to gather demographic and historical information when they would rather focus on engagement. They are often forced to formulate care recommendations with incomplete and inadequate information. When information is available, it may reflect the idiosyncrasies of the last provider and not conform to accepted and standardized practices.

Priority Three: Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.

Persons with COD are no different than any Connecticut resident seeking health care or other services. They desire a coordinated system of care and support as close to home as possible. Even those who purposely seek care outside their community (e.g., residential rehabilitative) will need follow-up when they return. When a person with COD seeks care, it is likely that their first point of contact is the local hospital, provider agency, peer support, physician, counselor, probation officer or clergyperson. In concert with a person-centered and family-centered approach, they will first try to initiate a local response to the needs of the person with COD, knowing that this is the least disruptive to the adult, child or family served.

The Judicial Branch operates a jail re-interview program in close association with the Department of Mental Health and Addiction Services. This program seeks to divert those adults caught up in the criminal justice system who could be better served by diversion to appropriate services. In the juvenile area, routine uniform administration of

standardized screening instruments to probationers allows for identification of issues, including mental health and substance abuse, and creates opportunity for family and individual referral to services. Judicial has had experience in meeting unique challenges presented by diverse cultural and linguistic needs. Each court location must maintain ties with translators and translation services for numerous languages are available 24 hours per day, 7 days per week. Court personnel, probation staff and detention centers, can access these services. This capability is an important stepping point in creating a strong welcoming environment.

Unfortunately, persons with COD often find that there is no one program capable of addressing their co-occurring disorders. Moreover, when they discover that multiple services are needed, they often find that their primary caregiver has limited knowledge of and communication with other providers. Why? Most communities lack a local coordinating effort that identifies current resources for persons with COD, assesses unmet needs, and advocates for capacity building.

Access to care is a significant problem for many Connecticut residents. Many live in rural areas and have limited options for care and no public transportation. Suburban Connecticut's transportation system is designed for commuters and not for access to shopping and services. Finding ways to bring persons with COD to care and bringing care to them is critical for successful plan implementation.

By definition, people with co-occurring disorders have complex and multi-layered needs. Treatment must consider current best practice and state-of-the-art knowledge while avoiding formulaic mandates that cannot possibly fit every individual. Evidence based practices must evolve with research, diverse populations and our changing society.

Thus treatment systems and providers must employ a range of expertise across various dimensions. Connecticut has already demonstrated leadership in this area by adopting the New Hampshire model and principles of Harm Reduction for people with severe and persistent mental illness who use substances. Additionally, in conjunction with New Hampshire University, Connecticut has developed Dame La Mano specifically for Latino people with co-occurring disorders of the same intensity. We have aggressively promoted Motivational Enhancement Therapy, the Stages of Change and Twelve Step Fellowships and other peer supports as ways in which to conceptualize and change the dynamics of co-occurring disorders. Connecticut is also finalizing definitions for "dual diagnosis capable" and "dual diagnosis enhanced" as a means of categorizing provider capacity to treat people with CODs. Connecticut has also implemented SATEP (Substance Abuse Treatment Enhanced Program), a nationally recognized program that brings together a network of providers to create seamless services.

The Department of Children and Families has also aggressively pursued and promoted models of treatment, such as Multi Systemic Therapy, that targets conduct disordered and substance using youth. DCF has also utilized Multi Dimensional Therapy to treat youth using substances, or at risk of using substances, who also have a mental illness (i.e. Bipolar Disorder). Both of these programs work intensively with the entire family constellation in the community rather than from a traditional outpatient clinic.

With welcoming environments, comprehensive screening and assessment tools and local community commitment, the service delivery system will have as its greatest priority the building of its capacity to serve persons with COD. State and private

providers and peer support networks will need to work together to break down old boundaries among mental health and addiction services, peer-support and treatment advocates, and various state agencies.

C. Recommended Strategies, Actions, Enhancements

Priority One: Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.

It is essential that all members of the system of care develop mechanisms for appropriate greeting and engagement of persons with COD. This strategy is comprehensive in scope, requiring that every person in contact with persons served receive innovative and comprehensive training.

Customer service training is the key component of this strategy. Connecticut will engage experts in the field of customer service (not behavioral health experts) to develop and deliver training in engagement. These industry experts will work with professionals and peer advocate from state agencies and private organizations to develop a training program that is person-centered and enhances Connecticut's "no wrong door" philosophy.

Throughout the service delivery system, training programs on managing difficult situations will be revised to include specific material on challenging behaviors (i.e., intoxication, disorganization) that may be presented as well as specific techniques that may be helpful. Protocols for greeting, engagement and crisis-response will be developed for support and "front door" staff. The criminal justice curriculum for officers, already in existence, will incorporate training to assist in their responses to persons with COD.

The physical environment the person or family encounters when first seeking care has a major impact on how welcome they feel. Enhancing the physical environment will improve the welcome we give. Throughout the system of care, providers will be encouraged to examine, with fresh eyes, the waiting and reception areas, consultation rooms and external environment greeting persons served. State agencies will make available bonding funds to providers to improve access points and safety.

Persons with COD speak many languages. They come from various cultural backgrounds, all of which influence their understanding and acceptance of mental health and addictive disorders. Providers must have the capacity to welcome persons from diverse cultures and do so in various languages. A workgroup to research and produce in various languages educational materials on co-occurring materials will be created. State and private collaboratives will create and distribute culturally sensitive signage, art, and literature to providers throughout the system of care.

DMHAS' provider cultural competency plans will be updated to include the needs of special populations with an emphasis on co-occurring disorders. The Department of Children and Families (DCF) will develop cultural competency plans for services to children, youth and families throughout its system of care. Within the state agencies participating in this plan, there will be efforts by the various commissioners to direct their agencies and contract providers to use person- and family-first language.

Priority Two: All providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools.

The first step in addressing this priority is to build and maintain competent person- and family-centered assessment utilizing common screening and assessment tools appropriate for the populations served. Two teams representing state and non-profit providers will be created to investigate screening tools and assessments being utilized within Connecticut and in other states. One team will focus on children, adolescents and families and the other on adults.

Following their investigation, these two teams will recommend available tools or develop new tools that are appropriate to populations served and are in compliance with the regulatory and accreditation bodies commonly reviewing providers in Connecticut. Statewide trainings, sponsored by the state agencies committed to this plan, will occur throughout the system of care.

Aware that training introduces new practice but may not maintain it, standards will be developed by state agencies to assess provider competence in screening and assessment. These will be included in routine program reviews.

Provider access to the health information of persons with COD facilitates accurate and comprehensive assessment. Connecticut plans to create systems that allow recovery information released by persons served to be easily shared among providers. It will form a health information team from the agencies involved in this plan and the Department of Public Health. The team will immediately develop standard "authorization to release information" forms that comply with all laws governing the release of mental health, addiction and medical disorders for both adults and minors. These will be distributed to all providers and individual practitioners in the state through the Internet.

The health information team will also examine web-based information sharing systems. The team will consult with providers and persons served to identify the key health information that, if readily available, would facilitate quality care in the system. Following this determination, the team will assess electronic sharing capabilities and create a long-term plan for information sharing.

With the screening of persons with COD able to be conducted anywhere in our "no wrong door" system of care, providers will need to be able to connect persons with COD to services. Connecticut will enhance centralized access and referral services. These will assist agencies identifying COD needs in individuals in accessing care, as well as providers in making referrals and discharge plans for persons with COD, assist individuals and family members seeking assistance, maintain listings of COD capable providers, and track availability of services needed by persons with COD. Staff of a centralized access and referral service will be trained to offer bias-free information to callers, facilitating access to various levels (e.g., residential, outpatient) and types of care (e.g., MH, SA, methadone, psychopharmacological, peer support).

