Transforming to a Co-Occurring Responsive System of Care

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Co-Occurring Recovery Conference
North Haven, CT
May 24, 2007

Department of Mental Health and Addiction Services (DMHAS)

Single State Authority that has responsibility for both mental health and addiction services.

Environment of Opportunity

DMHAS has been working on integrating services for years.

- **1990s – taskforces, research on co-occurring disorders (COD)**
- **2002 – CT Integrated Dual Disorders Treatment (IDDT) Initiative began and what is now the CT Dual Diagnosis Capability in Addiction Treatment (DDCAT) Initiative began**
- **2004 – National COD Policy Academy**
- **2005 – Co-Occurring State Incentive Grant (COSIG)**

Why Focus on Co-occurring?

- **Frequency of occurrence:**
  - Critical incidents
  - Poor treatment outcomes for people with co-occurring disorders in the absence of integrated care
  - De-institutionalization
  - Availability of substances
- **Better screening, assessment and treatment matching: refinement and maturation of co-occurring disorders treatment field**
- **Emphasis on integration: movement from specialty to general healthcare practice**

DMHAS' Systemic Approach to Integrated Care

- Establish conceptual and policy framework
- Build competencies and skills
- Enhance programs and service structures
- Align fiscal resources and administrative policies in support of integrated care
- Monitor, evaluate and adjust
- Develop co-occurring program guidelines (currently in development)

Strategy for Change

- Multi-year implementation process, i.e., COD Practice Improvement Collaborative
- Big tent approach to consensus building
- Use technology transfer strategies to develop, implement, and sustain evidence-based or preferred practices
- Incorporate existing initiatives, i.e., Recovery
- Re-orient all systems to support integrated care
- Transition providers to co-occurring oriented performance outcomes

Commissioner's Policy Statement # 84

"Serving People with Co-Occurring Mental Health and Substance Use Disorders"

PURPOSE

- Support DMHAS' overarching goal of promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care
- Communicate expectations: Improve processes of care and outcomes for people with co-occurring disorders
- Implement advances in research and practice related to co-occurring disorders (close the science-to-service gap)
- Transform DMHAS' system of care

Definitions in the Policy Document

- *"**Co-occurring disorders** are defined as the co-existence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder."*

- *"**Integrated treatment** is a means of coordinating both substance use and mental health interventions; it is preferable if this can be done by one clinician, but it can be accomplished by two or more clinicians working together within one program or a network of services. Integrated services must appear seamless to the individual participating in services."*

Policy Statement

"The publicly funded healthcare system in Connecticut will be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care)."

Guiding Principles

- People with co-occurring disorders are the expectation in our healthcare system, and not the exception.
- There is “no wrong door” for people with co-occurring disorders entering into the healthcare system.
- Mental health and substance use disorders are both “primary”.
- The system of care is committed to integrated treatment with one plan for one person.
- Integrated care must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.

Linkage with Recovery Initiative

Continued focus on being a Recovery–Oriented Healthcare System.

- Commissioner's Recovery Policy Statement, 2002.
- Recovery Practice Guidelines, 2006.
- Umbrella for integrating services and improving outcomes for people with COD; recovery lessons from both fields.

CT COD INITIATIVE - STRUCTURE

- Steering Committee – Commissioner Kirk, Chair
- Workgroups
  - Screening Workgroup
  - Workforce Development Workgroup
  - Services Workgroup
  - Co-Occurring Guidelines Workgroup
  - Co-Occurring Practice Improvement Collaborative
  - State Facilities Workgroup

COD Steering Committee Partners

- 2 COSIG pilot sites (Morris Foundation, Hispanic Clinic)
- CT Substance Abuse and Mental Health Providers
- Recovery Communities: CT Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU)
- Academic Partners: Yale University, Dartmouth Medical School
- CT Certification Board

COD Screening Pilot

Measures

- Mental Health Screening Form-III (MHSF-III).
- Modified Mini International Neuropsychiatric Interview (Modified MINI).
- Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD).
- CAGE-AID (CAGE Adapted to Include Drugs).

COD Screening Pilot

- 30 providers (mental health and addiction, state-operated and private non-profit) participated in the pilot.
- Monthly conference calls, provider data feedback reports.
- Pilot began in May 2006 and continued to Spring 2007.
- Based on positive results, statewide implementation of COD screening instruments will begin in July 2007 (See DMHAS Information brief for summary of pilot results).

Integrated Services

- **Integrated service delivery implementation support**
  - Training plus ongoing coaching on Integrated Dual Disorders Treatment (IDDT) and the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.
  - Pilot sites (Morris Foundation and Hispanic Clinic)
  - Practice Improvement Collaborative (8 private non-profit (PNP) agencies – focused ongoing training, consultation and implementation support).
  - State Agencies (8 agencies same focus as above).
  - Program Guidelines

COD Outcomes

- **Outcomes-Measuring Inputs and Outputs**
  - Identifying people with COD within existing management information systems
  - Identifying outcomes for people with COD
  - Provider quality assurance activities
  - Fidelity Scales

COD Communication Strategy

- **Communicate Successes**
  - Information brief on our Screening Pilot and COD Evidence-based and Preferred Practices
  - Message from the Office of the Commissioner
  - Bimonthly mailings to all CEOs with COD products
  - Monthly report of COD activity reports
  - Development/Dissemination of COD information materials

Next Steps

From the pilot stage to systems change

- Statewide implementation of standardized screening measures
- Continue practice improvement collaboratives with additional agencies
- Developing co-occurring program guidelines
- All providers to submit implementation plans; statewide technical assistance event
- Increased use of data to identify people with COD, their service use, and outcomes; to assist programs in the use of data
- Comprehensive vision statement with short, intermediate and long-term goals for the system; an elaboration of the Commissioner's Policy Statement

What is this all about?

