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RECOVERY TIMES

Healthy People, Healthy Communities. Let's Make It Happen!
State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

Emphasis On: Evidence-based and/or Preferred Practices/Approaches

BETTER HEALTHCARE IMPROVES RECOVERY

Crossroads, Inc., in collaboration with the Hill Health Center (HHC), has launched a satellite clinic within Crossroads' to provide primary healthcare services to persons served by Crossroads. Crossroads has established space for two exam rooms, an office, and a phlebotomy room within its facility. HHC provides a phlebotomist and internal medical doctor on-site.

Most often individuals admitted to residential programs, such as Crossroads, have not adequately addressed medical concerns that may compromise their health and interfere with their efforts to recover from substance abuse. This initiative streamlines access to essential medical and wellness care through on-site primary healthcare services, including physical exams, tuberculosis screening, service coordination for individuals with medical needs, and diverts care from costly emergency room visits.

Supported Education is an evidence-based practice with emphasis on person-centered treatment, psychosocial rehabilitation programming and most importantly, outcomes and goals articulated by the individual.

Since 1971, Crossroads has responded to the changing needs of men and women recovering from substance use disorders, including more recently addressing co-occurring disorders. Crossroads offers intensive and outpatient programs for addiction treatment within its Adult Psychiatric Clinic and collaborates with Uttermost Community Outreach to provide recovery supports in the community. Crossroads addresses the needs of Latinos through their residential and outpatient treatment programs.

For more information about Crossroads, contact Dr. Miguel Caldera at 203-387-0094.

SUPPORTED EDUCATION (SE) SERVICES

Historically individuals with mental illness received treatment based on a medical model and were viewed as not being capable of changing their behaviors, making life altering decisions or even having the ability to improve their functioning. Numerous studies and research projects in the early 1980's to the present time have disproved these beliefs. SE, an evidence-based practice with emphasis on person-centered treatment, psychosocial rehabilitation programming and most importantly, outcomes and goals articulated by the individual, is the result of this belief/treatment systems shift. This shift also put a spotlight on community services and emphasized the need to expand from just clinical treatment to include vocational rehabilitation-focused services, e.g., psychosocial, supported employment, SE programs.

Supported Education (SE) Fact Sheet:

What is it? SE helps people with serious mental illness begin or return to post-secondary education so they may receive the education they need to meet their education/recovery goals and/or become employed in the career of their choice.

How does it work? Staff assists participants to select an education goal, register, acquire financial aid and guide/support the individual through the education experience. College personnel provide academic counseling and address disability-related needs.

Who returns to school? The average individual is 30 years old and has a diagnosis of schizophrenia, major depression or bi-polar disorder. Approximately 60% of people with mental illness have completed high school and many have some college credits; the onset of the illness has often disrupted completion of their education. Others may resume their education by completing a GED or adult education.

What accommodations/services are necessary? The most common accommodations are extended time for exams, changes in format or timeframes for exams or assignments, tutoring, note taking assistance and/or tape recorders. The most common services needed are assistance with registration and financial aid. Research has shown that individuals with psychiatric disabilities do not need more accommodations than students with other disabilities and their need for supports services usually decreases over time.

What are common problems? Stigma is the largest issue faced by students. Research has shown that with treatment and medication, most people with mental illness do recover and can return to school or work.

Can individuals with a mental illness be successful? According to a recent study, students with mental illness complete 90% of the courses for which they enroll, with a grade point average of 3.14. Furthermore, a diagnosis of a mental illness does not significantly affect completion rates, credits completed or grades.

What are positive benefits of SE? SE is significantly related to successful employment and is the single best indicator for successful employment outcomes. Students report an increase in self-esteem and self-efficacy; some studies indicate a decline in hospitalization rates.

Description of SE Models in Connecticut:

Self-Contained Classroom: Students attend a specially designed program at a post-secondary site at a college, university, occupational school, etc., (e.g., MERGE–Mental Health & Education Resource Group for Excellence at Housatonic Community College). These students are not integrated into the general curriculum, but they may utilize some of the institution's resources and participate in some activities. They may move into general classes after completing the program. All support services are provided by the program.

On-Site Support: Students are integrated into the post-secondary institution's general curriculum. Students are matriculated and receive credits for completing classes. Support services are provided by the institution's counseling staff.

Mobile Support: Students are integrated into the post-secondary institution's general curriculum, matriculate and receive credits for completing classes. Support is provided by staff from a community-based service agency from which the participants receive other services such as therapy, housing, case management, etc. These can be agencies that are specifically funded by DMHAS to provide supported educational services or clubhouses, many of which provide supported education services. Community mental health agency staff can provide on-site support to individuals at different post-secondary institutions as needed.

