Prepared for the State of Iowa Department of Human Services Department of Public Health

The Iowa Change Agent Manual: *A Resource Manual for Developing Multi-occurring Capability and Competency*

(2012 Edition)

ZIA PARTNERS

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Welcome to the Iowa Change Agent Team

Congratulations and thank you for representing your agency or organization as a Change Agent in the State of Iowa System Transformation Project, which incorporates implementation of the **Comprehensive Continuous Integrated System of Care (CCISC)** model for improving services system-wide to individuals and families with multi-occurring conditions. This project is organized within a welcoming framework in which people and families are the center of everything we do. Consumers, advocates, staff, clinicians, managers and administrators are partners in this Change Agent team called ICORN.

This manual is the State of Iowa Change Agent Manual. It is designed to help you in your important role:

- To help your organization improve welcoming, recovery, resiliency, and person-centered service for individuals and families with multi-occurring conditions.
- To help the system as a whole organize to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with multi-occurring conditions.

We are very appreciative that you have agreed to this undertaking, and welcome your participation and input as a Change Agent in helping make system changes to improve the experience of individuals and families with multi-occurring needs and the partnership for change by which we will all reach this goal.

We thought you might like to have a one-page resource to help you understand key concepts and principles of the change process that is underway, just to get a little grounding before you delve into this rather substantial manual. You will find this "one-pager" on the next page. Please use it to help others understand this information as well.

We look forward to your contribution, both to your own program or organization and to the system as a whole.

CCISC Description and Principles of Multi-occurring Capability

CCISC is a framework for person- and family-driven system design and a process of getting there in partnership across the whole system.

The overall vision is to design the system at every level to be about the needs, hopes, and dreams of the people and families with all types of complex issues—including multi-occurring health, mental health, substance use, developmental, and brain injury disabilities—that are needing help.

The core of the vision is that ALL programs and ALL persons delivering care and support become welcoming, person-centered, resiliency-/recovery-oriented, hopeful, strength-based, trauma-informed, culturally fluent, and multi-occurring (complexity) capable. In any community, all programs work in partnership to help achieve this vision, and to ensure that individuals and families with complex needs receive more integrated care within any door.

Making the vision a reality is based on implementing a set of evidence-based principles of intervention, each of which is associated with interventions and strategies that can be used in any setting, with any population, by any person providing care.

Making the vision a reality is also based on organizing a system-wide quality improvement partnership, in which all types of programs and providers are welcome to come together to move toward the common vision, and all levels of the system—state leaders, CPCs, agency CEOs, program managers, front-line service and support staff, and people and families who are service recipients—come together in an empowered partnership for change.

ICORN represents the collective front-line voice of change agents all over Iowa who are engaged in this process representing their organizations, communities, and other constituencies.

The principles are:

- Complexity is an expectation, not an exception. This expectation must be incorporated in a welcoming manner into everything we do.
- Service partnerships are empowered, empathic, hopeful, integrated, and strength-based, working with individuals and families step by step over time, building on their periods of strength and success, to address ALL their issues in order to achieve their vision of a happy, meaningful life in the community.
- All people with multi-occurring disabilities are not the same. Different programs and different systems have responsibility for serving different sub-populations, but all programs are multi-occurring capable. Each program provides multi-occurring-capable services to its own population, and helps other programs with their populations.
- All the multi-occurring issues are primary, and integrated best-practice interventions for each issue at the same time are needed.
- Progress for any issue involves moving through stages of change; integrated interventions are stage-matched for each issue.
- Active change for each issue involves adequately supported, adequately rewarded skill-based learning, so that individuals and families develop and practice the skills they need to succeed for each issue, with big rounds of applause for each small step of progress.
- There is no one correct program or intervention for individuals or families with complex and multi-occurring conditions. For each person or family, the correct match is based on these principles.
- In CCISC, the principles inform every program, practice, policy, procedure, and person providing service, with every available dollar and resource, to design the system to be about the people who need us the most.

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Part 1: The History of "Changing the World" in Iowa

Toward an Integrated System of Care in Iowa: The History of ICORN and Multi-occurring Capability Development

The recognition of the need for more integrated systems and services for Iowans with multi-occurring conditions goes back many years. In 2003, Iowa was funded to participate in a SAMHSA Co-occurring Policy Academy, and developed a state-level team and strategic plan to begin to address integrated system development for mental health and substance abuse treatment. In 2007, with the formation of the Division of Mental Health and Disability Services within DHS, there was a reprioritization of interest in integrated system development. The University of Iowa Mental Health Consortium began a series of statewide trainings with many community mental health centers to learn the principles of evidence-based practice Integrated Dual Disorder Treatment. The legislature requested a position statement on integrated mental health/substance abuse treatment. ZiaPartners, Inc., was contracted to work with a statewide stakeholder group to develop a consensus document supporting the implementation of the Comprehensive Continuous Integrated System of Care (CCISC), a quality improvement partnership process in which all programs and all persons providing care become welcoming, recovery-oriented and co-occurring capable. At the same time, Iowa Department of Public Health was proactively supporting co-occurring capability development among its providers, within the implementation of Access to Recovery, as well as in statewide implementation of NIATx as a quality improvement process to improve welcoming and access.

During this same time period, disability advocates (primarily but not exclusively representing intellectual disabilities, through the Center for Developmental Disabilities at University of Iowa) began advocating for a comprehensive statewide Olmstead Plan to define the broad strategic vision of DHS. The plan that was adopted over the past few years incorporates specific attention to the importance of community-based services to successfully support people with "multi-occurring" disabilities, including developmental disability, mental health, brain injury, and substance abuse issues. The

Olmstead Plan developed strong consensus support, and was in need of a framework for statewide implementation around multi-occurring needs.

In 2009, ZiaPartners was contracted to begin an organized process of CCISC implementation for mental health and substance abuse providers statewide. ZiaPartners worked with volunteer programs across the whole state, providing quarterly "Change Agent" trainings and technical assistance for how to use the ZiaPartners toolkit (COMPASS-EZ™ , CODECAT-EZ™) so that any program could make progress in becoming more welcoming, recovery-/resiliency-oriented and co-occurring capable. By the end of 2009, the Change Agent team training had grown, and began to organize itself into an independent partnership, giving itself the original name *Iowa Co-occurring Recovery Network* (ICORN). ICORN established a leadership team with representation from CPCs, consumers (IAMHR), advocates (NAMI), mental health providers, substance abuse providers, front-line clinicians, Magellan, IDPH and IDHS/MHDS. The mission of ICORN is to provide mutual support to developing integrated services and to work in partnership with state leadership to support statewide transformation. In 2010, ICORN meetings regularly attracted 100 attendees from across the state, and certain CPCs (Linn County, Webster County, etc.) began organizing local networks of Change Agents to support CCISC implementation in their local systems.

Beginning in 2011, DHS began to address the opportunity of using the existing energy of ICORN and the CCISC process to welcome the DD/ID/BI system into the process, and to use the CCISC framework to develop universal "multi-occurring capability" as a mechanism for facilitating statewide implementation of the Olmstead Plan vision. During 2011-12, there has been specific outreach to ID and BI providers, with the specific support and advocacy of Iowa Association of Community Providers, and in early 2012 increasing numbers of DD providers joined the ICORN process. DHS continues to work in partnership with DPH, ICORN leadership, and ZiaPartners to organize step-by-step expansion of involvement of individual provider agencies, local county or community networks, regional partnerships and state institutions in the process of implementing multi-occurring capability statewide. Further, the legislatively initiated reorganization process that began in 2011 resulted in clear recommendations from stakeholder workgroups supporting the concept of universal multi-occurring capability development within the framework of CCISC principles, as part of reorganization and potential regionalization. This is a wonderful opportunity for the state to leverage limited resources to improve services for individuals and families with complex needs statewide.

More recently, DHS has been working with its partners to bring multiple initiatives together into a common vision and direction for change. Existing providers working in learning communities on Trauma-informed Care (TIC), Children's Systems of Care, and

Positive Behavioral Intervention and Supports (PBS) have been welcomed into ICORN and the CCISC process, aligning principles of TIC, PBS, and CCISC to share an inspired vision of how the whole system can be more effectively designed to be about the needs, hopes, and dreams of the individuals and families in Iowa with complex, multi-occurring issues of *all* kinds that are coming to our door . Change Agents are joining the process with all kinds of background experiences, and sharing a common passion about being empowered partners in the change.

Welcome to the process! You are in the right place! We are really glad you are here!

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Part 2: Preface and Overview of Terms

Preface

This manual is best used as a resource manual for developing your skills and talents as a Change Agent. The working assumption for this resource is that individual Change Agents are already competent in the field in which they practice or in the roles and functions they perform in their jobs or volunteer positions. These materials are intended to augment that base of knowledge, focusing on extending your understanding to incorporate multi-occurring issues. The manual also provides ready access to information needed to be a helpful participant in the change process within an organization and throughout the system as valuable member of the Change Agent Team. Please do not feel like you should sit with the manual and study it cover-to-cover. It is not a textbook. It is a compendium of resources, some of which will be used in the Change Agent meetings and others that are simply there for you to reference should you need them in your work as a Change Agent.

Focus on Best Practices for System and Programs

The Change Agent Manual emphasizes methodology for designing a system-of-care model (CCISC) recognized by SAMHSA as a best practice for system change. This model emphasizes helping agencies and programs become welcoming, recovery- and resiliency-oriented, and multi-occurring capable by routinely implementing best-practice interventions throughout the organization. Individuals of any age and families with multi-occurring issues are seen and helped within the framework of an overarching vision of recovery- and resiliency-oriented, person-centered and culturally fluent services system-wide.

Focus on Best-practice Clinical Interventions and Supports

The manual also supports learning and application of many clinical consensus and evidence-based best practices for treatment and support of individuals and families with complex issues.

Basic Layout of the Manual

Part 1: History of "Changing the World" in Iowa

As with all worthy change processes, it is important to know the building blocks upon which the transformational effort rests. Part 1 presents a brief history of the Integrated System of Care in Iowa: The History of ICORN and Multi-occurring Capability Development.

Part 2: Preface and Overview of Terms

Part 3: Roles of the Change Agents

Change Agents and the empowered Change Agent team are essential to the CCISC change process. Change Agents help their own organizations develop multi-occurring capability and help staff to develop multi-occurring competencies. And, over time, the Change Agent team has system-wide impact by helping to shape the system's policies, procedures and practices based on the working knowledge attained across the multiple organizations. This "anchoring" gives lasting structure to the transformation.

Part 4: Comprehensive Continuous Integrated Systems of Care (CCISC)

The Change Agent Manual emphasizes principles of service and treatment for individuals and families with multi-occurring issues and focuses on aspects of core capability and competencies regarding integrated care and service design. The principles and design are essential elements of the CCISC systems and services transformational change model.

Part 5: Modules on Improving Practices

To supplement the story-based learning, Change Agents are provided resource modules addressing various practice improvement topics. These modules can be continually revised and upgraded with newer materials over time.

Part 6: Group Learning Exercises

This manual emphasizes the use of story-based examples to illustrate principles of care and to promote creative problem solving. These story-based examples are embedded in Group Learning Exercises that encourage interactive learning and practice. Change Agents are encouraged to use similar material as part of their training efforts within their own organizations.

Part 7: Continuous Quality Improvement

One of the most critical practices addressed in this manual is Continuous Quality Improvement (CQI). The tenets of CQI are promoted throughout the manual; a specific section of the manual is dedicated to the application of CQI in developing multi-occurring capability.

Appendices

Additionally, you will find many useful items in the Appendices to this manual. We encourage you to browse through them so you know what is there. You can pull them out as reference material should you need them.

Overview of Terms

Comprehensive Continuous Integrated System of Care (CCISC)
(Minkoff and Cline, 2004, 2005)

CCISC is both a framework and a process for designing a whole system of care to be about the complex needs of the individuals and families being served. In CCISC, all programs in the system engage in partnership with other programs, along with the leadership of the system and consumer and family stakeholders, to become welcoming, person-centered, recovery-oriented, and complexity-capable. In addition, every person delivering and supporting care is engaged in a process to become "complexity-competent."

Implementation of CCISC in real-world systems with limited resources is based on significant advances in clinical knowledge over the last two decades. We now have enough knowledge to know how to successfully embed practices in any program in order to be helpful to individuals and families with complex needs. Such practices are organized by **Eight Core CCISC Principles** (See Minkoff and Cline, 2004, 2005), and placed in an integrated recovery framework to create a common language throughout the whole system. Such practices involve welcoming access, integrated screening and assessment, empathic hopeful integrated relationships, stage-matched interventions, strength-based skill-based learning, and using positive contingencies to reward progress a day at a time. CCISC implementation helps all programs in the system, through the use of tools such as COMPASS-EZ™ for program self-assessment and CODECAT-EZ™ for clinician self-assessment, to learn how to apply the CCISC principles to build recovery-oriented co-occurring capability into all areas of practice and programming.

Complexity Capability

In the past decade, CCISC has evolved to address more than just mental health and substance use issues. In real-world behavioral health and health systems, individuals and families with multiple co-occurring needs are an expectation, not an exception. Individuals and families not only have substance use and mental health issues, they frequently have health issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, these are people and families who are characterized by *complexity*, and they tend to have poorer outcomes and higher costs of care. However, instead of systems being designed to clearly welcome and prioritize these complex individuals and families with high risk and poor outcomes, individuals and families with complexity have historically been experienced as "misfits" at every level. This realization has become a major driver for comprehensive system change.

In order for systems with scarce resources to successfully address the needs of the individuals and families with complex issues who are the "expectation," it is not adequate to fund a few special programs to work around a fundamentally mis-designed system. We need to engage in a process of organizing everything we do at every level with every scarce resource we have to be about all the complex needs of the people and families seeking help. By doing a self-assessment of capability or competency to routinely address complexity in an integrated manner, each program can begin an organized process to become a welcoming, recovery-oriented, complexity-capable program, and each person delivering care can begin a process to become more welcoming, recovery-oriented, and complexity-competent as well. Some systems implementing CCISC have begun to use this terminology to reflect this broader perspective. We anticipate that over time the term *co-occurring capability* may well be replaced with *complexity capability*, or other terms that reflect this advancement in understanding. In Iowa, the agreed-upon term for complexity capability is *multi-occurring capability.*

Multi-occurring Capability in Iowa

In service and support settings, individuals and families with complex needs are the expectation, not the exception. Individuals and families often have combinations of issues and conditions such as learning, cognitive and intellectual disabilities; mental and emotional health concerns; substance use issues; traumatic brain injuries; psychological and emotional traumas; sexual and physical abuse issues; health concerns and conditions; housing and homelessness; correctional and court issues; transportation, basic welfare, educational and vocational concerns; and potentially

many more. People and families in service are characterized by complexity, and these complexities are termed *multi-occurring conditions*. The more complex the issues are, the poorer people and families have a tendency to do in systems and services as they are currently designed. Complexity of needs generally results in inefficient use of scarce resources, as well. In order to do a better job with scarce resources and improve the treatment and supports experience for individuals and families with multi-occurring conditions, Iowa stakeholders have committed to work together to create a quality improvement partnership across the state. This partnership is represented in ICORN and is commissioned to implement welcoming, empathic, hopeful, person-centered and integrated systems and services that meet the needs of complex populations as a fundamental design and achieve this multi-occurring capability over time, together.

Multi-occurring Competency

For any person delivering and supporting care to individuals and families with multi-occurring issues or other complex concerns, multi-occurring competency involves developing core attitudes/values and knowledge/skills so that the care provider becomes a helpful, hopeful, and skillful partner to the individuals and families with multi-occurring issues he or she serves. These attitudes/values and knowledge/skills are core competencies of the person's job, applied in the program in which he or she works.

Further, these core competencies are applied in accordance with that person's level of training, licensure, and experience. An individual providing care to individuals and families with multi-occurring issues does not need to have multiple licenses or special certification to become multi-occurring competent; multi-occurring competency is achievable by individuals with one license, two licenses, or no license at all, including peer specialists, residential aides, case managers, and support staff who are working directly with individuals or families.

Co-occurring Issues

(Also Called Co-occurring Conditions and Co-occurring Disorders)

Any person has co-occurring behavioral health issues if he or she has any combination of any mental health and any substance use problem, even if the issues have not yet been diagnosed. Many systems and programs include trauma issues, problem gambling and nicotine dependence in the list of co-occurring behavioral health issues. Co-occurring issues also apply to families. One member may have one kind of problem—such as a child with an emotional disturbance—and another member may have another kind of problem—such as a parent or caregiver with a substance use issue. This attention to affected families has given rise to the concept of a "co-occurring family."

Co-occurring Capability
(Minkoff & Cline, 2006)

For any type of program, within the mission and resources of that program, recovery-oriented co-occurring capability involves designing every aspect of that program at every level on the assumption that the next person "coming to the door" of the program is likely to have co-occurring issues and needs, and that they need to be welcomed for care, engaged with empathy and the hope of recovery, and provided what they need in a person-specific and integrated fashion in order to make progress toward having a happy productive life. Recovery-oriented co-occurring capability necessitates that all care is welcoming and person-centered. This dynamic approach to service and care is attuned to people and families with diverse goals, strengths, histories and cultures. Co-occurring capability involves looking at all aspects of program design and functioning in order to embed integrated policies, procedures and practices in the operations of the program to make it easier and more routine for each clinician to successfully deliver co-occurring-competent care.

Part 3: Roles of the Change Agents

Change Agents' Program Role

The role of Change Agents in their organizations is twofold:

- To provide peer mentoring and clinical support in accordance with recovery- and resiliency-oriented services and the principles of the CCISC model in order to establish and enhance welcoming, recovery/resiliency orientation and multi-occurring competency in program staff.
- To provide program consultation and technical assistance to facilitate development and implementation of quality improvement action planning to establish and enhance welcoming, recovery/resiliency orientation and multi-occurring capability in the program as a whole.

In the context of their existing training and clinical, supervisory or mentoring skills, staff will be trained to assume their Change Agent roles by being encouraged to learn to apply basic principles to solve both clinical and administrative problems. Consumer Change Agents partner with clinician and management Change Agents to ensure that the voice of individuals and families receiving service is central to the entire process, as well as to provide specific assistance inside programs serving populations of any age (children, transitional-age youth, adults, and older adults) and any cultural background.

Program Capability Standards

Change Agents will be trained to use the COMPASS-EZ™ and other complementary tools to assist programs in assessment of multi-occurring capability, and to support progress over time. The Change Agent Team will also participate in the development of multi-occurring capability standards within agencies, in concordance with the implementation of statewide standards.

Staff Competency Standards

Change Agents will be trained to use the CODECAT-EZ™ to promote assessment of multi-occurring competency among staff, and to monitor progress in competency evolution with staff and supervisors. The Change Agent Team may also participate in drafting scopes of practice and/or basic competency expectations for all Iowa system providers in any program.

Clinical Practice Guidelines

Change Agents will become familiar with the concept of Practice Guidelines and their use in clinical decision-making.

Change Agents' System Role: Change Agent Team-building

A critical component of the system quality improvement process is for the Change Agent Team to function as an empowered team throughout the system:

- To provide feedback to system leadership regarding policy support for multi-occurring competency and CCISC implementation.
- To share expertise, cross-train in one another's programs, and provide a network of peer support for problem solving and dissemination of information and ideas.

System Fidelity Assessment

Change Agents may become familiar with the CO-FIT100™ tool for assessment of progress in implementation of the CCISC model at different levels of the system.

Other CCISC Tools

Change Agents will also become versed in other CCISC Tools that might be used (depending on availability to Iowa providers). In addition to the COMPASS-EZ™, CODECAT-EZ™, and COFIT-100™ (see Appendix B, page 219), CCISC program/service self-assessment tools for integrated systems and services include:

- COMPASS-PH™ for primary health programs
- COMPASS PH/BH™ to help develop primary health capability in a behavioral health setting
- COMPASS-ID™ for intellectual disability services
- COMPASS-Prevention™ for prevention and early intervention programs
- COCAP™ – to be used after the COMPASS-EZ™ to identify system benchmarks of multi-occurring capability for all types of programs.
- SOCAT™ - for participating organizations in agencies in community-based system of care partnerships.

Part 4: Comprehensive Continuous Integrated System of Care (CCISC)

CCISC and "Changing the World"

This section of the manual describes the Comprehensive Continuous Integrated System of Care (CCISC) as both:

- A model for system design and transformation.
- A process for implementing the transformation at the system level, the agency/program level, the clinical practice level, and the level of competency of people providing care.

This section also describes the role of Change Agents, individually and as a team, in all aspects of the transformation process.

What is CCISC?

CCISC Description

The Comprehensive Continuous Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision-driven system "transformation" process for redesigning behavioral health and other related health and human service delivery systems to be organized at every level (policy, program, procedure, and practice)—within whatever resources are available—to be more about the needs and hopes of the individuals and families needing services, and to be developed according to values that reflect welcoming, empowered, helpful, and integrated partnerships for individuals and families with multiple challenges throughout the system.

The ultimate goal of CCISC is to help develop a system of care that is welcoming, hopeful, strength-based (sometimes termed *recovery-oriented* or *resiliency-oriented*), integrated, trauma-informed, culturally competent, and multi-occurring capable (sometimes termed *complexity capable*) in order to most effectively meet the needs of individuals and families with multi-occurring conditions of all types (mental health, substance abuse, cognitive and developmental conditions and disabilities, as well as medical, trauma-related, housing, legal, parenting, familial, and employment issues)

and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, every part of the system, every provider agency and program, and every person delivering support, services, and care engages in a quality improvement process—in partnership with each other, with system leadership, and with individuals and families who are receiving services—to become welcoming, recovery- or resiliency-oriented, and multi-occurring capable. Every aspect of service delivery, in every setting, is organized to make progress in this quality improvement partnership to be designed on the assumption that the next person or family entering service will have multi-occurring conditions, and will need to be welcomed for care, inspired with hope, and engaged in an integrated partnership to address each and every one of those conditions in order to achieve their most hopeful and important goals.

This model is based on eight research-based consensus best practice principles of service delivery (Minkoff and Cline, 2004, 2005) which espouse a person-/family-centered, hopeful and strength-based (recovery-oriented) philosophy that creates a common language for the mental health system, the substance disorder treatment system, the developmental disabilities system, brain injury providers, and other collaborative health and human service systems serving overlapping populations with multi-occurring needs.

CCISC Principles

Principle 1. Multi-occurring issues and conditions are an expectation, not an exception.

This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every service contact, to promote access to care and accurate screening and identification of individuals and families with multi-occurring issues.

Principle 2. The foundation of an empowered service partnership is an empathic, hopeful, integrated, strength-based relationship.

Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition. The emphasis of the partnership is to join *with* the individual and family, not do things *to* the individual and family, in order to prevent continuing trauma and promote person-centered/family-centered change.

Principle 3. All people with multi-occurring conditions are not the same, so different parts of the system have responsibility to provide multi-occurring-capable services for different populations.

Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the mental health and substance use conditions, as well as high and low severity of behavioral health conditions and cognitive/developmental disabilities.

Principle 4. When multi-occurring issues and conditions are present, each issue or condition is considered to be primary.

The best-practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.

Principle 5. Progress involves moving through stages of change for each multi-occurring condition or issue.

Individuals and families address multiple conditions and issues in their step-by-step journey to achieve their most important life goals. However, it is common that individuals and families are in different stages of change for different issues at the same time, and move through those stages according to their own choices and capabilities. Therefore, for each condition or issue, interventions and outcomes must be matched to stage of change.

Principle 6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each multi-occurring condition or issue.

For each multi-occurring condition or issue, progress (treatment and support) involves getting an accurate set of recommendations for that issue and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. The progress of learning must be structured and supported to match each individual's cognitive abilities. Further, in order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward (positive behavioral support) is much more effective in promoting learning than negative consequences.

Principle 7. Service and support plans, interventions, and outcomes must be individualized. Consequently, there is no one correct multi-occurring program or intervention for everyone.

For each individual or family, integrated interventions and outcomes must be individualized according to their hopeful goals; their specific diagnoses, conditions, or issues; and the stage of change, strengths, skills, and available contingencies for each condition.

Principle 8. CCISC is designed so that all policies, procedures, practices, programs, and service providers become welcoming, hopeful, strength-based, trauma-informed, culturally competent, and multi-occurring-capable.

Each program has a different job, and programs partner to help each other succeed with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships in which each multi-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based, community-based learning for each condition, in order to help the individual or family make progress toward achieving their hopeful goals for a happy, productive, and meaningful life.

How is CCISC Implemented?

CCISC implementation involves change activities at four levels of the system (system, program, practice, and staff competency), all at the same time.

Change Agents are involved in all four levels.

There are tools and steps for each level of the process, as outlined below. The various steps will be described in more detail later in this manual, along with a description of the role of Change Agents at each level.

System-level Implementation

- 12 Steps of CCISC Implementation (see page 359)
- 15 Steps for System Implementation Teams (see page 251)
- Anchoring change into system-level regulations, contracts, policies, and procedures.

- System tools:
  - CO-FIT 100™ - System-wide fidelity tool
  - COMPASS-EXEC™ - System leadership teams
  - SOCAT™ - Local system of care assessment

Agency-/Program-level Implementation

- 12 Steps for Implementation of Multi-occurring Capability
- Anchoring change into provider/advocacy agency and program-level policies, procedures, and staff development
- Agency/program tools
  - COMPASS-EZ™ - Mental health or substance abuse programs
  - COMPASS-ID™ – Intellectual disability, developmental disability, or brain injury programs
  - COMPASS-PH/BH™ - Primary health/behavioral health integration
  - COMPASS-Prevention™ - Prevention or early intervention programs

Practice Implementation

- Eight CCISC Principles (see page 16)
- Tools for practice implementation, including:
  - Integrated Screening Processes and Tools (see page 75)
  - ILSA™ - Integrated Longitudinal Strength-Based Assessment (see page 75)
  - CCISC Hopeful, Strength-Based Integrated Case Presentation Format (see page 77)
  - Integrated Service/Support/Recovery Plan Template (see page 82)
  - Psychopharmacology Practice Guidelines for Multi-occurring Conditions (see page 343)
  - Motivational Interviewing and Stage-Matching (see page 117)
  - Skills Training Manuals (see page 137)
  - Positive Behavior Supports and Contingency Management Interventions (see page 129)

Staff Competency Implementation

- 12 Steps for Multi-occurring Competency (see page 38)
- