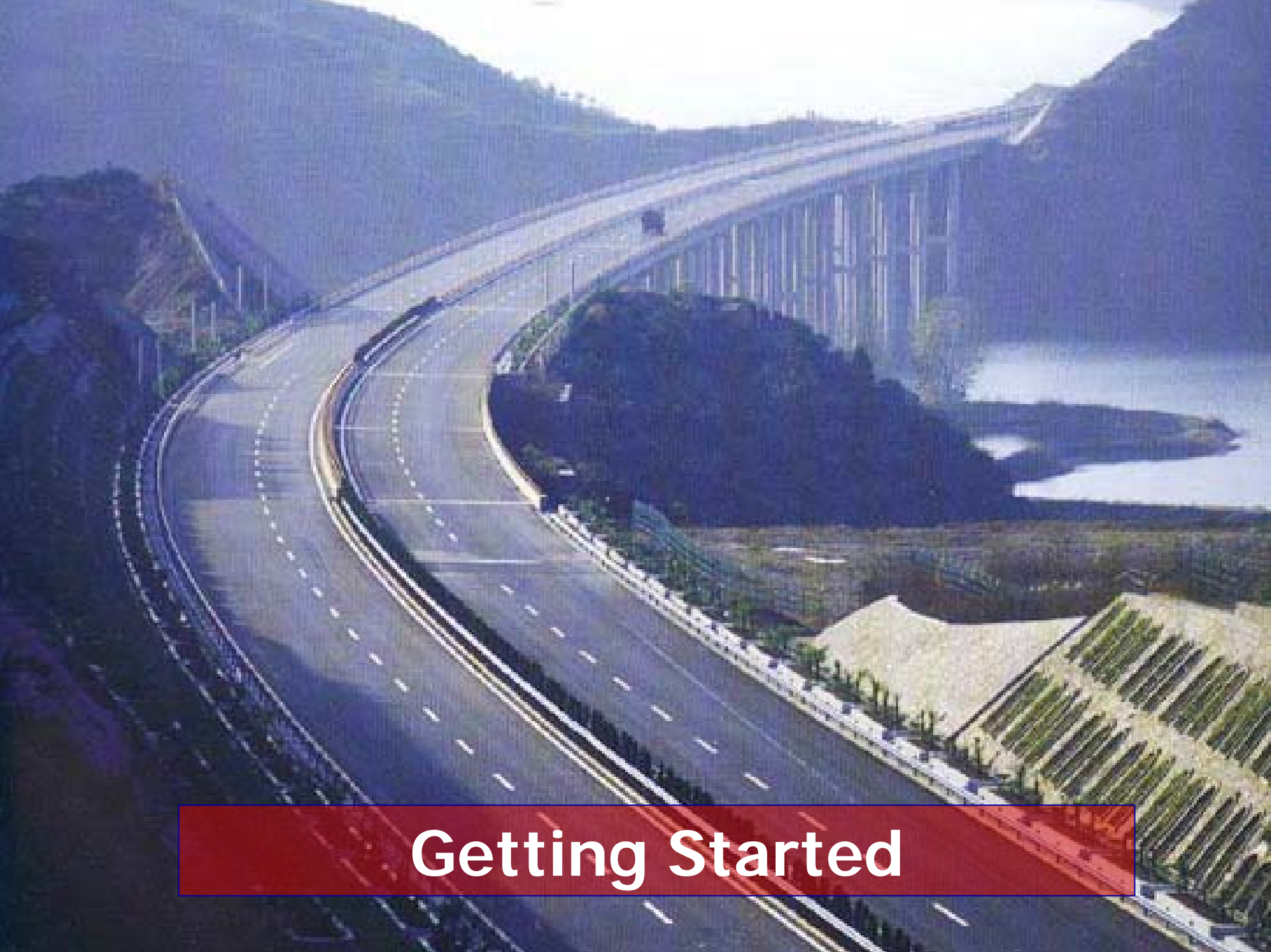


Transforming to a Co-Occurring Responsive System of Care

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Department of Mental Health and Addiction Services
A Healthcare Service Agency

Vermont Department of Health
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Getting Started

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 – with varying success.