Next Steps to Promote SE in Connecticut:

-Through a Mental Health Transformation Grant, Central CT State University (CCSU) facilitated a statewide interagency strategic planning process. The grant linked DMHAS stakeholders with post-secondary academic and skills training opportunities to increase the number of individuals that enroll in and successfully complete postsecondary education/training. Building on a SE model developed by Carol Mosely at the University of Michigan, CCSU is facilitating regional "educational collaboratives" consisting of persons in recovery, advocates, and representatives from local community colleges and universities, and DMHAS staff.

-Participants underwent a day-long training at CCSU and are currently holding regional meetings to promote greater knowledge regarding educational opportunities and referral/support protocols. They will identify local resources with the goal of leveraging services/supports from multiple systems to create an integrated coordinated network of career advancement services. Collaborative members will also review current practices and develop recommendations regarding policies/ procedures to increase enrollment and improve educational outcomes for persons in recovery. The project will also address stigma that discourages people in recovery from enrolling in school and finding supports that will allow them to be successful.

-DMHAS released a Request for Proposals to purchase supported education services during Fiscal Year 2009-2010. It is DMHAS' intent to fund SE programs in each of the 5 behavioral health regions.

For more information, contact Ruth.Howell@po.state.ct.us or 860-418-6821 or Sharon.Wall@po.state.ct.us or 860-418-6659.

FIDELITY SCALE FOR INTEGRATED DUAL DIAGNOSIS TREATMENT (IDDT)

Western CT Mental Health Network (WCMHN) has engaged in Fidelity Scale assessments of IDDT across 3 of its sites in Danbury, Torrington, and Waterbury. Often times, staff is apprehensive when they hear the term "fidelity assessment" because it denotes the potential to look "poorly" or "not doing the right thing". Fidelity assessments can and should be used as a mechanism for organizational and individual self-reflection regarding evidence-based practices.

With the help of the Co-Occurring State Incentive Grant (COSIG) partners in DMHAS' Office of the Commissioner and across the state, the most recent Fidelity Scale Assessment led to a realization of persistent difficulties that we were having in a couple of key areas related to fidelity; namely Family Psychoeducation practices and Psychopharmacological Approaches with Co-Occurring disorders. Each of these has historically been an area of low fidelity for WCMHN. What was particularly helpful this year was the realization that this was a statewide phenomenon and not just specific to Region 5. Even more helpful was the ability to get additional consultation to assist in achieving greater implementation success.

As a result of these focused consultations we have moved our Family Psychoeducation process into high gear. Each site now has family nights which serve as a vehicle for entry into receiving support and education regarding their loved one's treatment, how they can be

helpful in the process of treatment, and how to take care of themselves. The consultation process has been really helpful in providing ways to achieve better success in initiating and maintaining attendance over time, which has historically been very difficult.

Fidelity assessments are a temperature reading on implementation success, not a barometer of "failure". They serve as a focused reminder of what we do well, what we need to improve upon, and provide guidance and targets as to how to improve the process of integrated care.

For more information, contact Matthew.Snow@po.state.ct.us or 203-805-6405.

BETTOR CHOICE PROGRAM TRANSFERS EVIDENCE-BASED INTERVENTION TO CLINICAL PRACTICE

Research has established contingency management (CM) as an effective strategy that improves treatment compliance and clinical outcomes in (Preston et al., 1999; Rigsby et al., 2000; Petry et al., 2005). Dr. Petry shared preliminary results from a study in progress of CM with pathological gamblers in a presentation to DMHAS' Problem Gambling Services' staff this past fall. Results from this study are indicating that CM significantly improves therapy attendance, homework compliance and Gamblers Anonymous (GA) attendance.

Contingency Management significantly improves therapy attendance and compliance.

While problem gambling and substance use disorders have much in common and similar treatment strategies are employed, there are some significant differences that need to be recognized in transferring techniques for substance abuse to problem gambling treatment. For example, substance abuse treatment CM has employed reinforcement for clean urines. However, there is no comparable way to verify abstinence in working with problem gamblers. Therefore, the strategy has been modified to reward behaviors to support the recovery process such as attending therapy sessions, assignment completion, and GA attendance. While Dr. Petry's work has been based on CM in individual sessions, Cheryl Molina, Bettor Choice Program coordinator in Norwich at United Community and Family Services, has developed a group format for using this evidence-based strategy as a more cost effective approach in working with problem gamblers. She is currently in the middle of her third 10-week CM group. Each individual contracts for 3 recovery activities per week and receives a reward (about $5 value) for verification of completion of 2 of the 3 activities. Again as having clean urine cannot be used for verification, group members need to enlist the cooperation of family members, GA members, or others to assist with confirming goal accomplishment. Completion of a weekly homework assignment is the same for all group members and is mandatory. These assignments are based in cognitive behavioral and coping skills interventions. Rewards include gas cards, Dunkin Donuts cards, baseball game tickets, etc.

