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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: CO-OCCURRING SERVICES/APPROACHES

CONTINGENCY MANAGEMENT (CM) TO INCREASE USE OF INTERVENTIONS

***DMHAS' River Valley Services (RVS)**.* RVS will soon implement Contingency Management (CM) within its co-occurring disorders groups. CM is an evidence-based practice that has been utilized in addiction treatment with very positive results. Behavioral therapy based on B.F. Skinner's operant conditioning principles. Positive rewards increase retention in treatment programs, a strong predictor of positive treatment outcomes, when compared to counseling alone (Higgins et al., 1994, Petry et al., 2000). RVS' goal is to maximize group attendance by implementing the "fishbowl" technique. This intermittent reinforcement approach was introduced by Nancy Petry, Ph.D. in an effort to make CM more cost effective (as opposed to the traditional voucher system). There is an opportunity to win from 3 prize levels; a small prize is worth approximately $1.00, a large prize is worth approximately $20.00, and a jumbo prize is worth approximately $100.00. An escalating bonus system will be incorporated in an effort to continue to increase individual's motivation to attend groups. RVS will be monitoring outcomes and looks forward to sharing them in the future.

Positive rewards increase retention in treatment programs, a strong predictor of positive treatment outcomes, when compared to counseling alone.

For more information, contact Howard.Reid@po.state.ct.us or 860-262-5205.

***DMHAS' Western CT Mental Health Network (WCMHN)**–*Torrington Area implemented CM, an evidence-based practice defined as the systematic application of positive reinforcement to increase the frequency of desired behaviors, in both of its ongoing "Persuasion Groups" in August of 2005. Persuasion groups are for individuals with co-occurring disorders who are in the pre-contemplation through preparation stages of change. Persuasion Group members may be in denial over their use of substances, are often ambivalent about changing behaviors and, as a result, have sporadic and inconsistent group attendance, late arrival, or early departure. Individuals in recovery in any of these stages typically require much encouragement and assistance to attend meetings.

Torrington decided to focus on increasing behaviors related to 1) arriving to group on time, 2) remaining for the duration of the group, 3) maintaining consistency of group attendance, and 4) independently getting to group on one's own. The program was called "Recovery Rewards." Group members who arrive at or before the beginning group time, remain to the end of the group, and/or get to the group on their own receive reward tickets entitling them to drawing for prizes at the end of the group. Group members who attend two consecutive groups double the number of earned tickets; attending three consecutive meetings triples the number of tickets, etc. up to a maximum quintupling of the number of tickets (5). At the end of the group each ticket is good for a single "draw" from the "fishbowl," which contains "congratulatory" messages, $1.00 prizes, $10.00 prizes, and a single $100.00 prize.

The results of this program were immediate and have persisted since its implementation. Group attendance tripled and has maintained at a higher rate of consistent attendance over time. In addition, leaders of both persuasion groups also report an increase in camaraderie, group

cohesion, altruism, courtesy and respect and a sharing with each other. Group members become excited when others win prizes, as well as themselves!

Based on Torrington's success with this evidence-based practice, WCMHN has received additional funding from the Co-Occurring State Incentive Grant to implement CM in both its Waterbury and Danbury facilities. Each facility will utilize these proven methodologies to improve both attendance and adherence to current persuasion groups. We look forward to this and continuing our desire to become a Co-Occurring Enhanced Program.

For more information on the above, contact Stephen.Bistran@po.state.ct.us / 860-496-3707. For information on WCMHN, contact Colette.Anderson@po.state.ct.us /203-805-6400.

***DMHAS' Southwest CT Mental Health System (SWCMHS)**,* through its overall implementation of services to people with co-occurring disorders, has made an effort to increase use of interventions that have been found to be effective with this population. Contingency Management (CM) is a behavioral intervention designed to reward people with tangible reinforcers for positive behaviors. While a CM program can take many forms, such as rewards for clean urines, pro-social behaviors, or goal-related behaviors, SWCMHS has provided rewards for attendance at co-occurring groups. In July, a CM program was piloted in two groups and has been well received by the participants. Attendance in the active treatment group that recently started has increased on a weekly basis.

Additionally, our work to improve clinicians' skills in Motivational Interviewing (MI) continues. Dr. Raquel Andres-Hyman of the Yale Program for Recovery/Community Health utilizes the MISTS (MI Supervision and Training Scale) to review submitted tapes and offer feedback to supervisors and clinicians. Outpatient teams in Bridgeport and Stamford dedicate time monthly to review cases from an MI perspective. Team leaders at both sites are receiving specialized training to be able to provide clinical supervision on the practice. Both Bridgeport and Stamford have ongoing consultation groups focused on offering guidance to clinicians providing services to individuals with co-occurring disorders.

For more information on the above, contact Kate.Powell@po.state.ct.us or 203-551-7515. For more information on SWCMHS, contact James.Pisciotta@po.state.ct.us or 203-557-7368.

CO-OCCURRING DISORDERS SEMINAR FOR STAFF

DMHAS' CT Mental Health Center (CMHC) has begun a biweekly seminar on co-occurring disorders for all clinical staff. The seminars are both case and topic oriented and guided by clinical problems on the teams. Drs. Steve Martino, a local consultant, and Donna LaPaglia, Director of CMHC's Substance Abuse Treatment Unit (SATU), lead the seminar. The seminar establishes both of them as local experts for consultations in between meetings. Coincidentally and partly as an outgrowth of these education efforts, the entire clinical staff of SATU applied for and received the nationally recognized certification in treating co-occurring disorders from the CT Certification Board (i.e., the CCDP—Certified Co-Occurring Disorders Counselor or SCCD—Specialty Certificate of Competency in Co-Occurring Disorders).

For more information, contact Selby.Jacobs@po.state.ct.us or 203-974-7144.

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EMPLOYMENT/VOCATIONAL REHABILITATION SERVICES

One of the most innovative approaches in the co-occurring field is the provision of evidence-based Supported Employment (SE) services. Several studies on SE have shown that people with co-occurring disorders (COD) do as well or better as people with a single diagnosis. Researchers have speculated that people with co-occurring disorders may do surprisingly well in the

vocational domain because they have social skills that may transfer to employment situations. "The preponderance of evidence suggests that CODs do not predict how well a consumer will do in employment, (Bond 2004)." SE helps to distinguish and clarify the "Myths" about employment of people with CODs versus the "Facts".

Myth: Work is too stressful for people with CODs.
Facts:, Work improves self–esteem and adds a sense of purpose and may motivate individuals to reduce substance use. Some studies document lower re-hospitalization rates and reduced psychiatric symptom.

Myth: People with CODs lack good work skills.
Facts: Framed as a key element of recovery, CODs do not lead to lower employment rates.

Myth: People with CODs don't want to work.
Facts: Like other people in our society, many people with CODs are interested in working and find work to be a good reason to cut back or stop their substance use.
A history of CODs is not a consistent predictor of work success or failure.

Myth: People with CODs who relapse are poor candidates for supported employment.
Facts: For many people with CODs, relapse is part of the long-term course of recovery. Rates of employment for people with CODs are similar to rates for people with a single diagnosis. People generally do better in supported employment than in alternative programs regardless of their characteristics (e.g.; diagnosis, substance abuse history, hospitalization history, cognitive functioning, gender, education, ethnicity, etc.)

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

IMPLEMENTATION OF INTEGRATED DUAL DIAGNOSIS TREATMENT (IDDT)

DMHAS' Cedar Crest Hospital. Following completion of an IDDT (Hospital Version) Fidelity Study in fall of 2007, a plan was developed to conduct a "pilot-implementation" on the transitional residential unit (TSLP) at Cedar Ridge, with the goal of making the unit's services as consistent as possible with the IDDT Model. Subsequently the practice would be disseminated to other units in the hospital. In early March, 2008, the plan was formally launched, with staff from the TSLP participating in a 2-day training on Motivational Interviewing (MI) and the Stages of Change Model. Direct service staff responded positively to the training and to the prospect of applying the principles when working with individuals served. After the training the following activities occurred:

-Weekly staff meetings to review application of the stages-of-change model and MI skills;
-Weekly supervisors' meetings to train in use of M.I.T.I. (Motivational Interviewing Treatment Integrity Coding System) to better assess competency of staff in learning basic MI skills;
-Development of a supplement to the hospital's standard psychosocial assessment for use in staging both Substance Use and Psychiatric problems collaboratively with clients;
-Monthly consultation meetings of the TSLP staff with Rusty Foster of the Dartmouth Evidence-Based Practices Center;
-Participation with the DMHAS-wide psychiatrist/APRN training by Dartmouth faculty, Mary Brunette, MD, on prescribing for individuals with co-occurring disorders;
-Initiation by our substance abuse specialist in the *Fresh Start* curriculum-based group treatment for individuals in the pre-contemplation, contemplation, and preparation stages of change;
-Initiation of an introductory training for newly hired and existing direct care staff in the Stages of Change Model and principles of MI; and
-Initiation of a variety of quality monitors pertaining to documentation of individual stages of changes, provision of evidence to support the assessment, and use of therapeutic interventions appropriate for the given stages.

For more information, contact Randy.Kaplan@po.state.ct.us or 860-666-7697.

DMHAS' River Valley Services (RVS). RVS recently completed its third agency-wide study to examine how closely it is following the

Integrated Dual Disorder Treatment (IDDT) model. The study was conducted following SAMHSA Fidelity study guidelines with case managers, program managers, psychiatrists, clients and chart reviews. Three successive administrations allow for the examination of the effectiveness of performance improvement efforts in following the evidence-based guidelines. In the past year RVS has continued to provide training to staff, including specialized training for prescribers in the agency. Additionally a Co-Occurring Disorders Implementation group meets monthly to plan and monitor progress of PI efforts. As a result the 2008 Fidelity Study revealed significant improvement in case manager and program manager knowledge and consistent use of stage-wise approaches and motivational interventions. A larger variety of motivational interventions were used and case managers and program managers were familiar with all the stages of change. Prescribers also demonstrated greater knowledge of motivational interventions. Overall, a stage-wise approach to treatment and the use of motivational interventions have become part of the day to day work at RVS.

For more information, contact Howard.Reid@po.state.ct.us or 860-262-52305.

DMHAS' Young Adult Services (YAS). One of the major goals of the DMHAS-wide implementation of the IDDT model is to ensure that IDDT services are provided across all DMHAS services, and not limited to those services which specialize in co-occurring disorders. At DMHAS' Capitol Region Mental Health Center (CRMHC), one example of this is the implementation of IDDT in the Center's YAS Program. The Division Manager of YAS was previously the program director of the CRMHC Co-Occurring Team, and is steeped in the IDDT model. All clinical staff in the program has been trained in the IDDT model, and in addition, the following steps have been taken to provide IDDT-based services:

-A program "champion" has been identified who is a Senior Clinician in the program, and will continue to encourage clinical staff to think in IDDT terms, teach them how to better engage young adults, consult on difficult cases, etc.
-Three IDDT-based groups have been put into place: a Persuasion Group, a Social Skills group, and an Active Treatment group.
-During the assessment process, individual's stage of treatment- e.g., engagement, persuasion, active treatment, relapse prevention- is identified via the clinical assessment process, motivational interviewing, and the use of the payoff matrix.
-The stage of treatment is than incorporated into the individual's treatment plan, and clinical interventions are tailored to the individual's stage of treatment along with working with the client around their readiness for treatment and understanding of the impact of their substance use problems on their lives and recovery.

For information on the above, contact Michael.Levinson@po.state.ct.us or 860-297-0975. For information on CRMHC, contact Karen.Evertson@po.state.ct.us or 860-297-0903.

INNOVATIONS IN CO-OCCURRING TREATMENT

DMHAS' Blue Hills Substance Abuse Services (BHSAS) has worked to develop interventions for persons with co-occurring disorders who are unwilling or unable to participate in traditional psycho-educational or process type groups. This type of group at times serves as the primary intervention for providers of substance abuse treatment services. Persons with co-occurring disorders may lack the social skills to feel comfortable in process groups or the concentration and retention necessary to benefit fully from educational groups. In the interest of our goal of trauma-informed services and creating an environment where patients feel safe, Blue Hills provides groups geared toward persons who have limited competence or confidence in these areas.

The weekly "skills building" group developed by the Rehabilitation Therapist is provided for persons who may be reticent to participate in the other types of groups. The context for the interventions include, but is not limited to, small discussion groups, crafts, table or board games, and light exercise or stretching. The group leader uses the activity to improve social

interactions and engagement in goal directed activities. Group size is limited to four to six individuals. This allows the group leader to select activities based on the needs and abilities of the participants.

The groups goals are to 1) Improve social skills, including awareness of self and others and the environment; 2) Increase tolerance for group settings and increase verbal interactions; 3) Improve task completion skills including concentration, ability to follow direction and decision making skills; 4) Increase self confidence, impulse control, and frustration tolerance; and 5) Expose individuals to positive alternative to drug-related activities. Improvement in these areas will allow the individual to be more comfortable in self-help programs and other programs offering group support when in the community.

A second group which has been well received is part of the gender-specific programming offered by BHSAS. The Rehabilitation Therapist has collaborated with a female Clinical Social Worker to create a monthly women's group which is conducted in the community (locations vary and may include the Library, a Park, or the Mall as examples). The activity or group setting is intended to expose participants to healthy drug-free activities. The blend of perspective in the co-led group allows for attention to process and group dynamics as well as improved leisure and recreational skills. The activity often ends with a coffee break to recap the session. Staff has found that groups held in a setting more similar to actual life experiences allow individuals to express themselves and relate in quite different ways than what is seen within the program. It is also the intent of this group to increase the ability of women in treatment to provide a mutual support system to reduce the vulnerability to male/female relationships, which oftentimes can interfere with personal recovery.

These two activities are examples of the Intermediate unit's attempt to create a range of contexts for quality interactions for individuals in early recovery.

For more information, contact Stephanie.Grard@po.state.ct.us or 860-262-6972 or Elaine.Flynn@po.state.ct.us or 860-262-6972.

INTERAGENCY SCHOOL HEALTH PROFILE TASK FORCE

DMHAS staff working on the Garrett Lee Smith Memorial Act suicide prevention project and the Mental Health Transformation grant have been meeting with colleagues at the State Departments of Education and Public Health to assess suicide and mental health curriculum utilization in middle and high schools. The DMHAS-DPH-SDE School Health Profile Task Force is exploring the possibility of adding state-specific questions to the 2010 School Health Profile surveys randomly distributed to principals and lead health education teachers across the state.

School Health Profiles is a system of surveys developed by the Center for Disease Control and Prevention that assess school health policies and programs. Profiles are disseminated biennially and monitor: the current status of school health education requirements and content; physical education requirements; health services; nutrition-related policies and practices; family and community involvement in school health programs; school health policies related to HIV /AIDS, tobacco- use prevention, violence prevention, and physical activity; and professional preparation and staff development for lead health education teachers. The Task Force is reviewing model language from across the country to develop questions related to youth suicide prevention, mental/emotional health, and HIV/STD curriculum utilization and staff training needs.

For more information, contact Dianne.Harnad@po.state.ct.us or 860-418-6828.

NEW PROSPECTS

New Prospects, a program of Regional Network of Programs, Inc., is uniquely positioned to offer gender-sensitive co-occurring enhanced intensive residential services to adult men and women. This program is designed to provide services for individuals who are experiencing

difficulties stabilizing their substance abuse and mental health issues and are in need of short-term, intensive treatment of approximately thirty (30) days. The program accepts referrals Statewide with exclusive funding provided by DMHAS in order to increase access to such necessary services, and as a means to effectively address overflow experienced in emergency rooms and hospitals.

Since it's opening on June 30, 2008, New Prospects has served over 35 men and women. The screening and assessment process is designed to ensure that individual's who are assessed with high severity substance use and low to moderate severity of mental health symptoms (Quadrant III), are able to participate in an intensive treatment program. A person-centered therapeutic atmosphere and interdisciplinary team approach are central to the program and its provision of clinical care.

"I'm learning that my addiction and my mental health diagnosis go hand-in-hand in my recovery."

The team at New Prospects is dedicated to providing treatment, which emphasizes the often complicated impact of how substance dependency and psychiatric symptoms are interwoven in the recovery process. Individuals asked about the program reported:

-"I'm learning that my addiction and my mental health diagnosis go hand-in-hand in my recovery."
-"I'm able to share different and difficult problems with others who are suffering with similar problems….I couldn't do that in the past."
-"This program is unique, but hopefully will catch on to other programs."
-"I'm grateful to have a program where I don't feel alone discussing my mental illness…and otherwise would be left unclear for me."

Regional Network of Programs is very proud to be offering a level of care that has been so well-received by individuals served, and appreciated by the other DMHAS providers throughout CT.
To make a referral, or for information, contact Program Director, Danielle Moreggi, Ph.D., or Clinical Coordinator, Lisa Van Heijningen, M.A.C.P, C.C.D.P., LADC at (203) 610-6252.

PEER SUPERVISION FOR CO-OCCURRING DISORDERS

DMHAS' Western CT Mental Health Network (WCMHN) has been conducting peer supervision in our network around the co-occurring initiative for several years. Like many other clinical initiatives, establishing and maintaining such a practice has been fraught with numerous challenges, including maintaining the activities after a key leader has left the organization, staff changes affecting the composition of the peer group, and additional demands placed on a staff member's time.

Peer supervision can be a valuable addition to program's supervisory capacities. Peer led supervision, unlike a traditional supervision, can provide a forum for support, clinical brainstorming, skill development, and mutual sharing. Although models vary considerably from site to site, most of our sites have experimented with taped supervision, case discussion, educational forums, and site maintenance activities around the co-occurring initiative. Part of the promise and the challenge of peer supervision are to maintain the enthusiasm for the process in spite of and in direct competition often times with competing demands.

Peer supervision at the network varies from site to site. Danbury has used a tape supervision model at various times, as well as Torrington. Waterbury has recently expanded its clinical programming, and the peer supervision group will now include historical members involved in the provision of group treatment, Young Adult Service staff who wish to implement a stage-based group for individuals in recovery, a staff member with CADAC skills from our clinical services division, as well as other new ACT clinicians. The composition of this group has dramatically changed in the past six months and their recent addition will be a source of enthusiasm for this group moving forward.

Key issues to address in the coming year include incorporating assertive twelve step programming (new to the network), fully implementing contingency management at each site, establishing a network-wide consistent mechanism for referrals to groups, etc. Focusing a continued refinement and enhancement of motivational enhancement techniques is key as well. Encouraging the use of taped sessions in these peer supervision meetings will be a major focus over the coming year.

For more information on the above, contact Matthew.Snow@po.state.ct.us /203-805-6405. For information on WCMHN, contact Colette.Anderson@po.state.ct.us /203-805-6400.

STAGE-WISE GROUP TREATMENT FOR CO-OCCURRING DISORDERS

DMHAS' Western CT Mental Health Network (WCMHN) has been implementing stage-wise treatment for co-occurring disorders for several years. WCMHN remains committed to the premise of stage-wise treatment in its delivery of clinical services for those who have a co-occurring disorder. Our network began with the establishment of persuasion based groups, and has subsequently branched out into stage-based groups over time. We have learned many important lessons along the way.

Group leaders sometimes have different skills in providing stage-based treatment. For example, a great persuasion group leader may not be as artful with a relapse prevention model, or vice versa. Persuasion group leaders lean heavily on motivational interviewing methods to foster engagement with the change process and to assist the client/individual in recovery in moving along towards meeting their personal goals. Active treatment and maintenance group leaders are focused on skill development, bolstering motivation for continued change, and to seek ways to encourage the individual in recovery to live the fullest life possible.

Initially, our groups focused on persuasion stages, as the greatest number of our clients/individuals in recovery reside there. Since then, we have developed other stage-based groups, including active treatment and maintenance groups (relapse prevention). We have discovered that many individuals in recovery, some of whom have been in a persuasion group for a considerable length of time (and with the same group leaders in some instances), do not wish to move on to another stage group. This is not to say that they do not wish to change; many have been clean or sober for 1-2 years despite their continued presence in the persuasion group. Why is this happening?

These situations have presented a quandary for some of our group leaders. Requiring individuals in recovery to move in these kinds of situations seems somewhat "anti" recovery. Some individuals in recovery who have been sober for a length of time wish to remain in their respective groups because of the connections they have made to other individuals in recovery and to the group leaders themselves. They serve as role models and find assisting others in their efforts to stay clean very rewarding and meaningful. Groups where this has occurred have modified their original curriculum to include items that would be considered more of an "active" treatment model. Topics have included sober activities, talking you through urges, developing sober supports, etc.

For other individuals in recovery who wish to move on, we now have the array of groups which permit a smooth transition. These individuals in recovery find it very difficult to be in groups with other members who may be using or have not made a commitment to change. For them, it is too difficult to remain in these groups and to keep their early sobriety intact. As such, they find the idea of transitioning very stage appropriate and in keeping with what they ultimately need.

For more information on the above, contact Matthew.Snow@po.state.ct.us /203-805-6405. For information on WCMHN, contact Colette.Anderson@po.state.ct.us /203-805-6400.

WOMEN'S JAIL DIVERSION (JDW) PROGRAMS

The majority of women who are incarcerated in this country have histories of physical, sexual, and/or emotional trauma and many experience

significant psychiatric affects of trauma that impact their ability to function effectively. Women with trauma histories are also at very high risk of using substances and are often identified and treated as substance abusers without adequate assessment and treatment for the effects of trauma. The DMHAS Division of Forensic Services funds 3 programs that provide integrated care for trauma, mental illness, and substance use: DMHAS' Capitol Region Mental Health Center (CRMHC) program serves Hartford Courts, the Community Mental Health Affiliates (CMHA) serves New Britain and Bristol Court, and the recently implemented DMHAS CT Mental Health Center (CMHC) program serves New Haven Court.

These programs target women at risk of incarceration who have the psychiatric consequences of physical, sexual, and/or emotional abuse and also substance use disorders. The programs provide comprehensive clinical services for mental health, substance abuse, trauma recovery, medication management as well as support in the community to obtain basic needs, and also provide intensive engagement and outreach. All services are delivered in a trauma informed manner by experienced clinical staff to meet the unique needs of women. The programs also have funds to provide limited basic needs for clothing, transportation, toiletries, etc. While most of the women who are admitted to these programs have a prior treatment history they generally have not successfully engaged in extended recovery in the past and often have multiple, though minor, prior arrests and incarcerations. More than half of the participants complete the program and avoid incarceration on the charge for which they were diverted to the program. Outcome studies for the CRMHC and CMHA programs, which started in 2003, with grant funding show that woman who participate in the program have fewer arrests in the year after starting the program compared to the previous year.

For more information, contact Erin.Leavitt-Smith@po.state.ct.us or 860-262-5879.

YOUTH SUICIDE PREVENTION COMMUNITY EDUCATION AND AWARENESS CAMPAIGN

As part of the CT Youth Suicide Prevention Initiative (CYSPI) supported by the SAMHSA's Center for Mental Health Services under the federal Garrett Lee Smith Memorial Act, DMHAS has contracted with the Connecticut Clearinghouse to administer a Community Education and Awareness Campaign. Nine competitive mini-grants ranging from $2,000-$4,000 were funded to allow youth and young-adult serving agencies, organizations and schools with pre-existing youth groups or prior experience to: establish an Active Minds chapter; participate in Yellow Ribbon Campaign activities; and develop innovative local approaches to mental health promotion with an emphasis on depression awareness and suicide safety. Youth Suicide Prevention Community Education and Awareness Campaign mini-grant recipients for 2008 are: City of Bristol Youth Services, Student Counseling Services at Connecticut College, Families United for Children's Mental Health, Greater Enfield Alliance for Kids and Families, Norwich Free Academy, the University of New Haven, and United Services.

For more information, contact Dianne Harnad, Director of Prevention at (860) 418-6828 or dianne.harnad@po.state.ct.us.