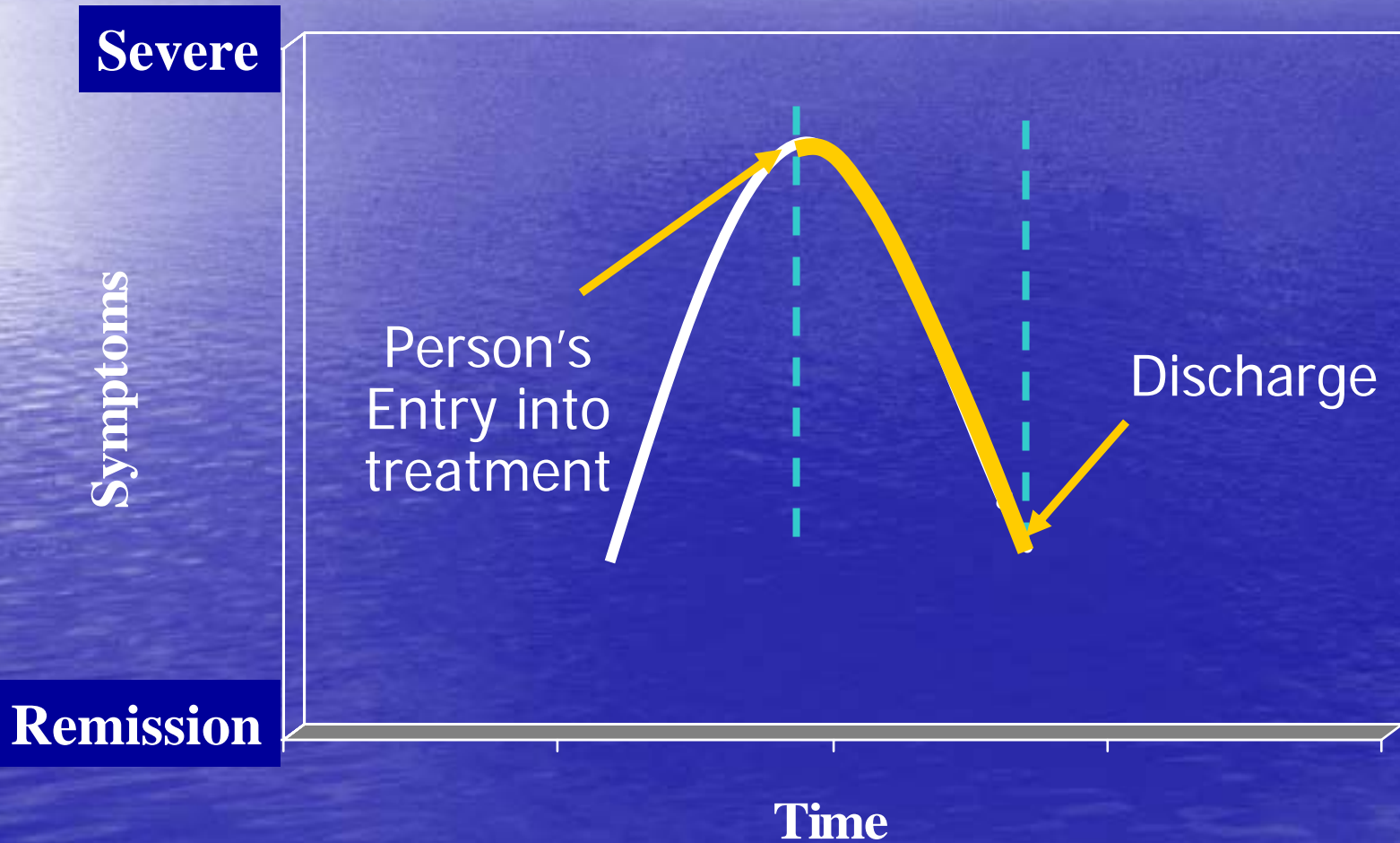
- **Late 1990s** – taskforces, research on co-occurring disorders (COD)
- **2002** – CT Integrated Dual Disorders Treatment (IDDT) Initiative and what is now the CT Dual Diagnosis Capability in Addiction Treatment (DDCAT) Initiative began
- **2004** – National COD Policy Academy
- **2005** – Co-Occurring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

Why Focus on Co-occurring?