As with Dr. Petry's research project, the Bettor Choice clinical CM group has had only 2 individuals who did not complete the group in the past 6 months, has had very high attendance rates and the majority of individuals have completed all of their contracted activities. Ms. Molina reports that it is interesting to see how group members have used their rewards, assignments and even the verification process to support their motivation for recovery. Several members have used their gas cards to support driving to GA and treatment. One individual used a baseball ticket to take his son to a game and commented, "I went to the game and realized how much of life I have been missing with all that gambling." As "proof" of assignment completion, one group member brought in a handwritten note from his son, "I walked three times this week with my Dad and it's great to have him back." Another member brought a note from her spouse saying, "We went out to dinner and it was the first time in a long time we focused on each other." While research has been based on using this strategy in individual sessions, Ms. Molina reports that using a group format has allowed individuals to support each member's goal completion and to problem solve obstacles in achieving recovery goals.

In efforts to inform clinicians of the most promising evidence-based practices, Ms. Molina presented the results of her initial CM group to all the Bettor Choice Problem Gambling Treatment Programs. Ms. Molina's work is a creative example of how evidence-based practices can be modified to enhance clinical practice.

For more information on the above, contact Cheryl Molina, cmolina@UCFS.org. For more on DMHAS' Problem Gambling Services, contact Lori.Rugle@po.state.ct.us or 860-262-6610.

RECOVERY-ORIENTED EMPLOYMENT SERVICES (ROES): RECOVERY IS WORKING

ROES is a new employment program that is currently operating in the north central and eastern regions of CT. In order to participate in ROES people must be receiving treatment from a DMHAS addiction treatment provider in the north central or eastern region. Persons are identified by their treatment provider as needing employment services and are referred to Alcohol and Drug Recovery Centers (ADRC), who manages the

program. The ADRC employment specialist administers a vocational screen to develop an employment/educational plan, which is coordinated with the person's individualized recovery plan. The employment specialist then makes referrals to employment/educational resources and employers.

ADRC also connects participants to the CT Community for Addiction Recovery (CCAR) for telephone recovery support service related to employment/recovery. Participants are required to volunteer at least 20 hours with CCAR which results in a volunteer job experience reference that can be used when securing employment. Participants are also required to attend an 8 module vocational skills training on financial management, resume writing, interview skills, and workplace ethics.

ROES is unique in several ways: 1) Employment specialists are mobile and able to meet participants at mutually accessible locations; 2) Participants receive recovery supports related to their employment/educational pursuits; 3) Program connects with employers, chamber of commerce and businesses to provide information about recovery while working to reduce stigma and provide employment connections; 4) Program is bridging the gap between addiction treatment and recovery services.

For more information, contact at linda.guillorn@po.state.ct.us or 860-418-6732.

SMOKING CESSATION

Diagnosing tobacco dependence historically has been rare and often seen as a minimal factor in a person's life compared to serious mental illness and addiction. However, tobacco is an addiction with potentially devastating effects on the smoker as well as those in his/her environment. Both immediate and long-term steps can be taken to increase awareness of the negative impact of tobacco use and to encourage smoking cessation. The following actions have demonstrated effectiveness in motivating people to cease tobacco use:

-Screen for tobacco use and diagnose for tobacco dependence according to most recent DSM.

-Ask at every visit about tobacco use and if individuals have thought about quitting.

-Increase awareness of tobacco use as an addiction that is treatable, targeting both service providers and people in recovery.

-Offer parallel smoking cessation assistance to staff where possible.

-Use Integrated Dual Diagnosis Treatment (stage of change, motivational interviewing, persuasion and active treatment groups) as an overarching comprehensive treatment model.

-Use contingency management to encourage attendance at persuasion groups and reinforce abstinence in active treatment groups.

-Offer people in recovery choices to how they want to stop tobacco use (cold turkey, nicotine replacement therapy (NRT)).

-Assist people in recovery to save money to defray expense of NRT.

-Include some form of individual and/or group counseling as an adjunct to choice of smoking cessation procedure (success rate is higher).

-Train hotline staff to offer support after hours.

-Assist people who have achieved tobacco cessation to utilize support groups if they desire.

Available Resource: The U.S. Public Health Service Agency has available Clinical Practice Guideline: 2008 Update, a comprehensive overview of current best practices for treating tobacco addiction. A free copy (additional copies available for $1.00 each) can be ordered by calling 1-800-358-9295 or writing to AHRQ, P.O. Box 8547, Silver Spring, MD 20907-8547.

For more information, contact Steve.Bistran@po.state.ct.us or 860-496-3707.