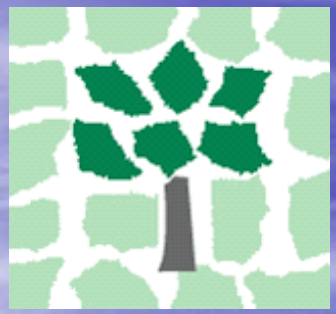
- Better care and outcomes for persons with co-occurring disorders
- Systems Transformation
- Change
- Partnerships
- Continual assessment and communication
- Technology Transfer (science-to-service)
- Sustained focus

What are the barriers?

- Competing priorities
- Resources
- Workforce
  - Recruiting, retaining, training

What are the opportunities?

- Federal partnership with SAMHSA
  - National Policy Academy
  - Co-Occurring Center for Excellence (COCE)
  - COSIGs
  - Publications: Treatment Improvement Protocol (TIP) 42, IDDT Toolkit
- Science base is continually strengthening
- Widespread recognition
  - That the “pain” of non-integrated or semi-integrated care is high and we know we can and must do better.



Morris

Foundation

Behavioral Health Services

COSIG Pilot Site

Rachael Petitti, LCSW, VP/Chief Operating Officer
Cindy Salmoiraghi, CADC, CCS, Administrative Director of Outpatient Services
Joan Huskins, LCSW, COSIG Coordinator
Meghann Collins, LPC, COSIG Clinician
Katie Peterson, BA, COSIG Engagement Specialist
Michael Reynolds, CADC, COSIG Engagement Specialist

Integration of Co-Occurring Treatment In A Predominantly Substance Abuse Agency

THE WAY WE WERE

- Substance Abuse Treatment Only
- No Continuum of Care
- Hospital Behavioral Health Management
- Positioning for Growth

SUBSTANCE ABUSE TREATMENT ONLY

- No Screening for Mental Health Disorders
- Denial of Services for MH
- “We Don’t Have the Resources…”
- Lists of Unacceptable Medications
- Generic Interventions

WHAT WE DID

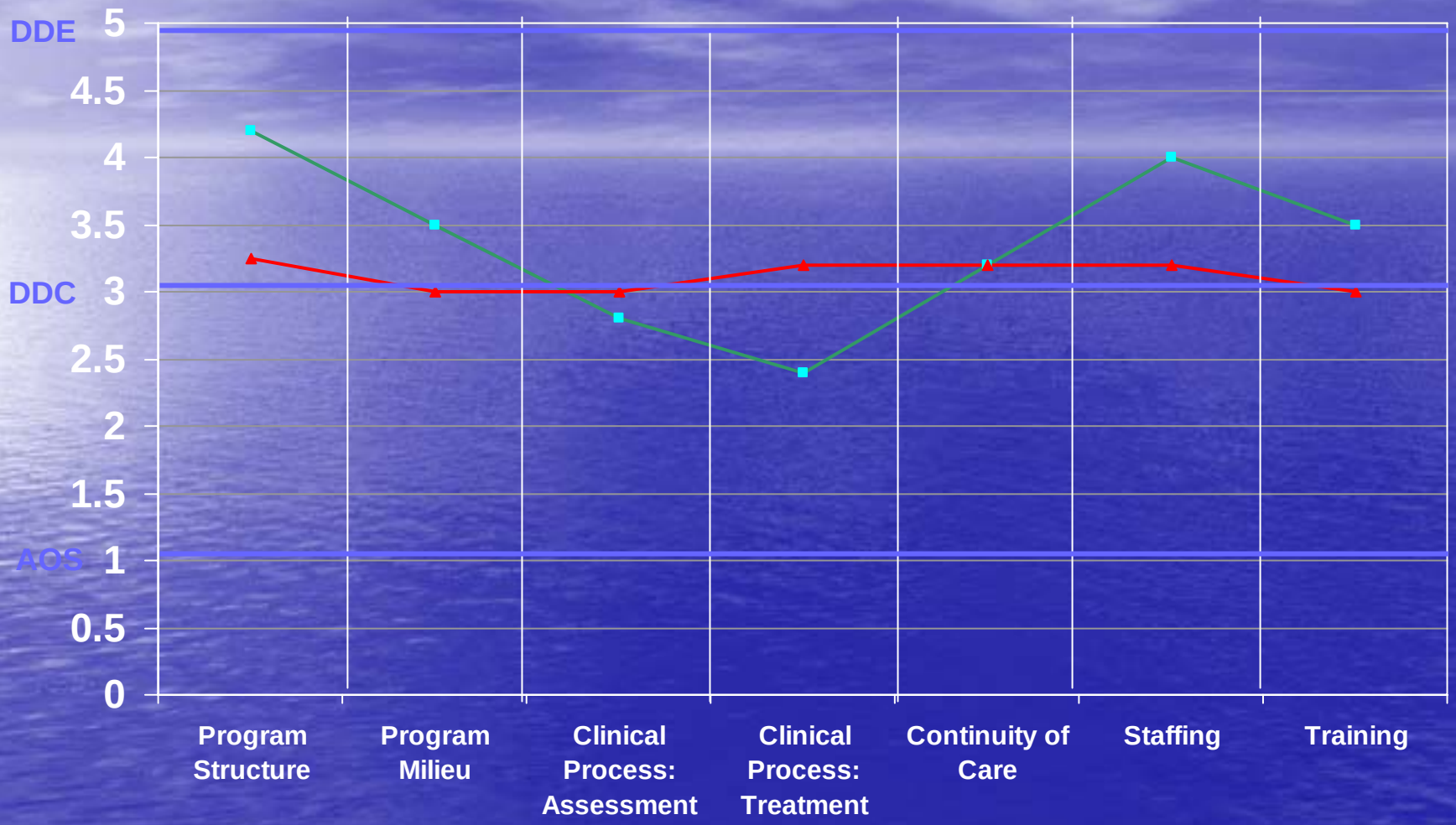
- Mission and Vision
- Outpatient Reorganization
- Integrated the COSIG Team
- DDCAT Rating Profile
- Work Plan
- Staff Training
- Screening Tools

OUTPATIENT REORGANIZATION

- Physical Renovations
- Hiring of Licensed Staff
- Central Admission Center
- Curriculum Changes
- Addition of Specialty Groups

(i.e. Medication Education, TREM, Gender-Specific)

DDCAT Rating Profile: March 2006



WORK PLAN

- Utilizes DDCAT Index Toolkit
- Based on Our DDCAT Profile
- Reviewed & Revised Monthly
- Chronologically Formatted
- Goal is Dual Diagnosis Enhanced

STAFF TRAINING

- Basic COD Training for All Staff
- Advanced Training for Clinical Staff
- IDDT Instruction
- Implementing Stage of Change Care
- Mental Health Disorders In-Services

WHAT WE LEARNED

Dynamics of Systemic Change

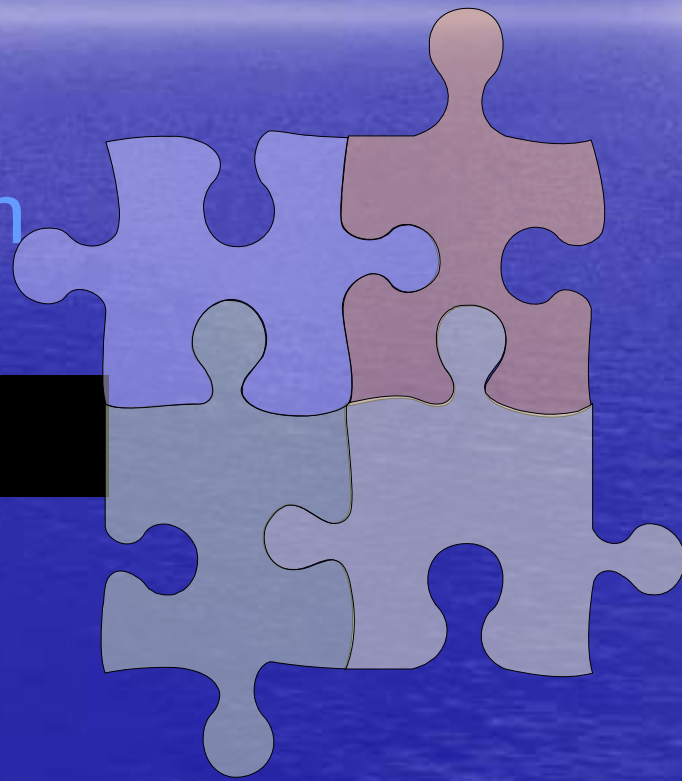
- Executive Leadership Support
- Change Managed Daily
- Internal Piloting

Integration of Recovery Support Systems

- Medication Management
- Family/Encouraging Persons
- Peer Support

WHERE WE WANT TO BE

- Co-Occurring Enhanced
- Agency-Wide Integration



Statewide Assimilation

imagine….

- Behavioral Health Parity
- System-Wide, Uniform Screening & Assessment Tools

Morris

Foundation

Behavioral Health Services

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REPLICATION OF "DAME LA MANO" PILOT PROJECT

Luis M Añez, Psy.D.
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Michelle Alejandra Silva, Psy.D.
Yale University
School of Medicine
May 2007

Why Hispanic Populations?

- 40 million Latinos in the United States, or 14.2% of total U.S. population (not including an estimated 4 million residing in Puerto Rico)

- By year 2030, estimated population growth to 73 million, or 20% of total U.S. population

(Source: U.S. Census Bureau, American Community Survey, 2004)

Hispanic Clinic: Overview

- **Satellite clinic of the CMHC**
- **Provides clinical services to monolingual Hispanic clients**

- **<u>COSIG</u>:**
  - **Integration of 4 Latino values into stages of IDDT with emphasis in engagement**