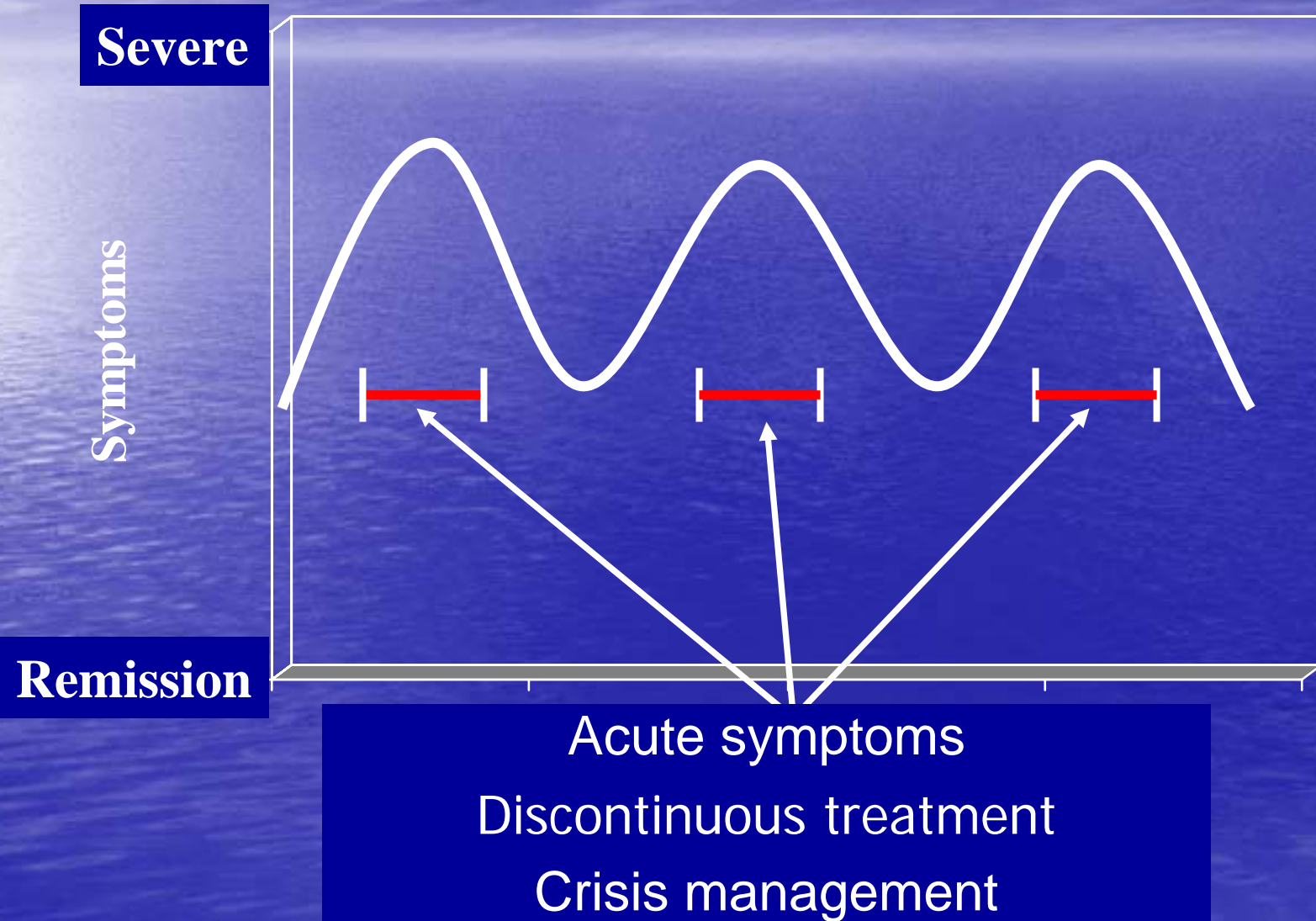


- **Frequency of occurrence:**
 - Critical incidents
 - Poor treatment outcomes for people with co-occurring disorders in the absence of integrated care
 - De-institutionalization and more Community care
 - Availability of substances
- **Better screening, assessment and treatment matching: refinement and maturation of co-occurring disorders treatment field**
- **Disproportionate cost allocations**