SOUTHWEST CT MENTAL HEALTH SYSTEM (SWCMHS) EVIDENCE–BASED PRACTICES

Since 2002 SWCMHS has implemented a number of Evidence-Based Practices (EBP), including Dialectic Behavioral Therapy (DBT), Illness Management and Recovery (IMR), Supported Employment (SE), Trauma Recovery and Empowerment Model (TREM), Integrated Dual Disorder Treatment (IDDT), and most recently Family Psychoeducation. A brief overview follows:

For the past 15 years SWCMHS has taken the lead in the development of DBT in Bridgeport. Recently DBT has begun to be offered in Spanish. In addition DBT substance abuse groups have been held on a frequent basis. Dr. Ellen Nasper has provided DBT consultation and training to community agencies and other DMHAS facilities. As a result of this program many individuals with self-harming behaviors have been helped.

IMR has also been implemented in Bridgeport and Stamford. Combining education, peer support and self-care skill building, IMR groups are available to all individuals backed up by individual counseling. A Spanish language group is also available. In some instances these groups are co-facilitated by staff and individuals in recovery. In 2007–2008 there were 40 participants and graduates of IMR. This year we project another 50 graduates. IMR has grown extremely popular with many referrals coming from former participants.

Employment Specialists are embedded in almost every SWCMHS community team in Bridgeport and Stamford. This has allowed individuals with an interest in work to have access to SE. Partnerships are in place with Kennedy Center and Goodwill to improve access to employment resources and integrate clinical care, case management and employment services. This has resulted in a 10% increase in employment among individuals served by SWCMHS.

It is recognized that a significant percentage of individuals served by DMHAS have experienced trauma. Given this, TREM groups have also been held at the Bridgeport site. There are Women's and Men's groups as well as a Spanish language TREM for individuals of the Hispanic Unit.

IDDT has gradually been implemented with new assessment tools, substance abuse groups and trainings in Motivational Interviewing (MI). In collaboration with Dr. Andres-Hymen, Yale Recovery Institute, MI trainings have been conducted with community staff in Bridgeport and Stamford. Supervision groups are being conducted and additional implementation is planned.

In the near future SWCMHS will be implementing a pilot Family Psychoeducation group in Bridgeport. These groups will consist of 10-months of bi-weekly meetings with focus on mental illness/substance abuse.

Training is not enough. Follow-up consultation, expert supervision and administrative support are necessary for successful Evidence-Based Practices implementation.

Lessons learned: Training is not enough. Follow-up consultation, expert supervision and administrative support are necessary for successful EBP implementation.

For more information, contact George.Hagman@po.state.ct.us 203-579-7406 or James.Pisciotta@po.state.ct.us or 203-579-7368.

WOMEN'S SERVICES PRACTICE IMPROVEMENT COLLABORATIVE

In October 2004, DMHAS launched an initiative to enhance the behavioral health service system for women in a way that is trauma-informed, gender-specific, and promotes self-determination. A best practice system of care for women, supported by system-level policies and standards and program-level practices, is currently under development. The goal is to improve treatment outcomes and the quality of services for women receiving substance abuse treatment by incorporating current best practices in gender responsive and trauma-informed programming. The Substance Abuse and Mental Health Services Administration (SAMHSA) in 2004 released study findings that show women with mental health and substance use disorders and histories of violence (trauma) can improve when treated with counseling that addresses all their service needs. Findings also noted that women who have a voice in their own treatment report better outcomes.

Providers, persons in recovery and policy makers all agree upon a common premise: that the current system of care does not adequately meet or address the needs of women with substance abuse issues; given the complexity of their lives and the many challenges they face. Women who may be considering substance abuse and mental health treatment options, are often overwhelmed by the many changes (community-oriented life, compliance to program rules) associated with entering treatment (Brown, Melchior, & Huba, 1999). Women who enter the system of care should experience positive clinical outcomes and a heightened sense of hope for the future in their roles as mothers, survivors, and contributing members of their communities.

DMHAS and stakeholders met early on to develop strategies to improve practice for women within their programs and identify ways in which to measure success after implementing the changes. A series of retreats were held with the (17) Women's Specialty programs, along with multiple stakeholders, including national experts in the field to develop standards and best practices that are gender-responsive and trauma-informed. As a result 3 products have been developed: 1) Gender-Responsive Treatment Guidelines; 2) Gender-Responsive Guidelines Self-Assessment Tool; and 3) Outcomes Tool and Research Methodology.

To ensure that WSPIC maintains its momentum and delivers new products and services, the Best Practices Committee was established. The purpose of the Committee is to gather provider input and make recommendations to the WSPIC Guide Team concerning the implementation of gender responsive care in the state. The Committee also directly implements strategies that will improve services to women and is developing a strategic plan. Based on provider feedback from a recent survey, this plan outlines the following next steps to continue the improvement of gender responsive care for women and their families: 1) Increase access and availability of trainings; 2) Improve access to/connection with recovery supports; and 3) Develop additional recovery supports.

For more information, contact Terry.Nowakowski@po.state.ct.us/860-418-6774.