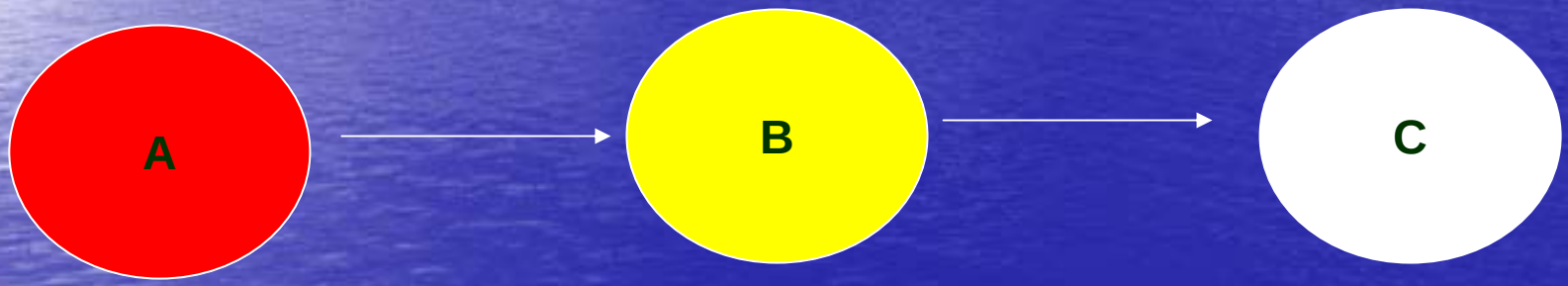
COSIG TEAM- HISPANIC CLINIC

- Luis M Añez, Ed.S., Psy.D. Pilot Director
- Manuel París, Psy.D. Project Coordinator
- Gerardo González, M.D. (Psychiatrist / Medical Director)
- Jennifer Ballew, D.O. (Psychiatrist)
- Eva M. Maldonado, Psy.D. (Senior Clinician)
- Myralys Calaf, Psy.D. (Clinician)
- Marylin Quintero, M.S.W. (Case Manager / Clinician)
- Ruth Martínez (Vocational Rehab Specialist)

WHY REPLICATE?

- Build upon successes of CT Dept. of Mental Health and Addiction Services (DMHAS) pilot project, *Dame La Mano*
  - **Develop and implement culturally appropriate models for Latino clients**

Typical Scenario

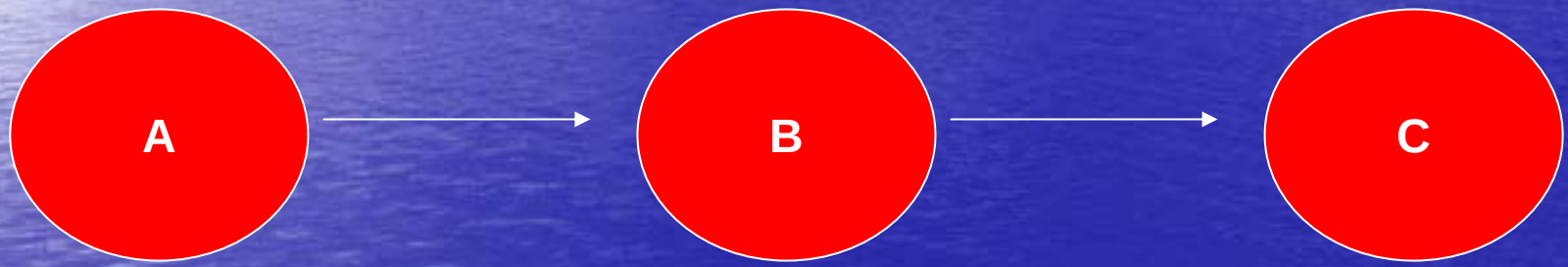


Culture (Value) and Language

<u>Mainstream</u> Culture (Value) and Language

Increased Risk for <u>Dropout</u>

Desired Scenario

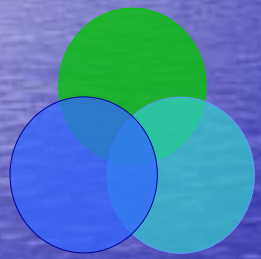


Culture (Value) and Language

<u>Mainstream</u> Culture (Value) and Language

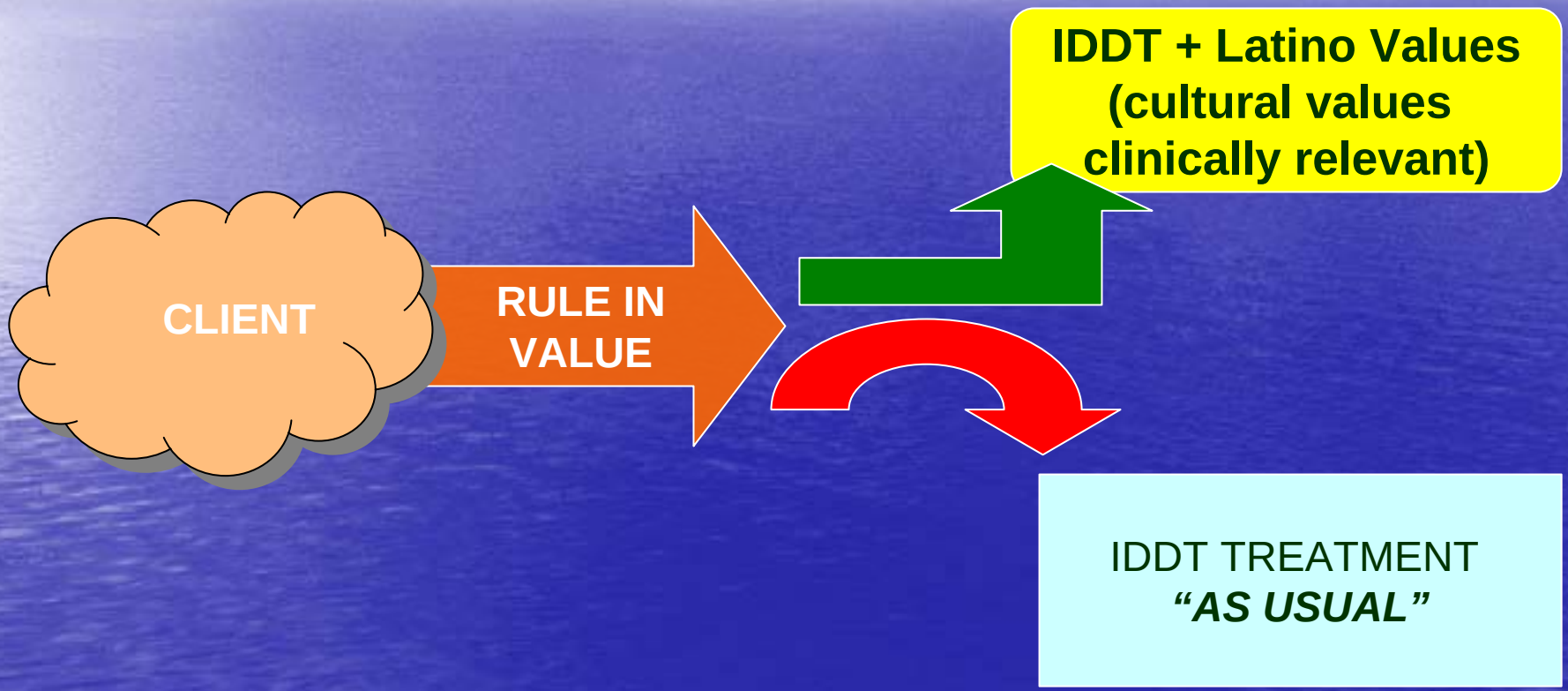
Increased Chance for <u>Retention</u>

ENGAGING LATINO CLIENTS



A. ***CONFIANZA (Trust)***
B. ***RESPETO (Respect)***
C. ***PERSONALISMO/SIMPATÍA (Interpersonal Orientation & Friendliness)***
D. ***FAMILISMO (Family Orientation)***

"RULE IN" ASSESSMENT



CONFIANZA: A PART OF OUR DAILY LIFE

"GM Goodwrench Announces New Hispanic Advertising Campaign: Mr. Goodwrench is my 'mecánico de confianza' (trusted mechanic)" (*Hispanic Business.com, 4/20/06*)

"Hablemos en Confianza" is part of SAMHSA's Hispanic/Latino Initiative (http://www.hablemos.samhsa.gov)

"Toyota Introduces its New Brand Message (*Avanza Confiado*), to Meet Latino Customers' Goals" *(Hispanic PR Wire, 10/11/04)*

A. *CONFIANZA IN CLINICAL SETTINGS*

- There must be a high degree of trust in order for **ANY** relationship to work

- For Latina/os it refers to an expression of the degree of **intimacy** felt in the therapeutic relationship

CLINICAL RELEVANCE OF CONFIANZA

- If the person adheres and it is not present, the client may not **disclose**
- If the person adheres it may result in excessive distress when there are interpersonal **changes** (i.e., transferring client to another clinician)
- If the person adheres it should not be **interpreted** as paranoia

ASSESSMENT OF CONFIANZA

Rule IN:

- "**How important is** *confianza* to you when you are first getting to know someone?"
- "Please describe *una persona de confianza* (a person of *confianza*) in your life."
- "What does it take for you to develop *confianza* with someone?
- What would have to happen for *confianza* to be broken?"

INTERVENTIONS (if adherence)

- **Make the development of confianza an explicit tx goal; utilize MET**
  - *Ex: "On a scale of 1-10 with 1 being none and 10 being the most, how much **confianza** do we have between us? What can we do together to move from (actual #) to (future goal #)?*

- Continuously assess as an integral aspect of tx
- If it is necessary to make a referral, use self as frame of reference *(i.e., "Yo le tengo confianza a...")*

B. *RESPETO*

- Demonstrating deference or acknowledging authority

- Strongly mediated by gender and age

CLINICAL RELEVANCE OF RESPETO

- If the person adheres and is not observed, it may increase risk for client **not to disclose** and drop out

- If the person adheres directness may be **misinterpreted** as impoliteness (i.e., sustained eye contact)

ASSESSMENT OF RESPETO

Rule IN:

- "**How important is *respeto*** to you?"
- "How would you like for me to refer to you? Señor? Señora? How do others refer to you?" Tú? Usted?
- "How would I know if you disagreed with me or with something I said?"*

can also be used to assess *Personalismo

INTERVENTIONS (if adherence)

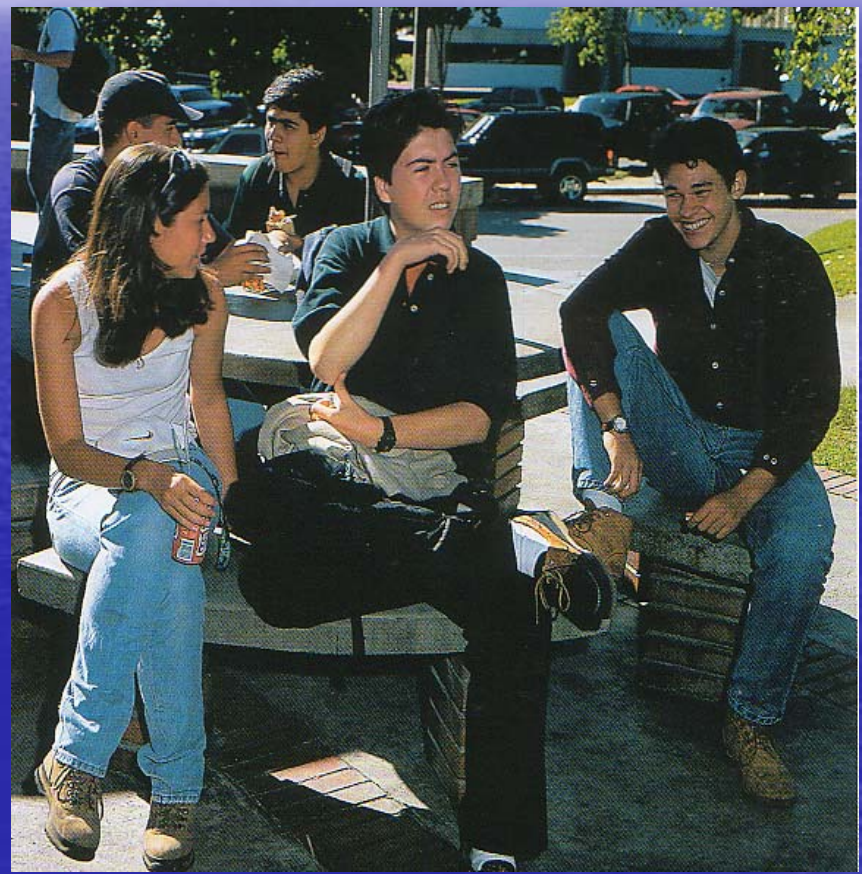
- Address clients via titles (**Don, Doña, Dr., Señor, Señora, Señorita**)
- Include clients' **title** on appointment cards
- Ask for **permission** when being direct

C. *PERSONALISMO/SIMPATÍA*

- Refers to values placed on maintaining relationships on a personal level & being interpersonally pleasant

  (i.e., "buena gente" vs. "antipatica/o")

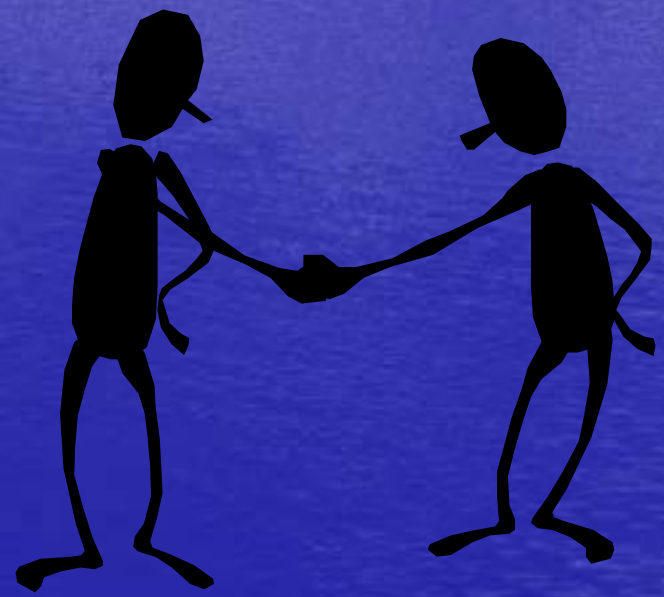
- Values harmony



PERSONALISMO

- If the person adheres there may be a strong value placed on **knowing** the person while organizational channels may be viewed as untrustworthy and rigid

- If the person adheres there may be preference for **direct**, interpersonal **contact**, *however*, confrontations likely addressed in an **indirect** manner through “indirectas” and “dichos’



CLINICAL RELEVANCE OF PERSONALISMO

- If the person adheres clients may tend to **avoid** conflict and direct communication
- If the person adheres client may present a pleasing, non-controversial attitude that is often mistakenly perceived as **non-assertive**
- If the person adheres client may drop out of treatment if confronted directly

ASSESSMENT OF PERSONALISMO

Rule IN:

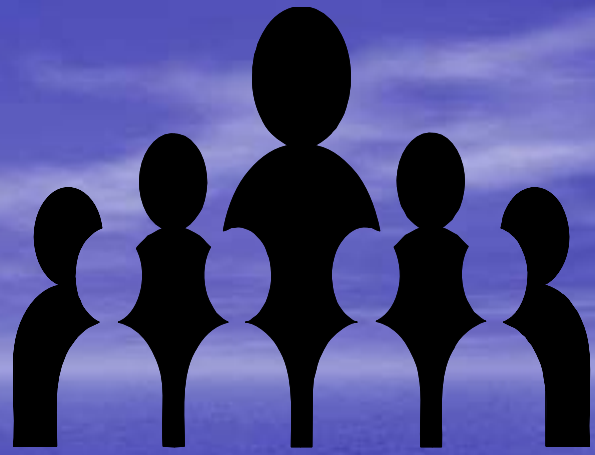
- "Many people often use the term *buena gente* to describe a likeable and friendly person. **How important is it to you to be considered *buena gente or simpatica/o*?** Or to be around *buena gente*?"
- "What helps to make you feel comfortable when you are first getting to know someone?"
- "I've asked you many questions today. I'm wondering what questions you may have for me?"
- **"How do you handle conflict/express disagreement?**

can also be used to assess *Respeto

INTERVENTIONS (if adherence)

- Allow time for **“small talk”** at the beginning of session
- Expand traditional therapeutic role to include areas of **advocacy and case management**
- Make therapeutic tasks very **collaborative**
- Include use of “**el diminutivo**” (diminutive)
- Utilize “**indirectas”** as a way of communicating as well as “**dichos / refranes**” if this value is endorsed

D. *FAMILISMO*



- Sub-type of collectivism
- Characterized by family loyalty, reciprocity, and solidarity
- Fosters a sense of dutifulness, respect and consideration, and inter-dependency and collaboration
- Kinship characterized by the additional inclusion of non-blood relatives (padrino/madrina; compadre/comadre) that share core family functions: support, security, resilience
- Flexible and expandable boundaries

CLINICAL RELEVANCE OF FAMILISMO

- If the person adheres treatment may be **influenced by family (and friends)**, who may not be direct participants in the therapeutic process
- If the person adheres treatment may have to **include systemic** strategies
- If the person adheres family should **not be viewed as enmeshed**

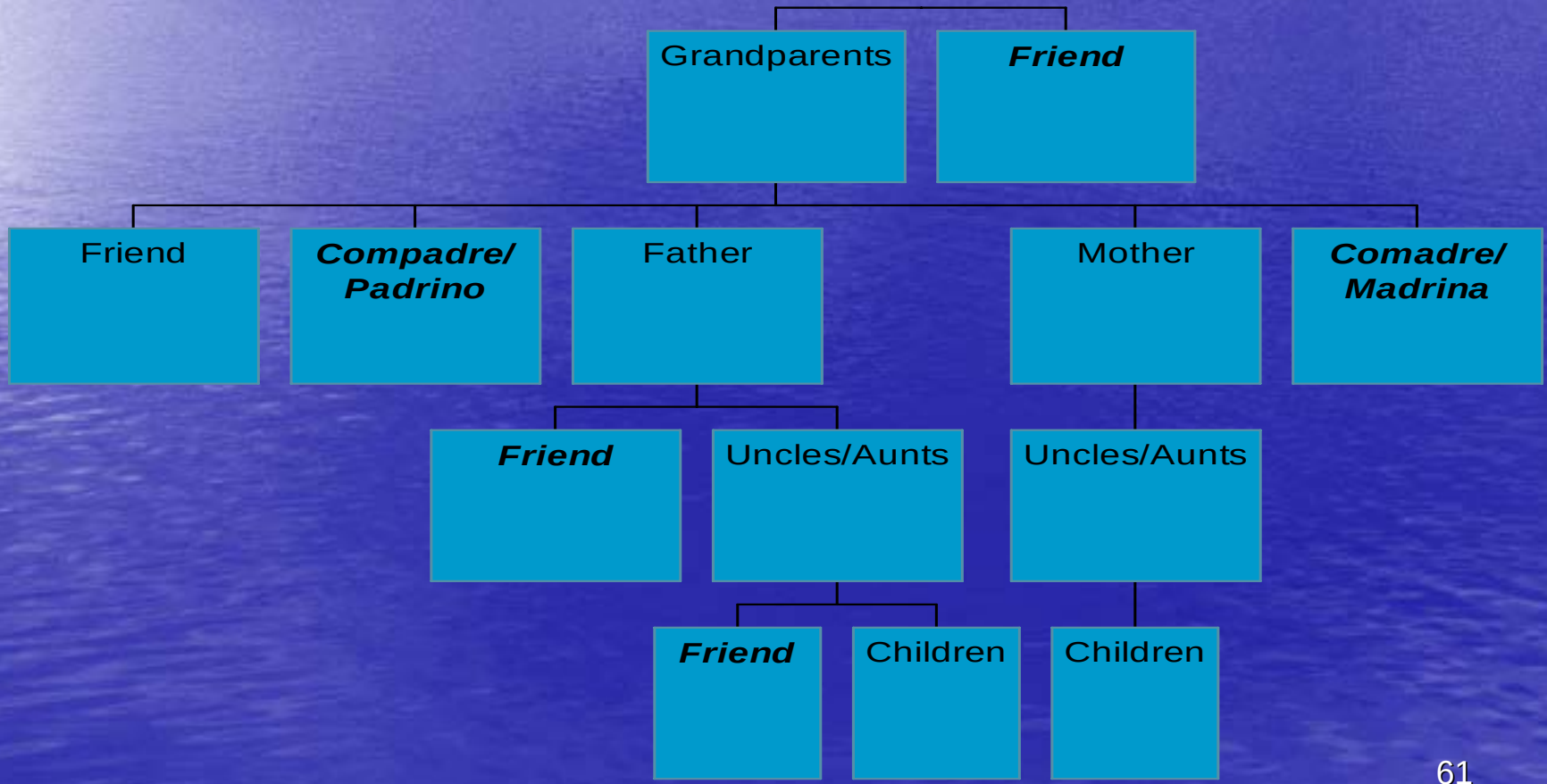
ASSESSMENT OF FAMILISMO

Rule IN:

- "How important is family to you?"
- "How important is your family's opinion when you make a decision?"
- "What other people would you like involved in your treatment?"

Intervention
Identifying "*family members" (if adherence)*

- Utilize Genogram:



OTHER INTERVENTIONS

- Use the word **“family”** when referring to those individuals defined as such by the client
- Mention/ask about the **family** in every single encounter with the client
- Conduct at least **2 family sessions** during protocol

Evaluation of Outcomes

- Use **quantitative** measures addressing the use of these four values (clinician and client) every three months

- Use of **qualitative** measures

Gracias

Co-occurring Disorder Workforce Development

Ensuring a co-occurring capable workforce able to meet the needs of individuals with co-occurring disorders wherever they enter our system of care

Setting Priorities

- Six areas were identified and established as priorities for the development of a co-occurring disorder (COD) capable workforce
  - Establish a COD Practice Steering Committee
  - Curriculum development
  - Supervision
  - Credentialing
  - Recruit/retain culturally diverse individuals and individuals in recovery
  - Collaborate with Universities, Colleges and other professional training institutions regarding the need for a COD competent workforce

Establishing a State-wide COD Steering Committee

- A COD Steering Committee was established right from the start! It is chaired by Commissioner Kirk and managed by the COSIG Project Manager Julienne Giard and meets monthly (having the Commissioner chair this group signifies the importance placed on this initiative and the investment our state is making to ensure the needs of individuals with COD's and their families are of the highest priority).

We didn't stop there!

- In addition to the COD Steering Committee chaired by Dr. Kirk, Julienne Giard, the COSIG Project Manager established two COD Practice Improvement Collaboratives comprised of agencies from all regions of the state (one for state operated facilities and one for 8 private non-profit providers).
  - COD Implementation plans have been developed
  - Monitoring of implementation occurs
  - Adherence to best-practices and QI are high priorities
  - Ideas are shared

Keep Going!

- Regionally based COD Steering Committees exist in all regions of the state
- Comprised of agencies throughout the various networks in each region
- Steering Committees oversee the development, implementation and sustainability of the COD workforce development at agency and program levels

Curriculum Development

- TIP 42, the Integrated Dual Disorder Treatment (IDDT) model, and the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index/toolkit has informed the direction for the development of COD curriculum.
  - Basic
  - Intermediate
  - Advanced

  Following the guidelines put forth in TIP 42 provides necessary competencies required at each level and COD curriculum will/does reflect that.

Creating COD Training Opportunities

- Established the Co-occurring Academy through the DMHAS Training and Education Department- increasing the number of COD trainings available
- Collaborating with the Community College system to develop COD course offerings. A course now exists and offered here at Gateway College through the Drug and Alcohol Recovery Counselor Program. Efforts are underway to expand COD course offerings throughout the Community College system

COD Training Opportunities Continued

- The development of on-line learning is beginning to take shape.
- DMHAS and the Community College system are poised to partner in developing on-line COD training modules
  - Allows for greater flexibility in meeting the needs of the workforce
  - Interactive format
  - Will have pre and post training assessments
  - Greatly reduces training costs
  - 8 COD modules have been identified and development should begin within a month

Examples of Proposed On-line Training Modules

- Addressing Attitudes and Values
- Outreach and Engagement
- Screening and Assessment
- Continuing Care
- Treatment Planning and Treatment
- Medications
- Implementing Integrated Treatment Programs

Supervision

- Supervision is essential for imbedding, developing and sustaining the practice!
  - A survey was conducted to assess clinical supervision that is currently occurring across the state, as well as barriers and plans to develop a supervision process
  - DMHAS Training and Education has developed a well-defined training for supervisors as well as implementation guidelines
  - Recommendations for next steps are currently under review

Credentialing

- COD credentialing of individuals has been in place in Connecticut since 2000 through the Connecticut Certification Board (our host for this 2 day event)
- Recently the IC/RC announced that a national/international COD credential has been adopted thus standardizing the requirements across states. Marshall Rosier, Executive Director of the CCB co-chaired the IC/RC COD task force playing a pivotal role in the adoption of the credential by the IC/RC. Implementation of the IC/RC COD credential is projected for late 2007.
- 2 Levels of COD certification are offered by the board and there has been a dramatic increase in the number of individuals pursuing and obtaining the credential over the past year.

Recruiting and retention of culturally diverse individuals and individuals in recovery

- Preliminary discussions have occurred with the Director of the MERGE program at Housatonic Community College. This is a unique program that actively recruits culturally diverse individuals and those in recovery into their Human Services program that has a focus on COD.
  - Under consideration is the funding of cohorts within this program.

Continued

- Also plans are set to work closely over the next year with the DMHAS Department of Multi-Cultural Affairs to develop strategies to increase cultural diversity in our COD workforce—this is tied to a larger ongoing DMHAS plan
- Plans to recruit and retain individuals in recovery are also underway- this too is tied to a larger ongoing DMHAS plan

Collaboration with Colleges and Universities to enhance our COD Workforce

- The Community College system has been very receptive to the development of COD course work and is now offering a COD course (offering an on-line COD course is under consideration)
- Partnering with the CC system to develop on-line COD curriculum is underway
- Plans are underway to develop day long COD trainings offered through the CC extension programs
- Next steps are plans to approach the 2 Schools of Social Work in the state in an effort to collaborate around the development of COD course offerings

Members of the COSIG Workforce Group

- Rick Callahan, LPC, LADC, CCDP (DMHAS)
- Rick Fisher, LCSW (DMHAS)
- Linda Frisman, Ph.D. (DMHAS)
- Marshall Rosier, LADC, CCDP (CCB)
- Collaboration and support from Julienne Giard, MSW, COSIG Project Manager (DMHAS)

Closing

- DMHAS has created a great web page that contains current information on the COD Initiative in Connecticut and contains many resources you may find valuable. Please visit www.ct.gov/dmhas.

Thank you!!

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