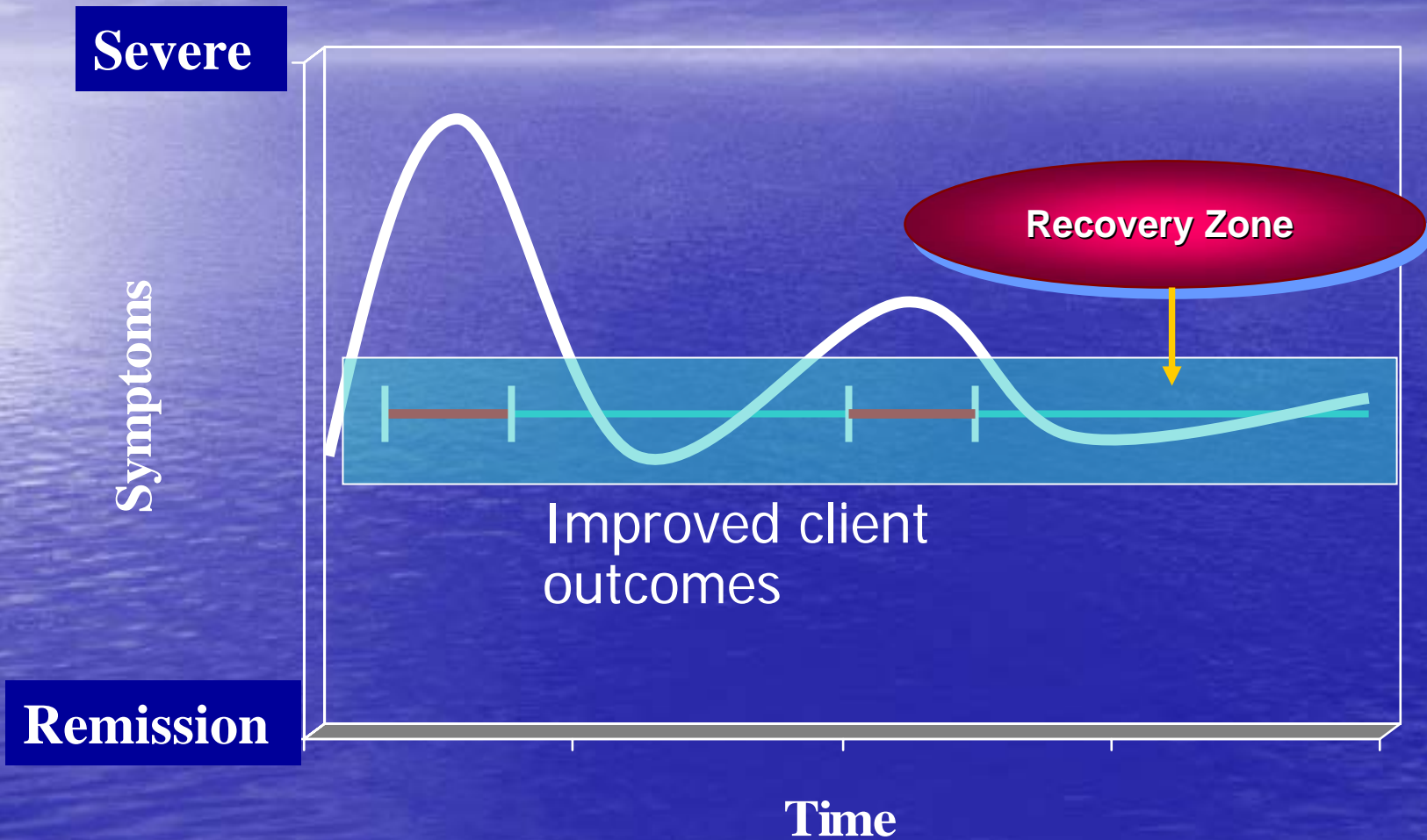
Substance Abuse/Mental Illness as too often viewed by the funder and/or service provider



Service Response



Helping People Move into Recovery Zone



VALUE-DRIVEN, RECOVERY ORIENTED SERVICE SYSTEM

- **QUALITY** IS THE MOTHER OF A RECOVERY-ORIENTED SERVICE SYSTEM
- **QUALITY** IS THE MOTHER OF VALUE

VALUE = QUALITY/COST



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 – “Project Du Jour?”



- Use Big tent approach for consensus
- Multi-year implementation process, i.e., COD “PIC”
- Use technology transfer strategies to develop, implement, and sustain evidence-based or preferred practices
- Relate to existing initiatives, i.e., Recovery, Quality focus
- 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

- Persons with co-occurring disorders, the expectation not the exception.
- “No wrong door” for entering into the system.
- MH and SA disorders are both “primary”.
- Integrated care, one plan for one person.
- Preserve and capitalize on the values, philosophies, and core technologies of both the mental health and addiction treatment fields, “one plus one = three.”

Guiding Principles (cont.)

- Recognize signs and effects of both conditions
- Know each phase of each disorder presents different treatment issues and needs
- Carefully attend to motivation for change and readiness for treatment
- Gradually increase expectations

Guiding Principles (cont.)

- Comprehensive array of services & supports
- Learn to manage one's own recovery
- Flexible, individualized person-centered services
- Provider "networks "(?) - integrated and coordinated
- Primary goal - shift from symptom stabilization to "recovery zone"

Linkage with Recovery Initiative

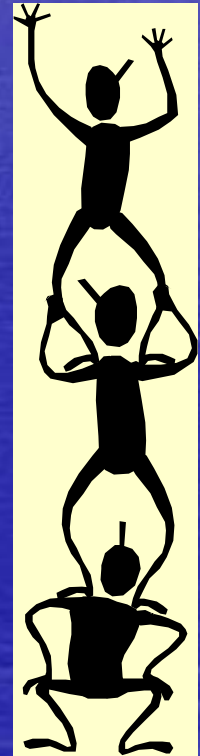
Continued focus on being a Recovery–Oriented Healthcare System.

- Commissioner’s Recovery Policy No. 83, 2002.
- Recovery Practice Guidelines, 2006 (Edition 2, 2008?).
- Umbrella for integrating services and improving outcomes for people with COD; recovery lessons from both fields.



CT COD INITIATIVE - STRUCTURE

- Steering Committee – Commissioner Chairs
- Workgroups
 - Screening
 - Services
 - State Facilities
 - Co-Occurring Guidelines
 - Workforce Development
 - Co-Occurring Practice Improvement Collaborative



COD Steering Committee Partners

- 2 COSIG pilot sites (Morris Foundation, Hispanic Clinic)
- CT Substance Abuse and Mental Health Providers (Trade Association Reps)
- 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

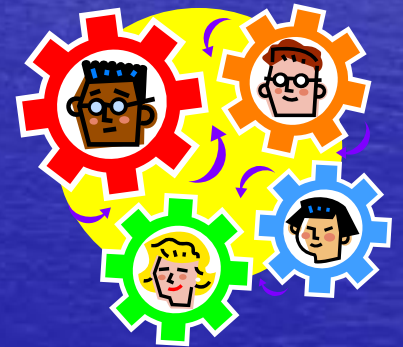
- Pilot began May 2006, complete Spring 2007.
- 30 providers (MH and SA, state and pnp) (\$2k/mo/6 mos, Onsite Training/TA)
- Monthly conference calls, data feedback reports.
- 3,050 completed sets of screens
- Based on positive results, statewide implementation of COD screening instruments will begin 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).
 - Eight DMHAS State Facilities (same focus as above).
 - Program Guidelines

Workforce Development

- Co-Occurring Academy
- On-line learning (RFP, 8 courses, \$20k)
- Clinical Supervision
- Specialty credentials (Next – Survey)
- Community Colleges (COD specific courses)



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”** - Screening Pilot and COD Evidence-based and Preferred Practices
 - **“MESSAGE from ...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 July 2007
- Continue practice improvement collaboratives with additional agencies
- 8 PIC providers to develop and submit COD implementation plans; statewide TA event
- Increased use of data to identify people with COD, their service use, outcomes; 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 COD Policy Statement

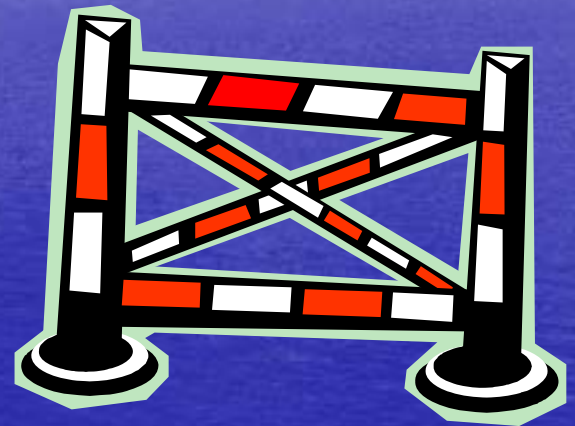
What is this all about?

- 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.

THE VISION



Connecticut...

First in the country by 2010...

- in overall health, economic growth and full quality of life
- in support of the hopes, strengths and goals of every person, family and community ... *across their lifespan.*

Contact Information

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