Connecticut has successfully implemented such a service in its capital, Hartford. The Department of Mental Health and Addiction Services has established a comprehensive service by contract with an Administrative Service Organization, Applied Behavioral

Health, that is utilized almost equally by providers and persons seeking care. The Connecticut Department of Children and Families has similarly developed a referral system, Project Safe, for parents and guardians in its system of care. The state will **build on these current resources** to ensure centralized access for COD services.

Priority Three: Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.

Persons with COD reside in communities and desire community supports in time of need. They rely on providers to take the lead in their local communities in developing linkages and engaging various community resources including peer supports. To facilitate this effort, the commissioners of the agencies participating in this plan will direct their staffs to create **local planning partnerships**. State agency leadership, working in local regions (e.g., DMHAS regional managers, Local Mental Health Authorities, DOC, and DCF Behavioral Health Directors), will facilitate creation of planning groups for both child/family and adult services, including in their membership all key stakeholders.

Each planning group will assess the needs of persons with COD in their community and the capacity of the system to meet these needs. Each will develop a **local plan** for coordination of behavioral health, peer advocacy and support services.

It is anticipated that participating agencies will need to build system capacity to ensure timely and appropriate services to persons with COD. Annually, local planning groups will make recommendations on capacity building to the commissioners participating in this plan. These recommendations may include coordination among agencies, expansion of existing services and creation of new services that meet local needs. Commissioners and their staffs will integrate these recommendations into statewide plans when possible. The state departments participating in this plan will actively seek grant opportunities that increase/enhance co-occurring capacity and provide technical assistance to local groups to do the same.

Participating state agencies will create a task force to expand provider system capacity for medication evaluation, prescribing, monitoring, and dispensing.

Participating state agencies and local coordinating groups will identify the major transportation obstacles facing person with COD and work to develop innovative solutions. Consideration will be given not only to how to bring people to providers, but to how services may be brought to people.

Numerous providers serving persons with COD treat mental health or substance use disorders, but not both. Providers will be encouraged to become co-occurring capable or enhanced. In particular, outpatient addiction treatment providers will be encouraged to achieve mental health licensure and DCF licensed psychiatric clinics for children and youth will be encouraged to achieve addictions treatment licensure. Other agencies may incorporate language into service contracts to assure COD capabilities.

Leadership at the state level will help build capacity and improve services for persons with COD. The Connecticut Certification Board offers a certificate program in co-occurring disorders to all certified, masters-level and licensed professionals. There will

be an increase in the numbers of clinicians who complete the program through program expansion and improved access (free local and web-based training).

Competence in delivering services to persons with COD is critical in building a system of care. State agencies, in conjunction with providers, will develop and implement plans for the utilization of evidence-based practice models and the measurement of quality care for persons with COD. Currently efforts are underway to build evidence-based services systems. Judicial has developed its own evidence-based unit to evaluate programs, as well as its own practices, in order to improve outcomes. As described previously, Connecticut has been a leader in bringing evidence-based practices to communities. Continuing these efforts, with a focus on co-occurring disorders, will be a priority in Connecticut.

Connecticut has a strong commitment to prevention and an infrastructure within several state agencies to design and deliver prevention services. Prevention services within DMHAS and DCF will initiate programs, provide funding and develop RFP's for prevention programs that target those at risk for co-occurring disorders.

D. Expected Impact/Outcomes

Priority One: Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.

Across the entire state's system of care, staff involved in any aspect of greeting persons served will be trained to create and act in accordance with an environment that understands, recognizes and warmly assists persons with COD.

Physical environments will reflect concern for safety and sensitivity to co-occurring disorders.

Programs will have cultural competency plans that address co-occurring disorders.

Materials on co-occurring disorders that assist the persons served (including all family and support persons) are available in a variety of languages.

Person-first language will be in use throughout the system of care.

As a result of the above, persons with COD will be able to enter any mental health or substance use program in the system and experience welcoming environments where staff members ensure that they receive appropriate assistance in addressing their presenting concerns.

Priority Two: All providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools.

Providers use common screening and assessment tools in their work with persons with COD. The effective use of these tools is regularly monitored ensuring consistency throughout the system of care and reducing the number of times people with COD need to go through a full assessment.

A standardized release of information form that satisfies all regulatory requirements are in use throughout the system enabling all state departments and private providers to release information within 48 hours of receipt of the request.

A plan for improved information sharing among providers is created maximizing the potential of electronic data transmission in real time.

Providers and persons with mental health and substance use needs utilize a centralized access and referral system to identify appropriate and available resources, reducing waiting time to enter services, improving utilization of treatment slots and match to needed level of service.

Priority Three: Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.

In regions/communities throughout the State of Connecticut, planning partnerships exist to improve care for COD through processes that include: coordination of services; fostering of collaborations and peer advocacy; assessment of local needs and capacity; and recommendations for system changes to state agencies.

The state agencies participating in this proposal will meet at the state level to review local recommendations and collaboratively improve the system of care for persons with COD.

The system will develop plans to improve its capacity to provide psychopharmacological care to persons with COD so that all persons with COD will be medicated in their local community.

State departments and private providers will participate in research and develop protocols to measure treatment outcomes for persons with COD.

The state will address licensure issues and create incentive so that providers will pursue COD appropriate licensing and/or credentialing and regions will have sufficient number of providers who are co-occurring capable or enhanced.

Prevention programs will include specific foci on co-occurring disorders.

E. Technical Assistance Needs

Priority One: Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.

Request 1.1

Connecticut seeks technical assistance to develop and implement a customer service training program for the staff of its state-operated and private nonprofit provider organizations. Technical assistance from a customer service expert will bring new ideas into the behavioral health system, refresh our attitudes, and enhance our person- and family-centered practices. Within this technical assistance request will be the

establishment of a communication plan on the use of person-first and family-first language and approaches.

Request 1.2
Connecticut seeks technical assistance from Dr. Minkoff to assist in identifying and developing standards for safe and welcoming COD service environments.

Priority Two: All providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools.

Request 2.1
Connecticut seeks technical assistance in reviewing existing COD screening instruments, identifying a COD screening instruments that best meets the needs of Connecticut's stakeholders, and making adaptations to the selected screening instrument for implementation within the Connecticut system.

Request 2.2
Connecticut seeks technical assistance to support modifications to its data information system to facilitate system-wide sharing of information while ensuring compliance with all privacy standards. Additionally, technical assistance is requested to ensure these modifications are responsive to meet the needs of COD enhancement system of care

Priority Three: Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.

Request 3.1
Connecticut seeks technical assistance in further developing local systems of care which build upon and further enhance Connecticut's existing infrastructures, including DMHAS' Local Mental Health Authorities (LMHAs), the Department of Children and Families (DCF) Care Coordination and Mobile Care Initiative, etc., and improve the coordination and delivery of COD services. Coordination of these systems enhances the quality of services by removing barriers that impede access, retention, and favorable behavioral health treatment outcomes, leading to a cohesive, coordinated, and integrated delivery of services and programs for individuals with CODs, thus, reducing the burden on the individual to negotiate services and maximizing use of limited resources within both treatment "silos." Specifically, Connecticut is interested in technical assistance from Hawkins and Catalano in applying their Community Mobilization Model in Connecticut's regions.

Request 3.2
Connecticut seeks technical assistance to support the establishment of a centralized COD access and referral service, through enhancements to Connecticut's existing administrative service organization infrastructure.

Request 3.3
Connecticut seeks technical assistance to expand and enhance the CT's existing prevention infrastructure and services/programs to be inclusion of prevention strategies for CODs. This technical assistance request includes assistance with developing a statewide educational campaign to increase awareness of CODs among providers,

consumers/family members, educators, and the general public, while reducing the stigma associated with CODs.

Request 3.4
Connecticut seeks technical assistance for the development of outcome-based performance measures for person-centered COD care that allows the use of data to inform quality improvement.

Request 3.5
Connecticut requests technical assistance to support local communities and service providers in identifying and pursuing federal and private/public foundation funding opportunities for the expansion and enhancement of COD services.

Request 3.6
Connecticut seeks technical assistance to identify innovative methods to increase access to COD services in all areas of the State.

Request 3.7
Connecticut seeks technical assistance in the development of clinical care criteria for COD services that will support person-and family-centered approaches, regardless of where the individuals present for care.

F. Timeframe

See table below.

Service Delivery Timeline

Priority	Year One	Year Two	Year Three
Priority One: **Any person with mental health and substance use disorders is welcome anywhere in the service delivery system**	Develop/purchase Customer Service Training, implement training schedule and begin training Develop incentives for providers to participate in trainings Revise current training on Managing Difficult situations Develop protocols for greeting and engagement for support and other "front door" staff Develop criteria and self-administered survey for a welcoming physical environment, especially access points and safety areas State departments will create/commission culturally sensitive signage, art and literature Review existing documentation and expand/develop forms and paperwork in diverse languages that utilize person-first language and recognize COD needs/issues. Assess data collection systems for ability to collect COD data, revise and update as needed	All providers will have 50% of identified staff complete training Develop intact training module for future use All providers will implement protocols All providers will implement survey and identify any needs. Providers will apply for bond funding, as appropriate Culturally sensitive signage, art and literature will be distributed and utilized throughout the service system Develop feedback mechanism from various service levels to identify needs and issues as they arise. Develop feedback mechanism from various service levels to identify needs and issues as they arise	All providers will have 50% of identified staff complete training. By the end of Year 3, all service providers will have approximately 75% of identified staff trained. Ongoing training opportunities will ensure reaching the goal of having 100% of identified staff trained. Develop comprehensive plan so that new staff will be trained in a timely manner Develop and implement a system that annually measures how well protocols are being followed and build in feedback loop for improvements State departments will identify a % of future bond funds to be set aside for this category On-going review of needs and competencies to be addressed via Cultural Competency Plans Develop capacity to share forms between state departments and between provider networks
Priority Two: **All Providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools**	Develop capacity for all providers to identify COD needs at any level/place in the service system Develop 2 teams (one for adults, one for children's services) to investigate standardized tools Create a Health Information Team representing all state partners and providers. This team will immediately develop a standardized "authorization to release	Develop incentives for providers to identify COD needs Identify standardized prescreening tool(s), train and implement state wide This team will examine feasibility of web-based information sharing systems All state departments and providers will release	Require providers to identify COD needs through contracting language with state departments Determine if a standardized assessment tool(s) is feasible and make recommendations for further action Implement recommendations And create a long-term plan for the state

Priority	Year One	Year Two	Year Three
Priority Two Continued	information" form. Distribute and require all providers to utilize standardized "authorization to release information" Implement pilot for a statewide Central Access and Referral Service, either by phase (referral/availability or discharge planning) or by region.	information, as authorized, within 48 hours of receipt of this standardized form Continue implementing state wide Central Access and Referral Service. Begin utilizing data collected to measure demand and capacity to meet demand	
Priority Three: **Persons with co-occurring disorders will receive comprehensive treatment and support services in their home communities**	State department leadership will mandate a joint standing committee between mental health and substance use silos, across state departments and including private providers for a period of two years. Joint Committee will review existing COD initiatives and, building on the Robert Wood Johnson Technical Assistance Award for collaborative contracting and the Integrated Dual Disorder Treatment Initiative, will implement common contract language to ensure all providers report on people with COD needs Joint Committee will assess the existing planning, collaboration and treatment delivery capacity within local communities and peer advocacy groups and will expand immediately to encompass COD needs and issues. Will also develop linkages and engage community resources to build wrap-around supports for people with COD, including housing and transportation needs Incentives will be developed for providers who pursue COD appropriate licensing and/or credentialing State agencies will initiate programs, provide funding and develop RFPs for Prevention programs that target persons at risk for COD	Joint Committee will identify COD Champions in each state department, provider and region to provide on-going leadership, facilitate working through systemic roadblocks and reconvene an ad hoc committee as needed Joint Committee will implement recommendations across state departments to contractually define and measure "dual diagnosis capable" and "dual diagnosis enhanced" providers (within both silos) and attach incentives. State department leadership will integrate recommendations regarding system capacity and needs into contracts and RFPs Persons with COD will be actively solicited to serve on advisory boards and in communities to strengthen relationships and improve communications between the service sector and the community All persons with COD seeking medications will be able to access prescribing services in their local community	

WORKFORCE

Workforce

A. Statement of Issues

The charge to the Workforce Workgroup was to create a plan to build a competent and skilled labor force that will effectively provide behavioral health services to those with, or impacted by, co-occurring mental health and substance use disorders. Though broad in scope, the overall issue addressed by the Workforce Workgroup is to ensure a workforce with core competencies in co-occurring disorders that can effectively serve those with co-occurring disorders, regardless of where they enter the system of care.

This requires, in part, the development of a core curriculum and supervision structure based on evidence-based and/or best practice principals of treatment for co-occurring disorders. These core competencies must be applicable to all providers, regardless of training or job class. The basic components of these best practices, as pointed out by Ken Minkoff, M.D., are "Attitudes, Values, Knowledge and Skills."

B. Priority Areas

Priority One: Connecticut will develop and implement a co-occurring disorder core curriculum that is applicable to all behavioral health providers and has measurable outcomes to assess its effectiveness over time. Specialized curriculum will be developed for advocacy organizations (i.e. Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU)) and for people who are in recovery.

This curriculum will be based on current evidence-based and/or best practices in the co-occurring disorder field, insuring high quality services and increasing the possibility of recovery for those with co-occurring disorders.

Priority Two: A clinical supervision structure must also be designed that fosters and continually assesses the skills of the workforce.

This will ensure continued individualized co-occurring disorder competency and skill development. In addition, it will ensure the sustainability of the co-occurring disorder practice.

Priority Three: The credentialing of co-occurring disorder practitioners will be addressed.

The current co-occurring disorder credentialing process will be reviewed with both the Connecticut Certification Board (CCB) and the Department of Public Health (DPH) in an effort to ensure credentialing requirements meet best practice standards. In addition, a specialty credential will be developed for people in recovery to work as peer supports and recovery specialists.

Also at issue here are:

- Accessibility to required training.
- Possible development of a state COD certification or license through the DPH as is currently in place for alcohol and drug counselors.
- Enhanced reimbursement for COD-credentialed practitioners.
- Incentive for employers and practitioners to pursue the COD credential.

Priority Four: CT will develop a mechanism to recruit and retain culturally diverse individuals and individuals in recovery to enhance the workforce.

A culturally diverse workforce that includes people in recovery will strengthen the workforce. It will allow for further needed expertise in these areas while ensuring that our workforce is representative of the communities it serves. A culturally diverse workforce will increase the welcoming component of the system and expand the overall skill set of the workforce.

Priority Five: A statewide committee comprised of key individuals across agencies will be established to stand as a Co-Occurring Disorder Practice Steering Committee.

This will ensure accountability, consistency and sustainability of this initiative. Conceptually, the membership could consist of Regional Liaisons with a Chief Educational Officer. Liaisons would be responsible for project oversight in their respective regions.

Priority Six: Dialogue with the State Universities, Community Colleges and other professional training institutions will be initiated regarding the need to develop and cultivate a new pool of COD professionals to join the co-occurring disorder competent workforce in the behavioral health field.

This longer-term goal would require a re-tooling of current academic curriculum to meet these workforce needs.

C. Recommended Strategies, Actions, and System/Infrastructure Enhancements

Priority One: Connecticut will develop and implement a co-occurring disorder core curriculum that is applicable to all behavioral health providers and has measurable outcomes to assess its effectiveness over time. Specialized curriculum will be developed for advocacy organizations (i.e. Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU)) and for people who are in recovery.

The state will begin by reviewing existing competencies already present within the workforce. This can be accomplished by using a competency assessment tool developed by Ken Minkoff, MD. Such assessment would evaluate the workforce

training needs. The evaluation would also raise provider awareness of the components needed for core competency in the service delivery of co-occurring disorder practice. The survey findings will also indicate the percentage of the service provider network that needs to be targeted for co-occurring disorder competency training.

Next a core co-occurring disorder curriculum will be developed that will provide basic COD competence and will be applicable to all staff across agencies, regardless of the person's position. Again, the state would look to a train the trainer curriculum currently developed by Ken Minkoff, MD. There are four key areas required to develop basic COD competency. They are:

- Attitudes
- Values
- Knowledge
- Skills

With regard to system/infrastructure enhancements Connecticut will ensure that there are adequate systems in place to train the workforce. This may include web-based training, a retooling of existing training and education departments across agencies and developing other means of technology transfer. It may also include encompassing non-traditional referral agents such as probation officers and child welfare workers. In addition, Connecticut will ensure that appropriate levels of care exist within service provider networks (i.e. safe havens). Training modules will be developed for each of the identified core areas and policies will be adopted to support the attitude/value components. Once competency is defined job descriptions (competency based) will be established to reflect this. Managers and human resource departments will be engaged to develop the new job descriptions and participate in negotiations with labor unions.

Priority Two: A clinical supervision structure must also be designed that fosters and continually assesses the skills of the workforce.

A clinical supervision structure will be created in which supervisors will be required to demonstrate COD core competency as outlined above. In addition, they must demonstrate the skills necessary to provide clinical supervision. Clinical supervision will be the expectation and not the exception. A similar process for development of core COD competencies will be applied to the development of clinical supervisors. A training module for clinical supervisors will be developed to ensure that those providing supervision have the necessary skills to do so.

Supervision will be conducted on a prescribed basis and will be available to all staff providing direct care to clients. Policies and procedures will be put into place that outline the requirements for both the supervisor and supervisee. A tracking system will be established to ensure that clinical supervision is occurring as designed. This will require structural changes in agencies that have not been providing this service and will also require that time be allocated to supervisors to accomplish this necessary task. It will also need to be added to a competency based job description for supervisors and assessed as part of an annual review.

Clinical supervision is vital to the growth and development of the COD competent workforce and will be crucial in sustaining the practice over time. Clinical supervision may be the single most important element of developing and sustaining a COD competent workforce. Here again, Connecticut will capitalize on what is already in place. Many agencies have solid supervision structures. There are some pilots occurring at agencies that are very successful and could be used as models from which to build. A well-developed training for clinical supervision already has been developed by the DMHAS Training and Education Division. The state will also look at national models currently in use that reflect best practice for this area.

Priority Three: The credentialing of co-occurring disorder practitioners will be addressed.

The Connecticut Certification Board (CCB) has implemented a COD certification for practitioners that the state sees as an important first step in fostering professional development. The state will review and update the current CCB curriculum, as necessary, to ensure that the content areas are in line with current best practices. The current curriculum consists of 18 core competencies across 5 domains. It requires approximately 340 hours of course work and 2-3 years of full-time work experience in the COD field in addition to 100 hours of supervision to achieve this credential. The curriculum will provide an excellent mechanism for practitioners to demonstrate competency and be credentialed for their expertise in the COD field.

The certification process requires a significant commitment by those that will pursue it and is well beyond a basic COD competency required for the workforce. As the Workforce Workgroup has already reviewed what is currently in place, the next step will be to meet with CCB and to develop criteria that would make acquiring the credential more accessible for individuals. As an example, could those individuals already certified or licensed as an Alcohol and Drug Counselor receive credit for this toward COD certification? Ways to get the required training to individuals via the web, self-learning modules will be developed.

The Connecticut Department of Public Health (DPH) currently issues state certification and licensure for Drug and Alcohol Counselors and would be instrumental in developing a similar arrangement for the COD credential. The state will explore the feasibility of a DPH COD credential as well as state certification of COD agencies, and network credentialing. Incentives for individuals, agencies and networks to pursue this credential will be designed. These incentives should be tied to both financial reward and professional growth within systems. At some point in time, the state will consider making COD credentialing a requirement for staff positions. Human resource departments and labor unions will need to participate in that work. The great news in this area is that training and credentialing process for COD practitioners is in place and will only require some potential retooling. Please see **Attachment** for a more in-depth discussion regarding credentialing.

Priority Four: CT will develop a mechanism to recruit and retain culturally diverse individuals and individuals in recovery to enhance the workforce.

Connecticut will develop and implement incentives within COD service structures to attract and retain culturally diverse and recovery/re-entry people into the workforce. This will require the creation of positions to attract candidates from the community who are culturally diverse and/or in recovery. The state will work closely with community leaders and advocacy groups to ensure these valuable resources are represented in the COD workforce. A well-defined professional development path will be put in place that will provide the opportunity for professional growth within organizations. This will assist greatly in retaining these individuals. (Please see **Attachment** for a more in-depth description of strategies to attract, retain and reduce burnout across the COD workforce)

Priority Five: A statewide committee comprised of key individuals across agencies will be established to stand as a Co-Occurring Disorder Practice Steering Committee.

Creation of a statewide COD steering committee will ensure accountability and sustainability for the initiative. The steering committee will be comprised of key individuals from all regions of the state who have the ability and authority to provide oversight in their respective regions to drive the COD initiative.

Connecticut has learned the importance of a Steering Committee from the current Integrated Dual Disorder Treatment (IDDT) training that is taking place throughout the state and is occurring in collaboration with Dartmouth. Connecticut may choose to use the existing IDDT statewide Steering Committee, in part, as both a model and starting point. This may require the creation of positions to accommodate this role.

Priority Six: Dialogue with the State Universities, Community Colleges and other professional training institutions will be initiated regarding the need for a co-occurring disorder competent workforce in the behavioral health field.

The steering committee will initiate a dialog with state universities and community colleges as well as other professional training institutions. The focus here is to inform them of the need for COD competent practitioners for our workforce. This will require meeting with key stakeholders from various state agencies. Achieving this objective may be a longer-term goal but the dialogue should begin as soon as possible.

D. Expected Impact/Outcomes

Regarding expected outcomes of a COD competent workforce, it is anticipated that the state will quickly recoup the initial investment. With a workforce that "works smarter," Connecticut can expect an increase in appropriate treatment matching, decreased emergency department visits, hospital admissions, critical incidents and incarceration for the individuals served. An increase in competitive employment, stability in housing and community involvement are all expected to increase for the individuals we serve.

The recent research from Dartmouth Psychiatric Research Center concludes, that if you train staff in best COD practice and maintain fidelity to these practices, recovery rates

increase from 15% seen in parallel or sequential treatment approaches to 60% over a four-year time frame. These expected outcomes mentioned above for people served also translate to staff outcomes such as an increase in job satisfaction, increase in moral, decrease in "burnout" and higher staff retention.

E. Technical Assistance Needs

Priority One: Connecticut will develop and implement a co-occurring disorder core curriculum that is applicable to all behavioral health providers and has measurable outcomes to assess its effectiveness over time. Specialized curriculum will be developed for advocacy organizations (i.e. Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU)) and for people who are in recovery.

Request 1.1
Connecticut seeks technical assistance from Minkoff and Cline to review current workforce COD competencies and assist in the development of a COD core competency curriculum and training that can be introduced across disciplines and agencies

Request 1.2
Connecticut seeks technical assistance in developing a COD curriculum, credentialing, training, and supervision module for peers or persons in recovery.

Request 1.3
Connecticut seeks technical assistance in developing technology transfer (i.e., teleconferencing, videoconferencing, etc.) in the delivery of training.

Priority Two: A clinical supervision structure must also be designed that fosters and continually assesses the skills of the workforce.

Request 2.1
Connecticut seeks technical assistance in developing and implementing COD clinical supervision, assessment, and training.

Priority Three: The credentialing of co-occurring disorder practitioners will be addressed.

Request 3.1
Connecticut seeks technical assistance in developing job descriptions, which reflect COD competencies/credentialing. In addition, this request includes assistance with recruitment of underrepresented groups, assistance with recruitment and retainment of the overall workforce, assistance with addressing staff burnout issues, and strategies on how to best negotiate these changes with organized labor unions.

Request 3.2
Connecticut requests technical assistance in developing system-wide incentives for providers and clinicians to become COD credentialed and/or hire COD credentialed staff.

Priority Four: CT will develop a mechanism to recruit and retain culturally diverse individuals and individuals in recovery to enhance the workforce.

Request 4.1
Connecticut seeks technical assistance in creating incentives for engaging and retaining a diverse workforce that includes persons from various cultural and ethnic backgrounds and persons in recovery.

Priority Five: A statewide committee comprised of key individuals across agencies will be established to stand as a Co-Occurring Disorder Practice Steering Committee.

No TA Requested for Priority Five

Priority Six: Dialogue with the State Universities, Community Colleges and other professional training institutions will be initiated regarding the need for a co-occurring disorder competent workforce in the behavioral health field.

Request 6.1
Connecticut seeks technical assistance in developing and implementing university and college curriculum that prepares a new pool of competent COD professionals.

F. Timeframe

- Conduct a review of current COD Workforce competencies to be completed within 6-9 months. Develop or adopt a core COD curriculum with a posttest applicable across disciplines and agencies in place and ready for implementation at 12-18 months. A COD trained workforce at 24-36 months. COD competency-based job descriptions will coincide with COD competency training and will be developed for all disciplines across agencies at 18-24 months. Performance reviews for measuring COD employee competency to begin after the completion of COD competency training at 24-36 months.

- Conduct a review of clinical supervision knowledge and skills within 6-9 months. Develop or adopt a core clinical supervision curriculum across disciplines and agencies to be in place and ready for implementation at 12-18 months. Trained clinical supervisors with a defined clinical supervision structure across disciplines and agencies at 24-36 months. Competency based job descriptions for clinical supervisors will coincide with clinical supervision training and will be in place across disciplines and agencies at 18-24 months.

- COD credentialing is not required at this time. However, this certainly will be encouraged. Making credentialing a requirement will be reviewed. The expectation is that it is probable that a COD credential will become a requirement for some job classifications. Should this become a requirement, it will facilitate revisions of job descriptions and will need to be tied to a timeframe for completion.

- Creation of positions to attract peer specialists (recovering/reentry individuals) to be created within 18 months. Initiatives and incentives to attract culturally diverse individuals to be developed within 18 months.

- The timeframe for establishing a dedicated statewide COD steering committee will need to be to have that committee place within 6 months. It is important that this be in place prior to other points mentioned above. This will ensure consistency, accountability and sustainability of the practice across agencies.

- A dialogue with professional and educational institutions, outlining the need for a COD skilled workforce and the role they could play in that, will begin within 12 months.

Workforce Technical Assistance Timelines

- Secure the services of Kenneth Minkoff, M.D. as soon as possible. This must be in place as the Workgroup proposal identifies a standardized review of core COD workforce competencies within 6-9 months. This will require the use of the standardized COD assessment tool developed by him and probable training of key staff to implement this and collect and interpret outcomes. In addition, the implementation of a core COD competent curriculum will be based on a researched best practice COD curriculum developed by Dr. Minkoff.

- Secure expertise in the area of Human Resource development. This will need to be in place within the first year to ensure necessary retooling of current job descriptions and evaluations, development of career ladders (incentives) and probable assistance with Labor negotiations. Also, to address the critical areas of recruitment and retention of the workforce.

- Secure the technical expertise to develop creative ways of implementing the COD core curriculum/supervision (i.e. teleconferencing, videoconferencing, and web-based training modules). This will need to be in place within 6-9 months if implementation for the core curriculum is projected to begin by 18 months.

- Secure expertise in the development of clinical supervision, to ensure necessary training and assist with the implementation of appropriate supervision structures required. This will need to be acquired within 12 months.

FINANCE

FINANCE

A. Statement of Issues

The broad range of initiatives and activities recommended by the workforce and service delivery workgroups requires an equally broad range of financing solutions. The priority areas are summarized below along with the financing strategies that provide the best opportunity for support.

B. Priority Areas

The priority areas for the Finance section are the same as those previously identified in the Service Delivery System and Workforce sections of the report.

C. Recommended Strategies and Actions

Service Delivery

Priority One: Any person with mental health and substance use disorders is welcome anywhere in the service delivery system.

> Strategy: Experts in the field of customer service (not behavioral health experts) will be brought in to develop and deliver training in engagement. Technical assistance from these experts will be financed by the National Academy grant.
>
> DMHAS, DOC and DCF will need to revise their training programs to include specific material on challenging behaviors (i.e., intoxication, disorganization) and protocols for greeting, engagement and crisis-response support for "front door" staff. The criminal justice curriculum for officers will incorporate training to assist officers in their responses to persons with COD These training program changes will be supported by existing training and human resource funds within each respective agency.
>
> State agencies will assist providers in creating more welcoming environments through capital financing (bonding funds) that place the improvement of access points on their priority lists.

Priority Two: All providers will be able to recognize and comprehensively assess co-occurring disorders using standardized tools.

> Strategy: DCF, DMHAS, DOC and CSSD will establish two committees to create standardized screening and assessment tools. These committees will not require financing over and above departmental resources.
>
> A separate health information committee will be established to include the above and the Department of Public Health. This committee will develop plans to create systems that allow recovery information to be released with patient consent and shared among providers. This plan may require financing over and

above existing departmental resources, although this cannot be determined until the plan is outlined. The team will review and pursue available sources of health information related grant opportunities. If none are forthcoming, the departments will establish a lead department to submit a budget expansion option for health information data sharing on behalf of the participating departments.

DMHAS will establish a centralized access and referral service, through a new or existing administrative service organization. The administrative service organization would be responsible for a) maintaining a provider file with COD credentialing status for all DCF, DMHAS, CSSD, DOC and DSS providers; b) the provision of access and referral services for all individuals with co-occurring psychiatric and substance related disorders, whether entitled or non-entitled, and regardless of whether such clients are associated with DCF, DMHAS, CSSD, DOC or DSS; c) providing reimbursement for welcoming services provided to such clients with COD; and d) maintaining a centralized database related to the administration of this program. The National Academy grant would provide funding for program start-up and a pilot period of eighteen (18) months duration. In addition, DCF, DOC, CSSD, and DMHAS will review existing private and federal grant sources and make application where applicable to supplement National Academy funding. DMHAS will be the lead for this pilot. Pending a favorable evaluation of the pilot and recommendation by the steering committee, DMHAS will prepare and submit a budget expansion option to support continuation of the program.

As an adjunct, DCF, DMHAS, CSSD and DOC will review available options for achieving centralized access and referral. These include the use of Connecticut Infoline, which may be able to enhance its director of mental health and substance abuse providers to include whether the provider is COD credentialed. Infoline staff could also then consider COD credentialing status in referring callers to appropriate providers. If review supports this component of the plan and additional resources are required, DSS will submit a budget expansion option for this purpose.

DCF, DMHAS, CSSD and DOC will assess the program costs associated with expanding services to include the capacity to screen and assess for co-occurring disorders. If there are increased costs, DMHAS will review substance abuse block grant expenditures to determine whether allocation can be modified to support adoption of standardized assessment. In addition, DMHAS will consider the costs associated with standardized assessment in the development of tiered fee schedules under the General Assistance Behavioral Health Program (GABHP) for providers that are either COD capable or COD enhanced.

DSS will require that it’s contractors responsible for the administration of behavioral health services under the HUSKY program use level of care/medical necessity criteria that are co-occurring capable. DCF and DMHAS will provide consultation to verify COD capability. No additional financing will be required, however, technical assistance under the National Academy grant is requested to assist in the process of defining COD capability in level of care/medical necessity criteria and the development of guidelines for reviewing and determining that such criteria are COD capable.

Priority Three: Persons with co-occurring disorders receive comprehensive treatment and support services in their home communities.

Most of the activities related to priority number three such as community organizing strategies to build coalitions and enhance coordination will require technical assistance, but may or may not require additional financing depending on the nature and scope of any activities proposed pursuant to the assistance. In this and other areas, technical assistance will help provide the specificity that will be the basis for identifying additional financial solutions.

With respect to the development of COD sensitive utilization review criteria, DMHAS currently uses such criteria under an ASO for the General Assistance Behavioral Health Program. Beyond technical assistance, modifications to these criteria can be made within available resources. The current system for financing and administering Medicaid services does not lend itself to the development and application of a single set of COD capable utilization review criteria (or perhaps distinct sets for children and adults). To the extent that the Medicaid administrative system is modified in the future, COD capability will be considered and no additional resources will be required.

With regard to the need to support comprehensive treatment and support services, DMHAS will review mental health and substance abuse block grant expenditures to determine whether grant allocations can be modified to support the adoption of comprehensive treatment and support services. In addition, DMHAS will consider the costs associated with the provision of COD capable services in the development of tiered fee schedules under the General Assistance Behavioral Health Program (GABHP) for providers that are either COD capable or COD enhanced. Technical assistance is requested for the purpose of helping the department to develop this tiered fee schedule option including the policies and procedures under which such a fee schedule would operate.

With regard to the question of comprehensiveness, DMHAS will review whether non-covered COD treatment and support services should be covered under the General Assistance Behavioral Health Program. If such expansions to the benefit package are warranted, DMHAS will pursue funding for such services through the reallocation of GABHP funds or the submission of a budget expansion option. Technical assistance is requested for the purpose of helping the department to identify those non-covered services and supports that should be added to the GABHP benefit package.

Workforce

Priority One – Evaluation of What We Have and What Is Needed

The development of the COD core curriculum should begin with a survey of the of COD competency that currently exists within the workforce of each state agency and private non-profit provider. The survey should include direct service providers as well as supervisors. This will require the use of a COD survey tool (i.e. COD Basic Competence Evaluation Tool—Developed by Minkoff and Cline).

This will need to be purchased and training to administer this will need to occur. National Academy funding is requested to support the survey.

Priority Two – Purchasing and/or Developing Core Curriculum for Use by State Agencies

In addition a core curriculum must be purchased or developed that can be provided to all levels of care providers, across the state and private non-profit provider systems. Again, the recommendation is to obtain the basic COD competency training developed by Minkoff and Cline. It appears that the Systems Development workgroup has identified Minkoff for some of their components, so it might be advantageous to allocate initial monies to contract with Minkoff and have him conduct a systems analysis that would include COD workforce competency and workforce training needs. National Academy funding is requested to support the purchase and/or development of the curriculum.

Priority Three – Supervision Structure to Support COD Practice

Supervision training must also be provided to insure proficiency in this area for supervisors. DMHAS currently has a supervision-training module that could be implemented across systems. Here the cost would be the time required by staff outside of their current role needed to develop proficiency in COD competent supervision. Time will have to be allocated to provide this supervision, for both the supervisor and supervisee. Also a tracking system will need to be developed to ensure that supervision is occurring. Supervision will need to be one of the conditions for credentialing (see below), the cost of which can be supported by means of a tiered fee schedule and/or reallocation of block grant and state grant funding.

Priority Four - Human Resource Retooling

Human Resource Departments will need to retool existing job specifications and competency based job descriptions to reflect the expected requirements of staff. Factoring in the cost of developing possible implementation of technology transfer (i.e., teleconferencing, videoconferencing, self-training modules). State agencies should cover the cost of the survey and training for their respective workforces. Each agency's training and education budget will need to be reviewed to determine what is spent on training annually and determine what percentage of training dollars can be directed to support this initiative. The agencies will need to factor in the percentage of the workforce that will require COD competency training and the percentage of time outside of direct service that will be needed to accomplish this. The costs of surveying and training the workforce and supervisors of private not profit providers will be covered by the requested national academy grant.

Priority Five – Credentialing of COD capable and enhanced

The COD certification process has four major components that will need to be considered.

1) required hours working in a COD capable or enhanced system,
2) completion of the required training modules, .
3) Supervision requirements that are already accounted for, and
4) continuing education requirements.

There will need to be some built in financial incentive if the goal is to have individuals pursue this certification. Financial incentives should focus on the private non-profit providers rather than independent practitioners.
The DMHAS General Assistance Behavioral Health Program network includes the great majority of psychiatric and substance abuse facility providers. It is recommended that the General Assistance Behavioral Health Program credentialing process be modified to recognize COD competent agencies. The credential could be based in part on the percentage of COD certified providers in an agency's workforce. This, in turn, could be linked to a higher rate of reimbursement on the GABHP fee schedule.

The creation of an oversight COD committee and initial work with educational institutions regarding COD workforce needs will require limited resources at this time. Criminal justice agencies will rely on inter-agency training opportunities. Having said this, Regional Steering Committee members should be in dedicated positions, as they will provide oversight for the initiative across multiple agencies. This is in line with the Dartmouth Psychiatric Research Center Integrated Dual Disorder Treatment model that calls for a "Champion" dedicated to the implementation of the initiative. The costs of these positions will need to be factored into a budget expansion option to support the COD initiative.

D. Financing Technical Assistance Needs

1.1. Connecticut seeks technical assistance to define COD capability in level of care/medical necessity criteria, including the development of guidelines for reviewing and determining that such criteria are COD capable.
1.2. Connecticut seeks technical assistance to develop a tiered fee schedule option, including the policies and procedures under which such a fee schedule would operate.

1.3. Connecticut seeks technical assistance in identifying non-covered COD services and supports that should be added to the State's General Assistance Behavioral Health Program benefit package.

1.4. Connecticut seeks technical assistance in maximizing the use of the federal Substance Abuse Prevention and Treatment and Mental Health Block Grant funds for COD services.

1.5. Connecticut seeks technical assistance for implementation of Rehabilitation Options for COD services, including assistance with defining COD services.

1.6. Connecticut seeks technical assistance in conducting a cost-analysis study on the cost-effectiveness of integrated CODs services VS. non-integrated mental health or substance abuse treatment services.

1.7 Connecticut seeks technical assistance in re-directing existing resources and re-designing all substance abuse and mental health programs to meet the needs of individuals with CODs. This is based on the understanding that system-wide dual diagnosis capability can be created most efficiently within the context of existing resources.

APPENDICES

Attachment I

National Policy Academy on Co-Occurring Disorders
Connecticut Team Members

CORE TEAM

Thomas A. Kirk, Jr., Ph.D., Co-Team Leader, Department of Mental Health and Addiction Services
Phillip Valentine, Co-Team Leader, Connecticut Community for Addiction Recovery
Brenda Sisco, Office of the Governor
Peter Panzarella, LADC, LPC, Department of Children and Families
Samuel R. Segal, LPC, LADC, Department of Mental Health and Addiction Services
Mark Schaefer, Ph.D., Department of Children and Families
John F. Chapman, Psy.D., Judicial Branch, Court Support Services Division
Daniel Bannish, Psy.D., Department of Correction
Joan M. Pesce, M.Div., Morris Foundation
Arturo Morales, M.D.
Leslie Woods, Advocacy Unlimited
Edward Spauster, Ph.D., Liberation, Meridian Group
Heather Gates, MBA, Community Health Resources
Richard Callahan, LADC, LPC, Department of Mental Health and Addiction Services
Susan Niemitz, LCSW, Hartford Behavioral Health
Sabrina Trocchi, MPA, Department of Mental Health and Addiction Services

PARTICIPANTS

Ron Fleming, LCSW, Ph.D., Alcohol and Drug Recovery Center
Collette Anderson, LCSW, Department of Mental Health and Addiction Services
Richard Bilangi, MS, Connecticut Counseling Services
Susan Silliman, Ph.D., Department of Mental Health and Addiction Services
Dennis Bouffard, Ph.D., Department of Mental Health and Addiction Services
Linda Frisman, Ph.D., Department of Mental Health and Addiction Services
Patricia Ottolini, R.N., Department of Correction
Thomas Griffen, M.A., Department of Mental Health and Addiction Services
Michael Hoge, M.D., Department of Mental Health and Addiction Services
Stephen Wyatt, M.D., Stonnington Institute
Kenneth Marcus, M.D., Department of Mental Health and Addiction Services
Denine Northrup, Ph.D., Department of Mental Health and Addiction Services
Jose Ortiz, MBA, MA, LADC, Department of Mental Health and Addiction Services
Justin Salvio, MHSA, Gilead Community Services, Inc.
Richard Stillison, Ph.D., Department of Mental Health and Addiction Services

ATTACHMENT 2

Workforce Development for Children and Families for In-Home Family Treatment

The Department of Children and Families (DCF) and Court Support Services Division (CSSD) has facilitated Connecticut's recognition nationally as a leader in development and implementation of evidenced-based in-home treatment for juvenile offenders and families involved with child welfare and voluntary services. These models have been promoted in the Connecticut Alcohol and Drug Policy Council Plan and Mental Health Policy Council Plan as effective models for youth with multiple child/adolescent diagnosis and substance abuse.

CSSD, for example, is engaging in an expansion of Multi-Systemic Family Therapy (MST). By June 2004, CSSD will have established 225 new slots of MST that will serve 675 children a year for youth involved in the courts. This will call for the hiring of 45 new therapists in the next 6 months alone. Moreover, DCF and CSSD are collaborating to expand the presence of Multi-Dimensional Family Therapy and Functional Family Therapy in Connecticut. Both are evidence-based, in-home models offered in Connecticut that has significant empirical evidence validating their effectiveness with substance abusing and/or dependent juvenile offenders. Including MDFT and FFT, there will be a need for a total of 50-55 new in-home therapists in Connecticut over the next year alone. Moreover, data from three MST in-home providers that served DCF Juvenile Justice and CSSD in fiscal year 2002-2003 indicates a disparity in the ethnic representation of therapists. These providers combined provided the majority of MST in the State of Connecticut during fiscal year 2002-2003. Across the three providers, 20% of clients are African-American, while only 10% of therapists are African-American, 26% of clients are Latino while 15% of therapists are Latino. Finally, even though only 45% of the clients served were Caucasian, 69% of MST therapists were Caucasian. These numbers support the need to develop and adopt recruitment strategies that can effectively attract ethnically and culturally diverse therapists into the field.

The providers of intense in-home intervention in Connecticut have reported the need to undergo aggressive means of recruiting qualified therapists, which often still fall short. These models are intensive, requiring therapists that are willing to go into the home environment of families and be available 24/7, thus requiring a special person to be not just qualified but motivated to engage in this challenging but effective work.

Without engaging in efforts to establish new mechanisms of recruitment, the State will experience a dearth of therapists available to staff the new positions that will be available currently, and in the future, resulting in both overworked therapists and underserved youth and families. Statistics indicate that the average in-home clinician remains in full-time, direct service for 2-3 years before moving to a supervisory level or leaving the work because of changes in life circumstances (Yale Child Study Center, 2004). This calls for establishment of a recruitment mechanism that will not only help meet the immediate need for therapists, but the ongoing need as well.

DCF has begun to address this pressing issue. An Intensive In-Home Training and Workforce Development Sub-Committee, which is a collaboration of DCF, In-Home Providers and parents were established in September 2003 to address the issues of workforce development. The committee organized a presentation to eight area graduate

training programs that occurred in November 2003. The goal of the presentation was to introduce intensive in-home models currently practiced in Connecticut to area graduate training programs, and engage in dialog regarding how to link with the Universities to establish mechanisms for training and recruiting their current and past graduate students to become in-home clinicians. After brainstorming with the graduate programs, graduate program representatives and committee members decided to work collaboratively to establish the following recruitment and training mechanisms:

1. Establishment of stipends for internships where graduate students are trained yearly and then become practitioners of in-home therapy. Training will be provided by model developers. Specific efforts to identify and recruit ethnically diverse interns will be developed and pursued.

Progress thus far: Five in-home providers have committed to training and supervising up to 10 advanced level graduate students beginning in the fall. These providers are currently in the process of interviewing candidates identified by area graduate programs for consideration as interns.

2. Establishment of an annual in-home Intervention Job Fair, where pending graduates of local training programs are invited to meet with providers around the State to hear of job opportunities.

Progress thus far: The first Job Fair occurred in April 2004. Seven providers of in-home therapy met and screened over 40 advanced level graduate students and practitioners for consideration as fulltime therapists. A questionnaire is being drafted to be disseminated to participants and providers to assess the experience.

3. Establishment of an introduction course in in-home intervention for students from local Universities. A number of graduate program representatives who attended the presentation stated that they would like to see this happen, so that their students can be exposed to this model of treatment early in their graduate training, and thus see it as a viable training and employment opportunity for them.

Progress thus far: Two area graduate programs thus far have expressed an interest in working collaboratively with the Training and Workforce Sub-Committee to establish didactic curricula that will expose their students to evidence-based in-home interventions for adolescents.

Goals and objectives:

A. Recruit 5-10 advanced level graduate students to start field placements in the fall that will provide training and clinical experience in evidence-based in-home interventions that treat adolescent juvenile offenders.

    1. Ten stipends will be created and available for recruited interns. The exact number of interns starting in the fall will be contingent upon the number of students referred from graduate programs and outcome of interviews with providers.
    2. Interview and place students referred by graduate programs in late spring 2004.

3. Sub-contract with an organization to provide coordination of the initiative beginning in summer 2004.
4. Coordinator will meet with in-home providers providing the field placement and the graduate program faculty over the summer to coordinate logistics of the fall field placements (evaluation standards, coordination of supervision and monitoring, hours per week of placement, training and subsequent Fall start date).

B. Establish mechanisms that will facilitate recruitment of ethnically diverse interns for field placements beginning in fiscal year 2005-2006.

   1. Beginning in the fall, coordinator will link with the DMHAS Project for Addictions and Cultural Competency Training (PACCT) in an effort to collaborate on recruitment strategies.
   2. Beginning in the fall, coordinator will link with Latino and African-American graduate student organizations along with African-American and Latino professional organizations in order to consult with them regarding recruitment of ethnically diverse students and professionals.

C. Establish an introduction course in in-home intervention at local Universities to be implemented in June 2005.

   1. Coordinator will meet with providers and graduate program directors to develop the course beginning in Summer 2004.

Activities and timetable:

A. The DCF Project Officer is currently receiving names of candidates from the area graduate programs, and arranging interviews with providers that are servicing the geographical that the students either reside in or are familiar to the student. These interviews will occur the first week of June. Afterwards, the providers will choose the strongest students to be trained for the fall.
B. The DCF Project Officer along with DCF contract management will submit a request for proposals from organizations to serve as coordinator of the internship experience. The RFP will be released this summer, with the goal of having a coordinator in place by mid-summer.
C. Meetings with providers and the graduate program field placement coordinators who have students placed as interns will start in July to coordinate the experience and begin planning for a spring course.
D. Interns will start field placements in fall 2004. First activity will involve an orientation to their provider organization and the treatment team they will be a part of, followed by training in the in-home models.
E. Once interns are deemed ready, as determined by the site supervisor, they will have their own caseload. The internship will be a 9-month experience ending in late spring 2004.
F. Efforts to recruit culturally diverse interns will be initiated by the coordinator beginning in fall 2004. The goal is to increase diversity of interns selected in the second year of the initiative, fall 2005.

Interagency Cooperation:

A. The providers committed to hosting interns provide intensive in-home for both DCF and Court Supported Services Division (CSSD). CSSD will be asked to be involved in the meetings this summer to coordinate the experience.
B. The DCF project officer will also link with the DMHAS Office of Multi-Cultural Affairs to explore the possibility of collaborating with their PACCT Program in an effort to increase the ethnic diversity of counselors.

ATTACHMENT 3

CREDENTIALING A COD WORKFORCE

COD Capable

All levels of the workforce should have basic core competencies to meet this criterion. This should not be interpreted that staff will hold a COD credential; rather it is defined as a workforce that has received basic core competencies in COD and is able to demonstrate an understanding of this skill/knowledge set. Demonstrating this level of skill at a program, agency or network level could be the standard for "COD Capable" credentialing. The key question here is, should all members of the workforce receive the same skill/knowledge set? For providers of direct service, the answer is yes. Kenneth Minkoff, M.D. is very clear that training in COD basic competency should be across all disciplines. The other question to raise here is, would you expect to go to a mental health or substance abuse facility and not have a workforce with basic competency in these areas across the workforce? NO. This should be the expectation for COD providers as well. To create this level of competency will require built in incentives to encourage providers to develop along this line. In addition, a specialty credential will be developed for peers, ensuring that the recovering community is included as a viable and capable resource in the COD workforce.

JCAHO and CARF do not at this time have a credential/accreditation process for COD at the agency level. So, it would be imperative that if we set the minimum standards outlined above, that there is a means in place to monitor this at the state level. To have this standard stand as a credential, we will need to have DPH as well as other key stakeholders involved in this process. Creating and having this credential ensures that those purchasing and receiving services are doing so with an organization that meets defined COD standards. Also, though there may be many political obstacles, the question should be raised concerning JCAHO and CARF and where these organizations stand with the development of a national COD credentialing process.

COD Enhanced

For this credential, the expectation should be that individuals within the agency hold specialized COD skills and knowledge that are well beyond the basic COD competencies mentioned above in a COD capable facility. This could be accomplished in certain disciplines by requiring individuals to have specific COD credentials in their field (i.e. physicians/ASAM, other direct service providers/CCB certification). This would require changes in job descriptions to reflect requirements for employment, financial incentives, appropriate supervision and professional advancement to attract, develop and retain a COD enhanced workforce. Developing and meeting these criteria could form the standard for a COD Enhanced credential for an organization. Next steps in the credentialing process may include credentialing at the network level, which is inclusive of all providers within a network of care.

As mentioned under COD Capable, JCAHO and CARF do not, at this time, have a credential/accreditation process for COD at the agency level. So, it would be imperative that, if Connecticut sets the minimum standards outlined above, there is a means in place to monitor this at the state level. To have this standard stand as a credential, Connecticut will need to have DPH, and all other key stakeholders, involved in this process. Creating and having this credential ensures that those purchasing as well as receiving services are doing so with an organization that meets defined COD standards. To restate again, though there may be many political obstacles, the question should be raised concerning JCAHO and

CARF and where these organizations stand with the development of a national credentialing process.

Credentialing, base on the above proposal, could occur on the following levels:

- Individual
- Organization/agency
- Network

Connecticut will consider expanding capability for practitioners in the physical health arena to identify COD and physical conditions that are prevalent among persons with COD, such as Hepatitis C and HIV.

ATTACHMENT 4

WORKFORCE RECRUITMENT AND RETENTION

This was mentioned earlier in this report in the context of recruiting and retaining culturally diverse individuals and individuals from the recovery community. However, as this is a concern across the behavioral health workforce and, in all likelihood, COD practitioners, with their specialized skill set, will be at higher risk for burnout. Recruiting and retaining them will be difficult. The following are recommendations/ideas to increase recruitment and retention as the state develops and/or continues to develop the COD workforce.

- Develop and define professional pathways or clinical ladders so that continued growth within the organization can be pursued. These pathways must be well established and clearly state what goals need to be met to advance to the next level within a job class (i.e. nursing would have clinical ladders that would clearly define what requirements are needed for advancement from a Clinical Nurse I, to Clinical Nurse II, to Nurse Clinician, to Clinical Nurse Specialist). The system must also be prepared to support professional development and growth by offering incentives to do so.

- Aggressively recruit from professional schools and provide incentives for those interested in entering the field.

- Aggressively recruit culturally diverse candidates and candidates from the recovery community and provide incentives for those interested in entering the field.

- Ensure a clinical supervision structure is in place and utilized appropriately. This promises and provides for professional development at all levels.

- As individuals with COD often have complex clinical presentations, be mindful of the size of caseloads.

- Need for parity in pay scales across organizations.

- Reimbursement for peer professionals, in line with other behavioral health providers.

While this list can be added to, it serves as a start to address this complex issue. TA is needed in this area to develop other creative strategies.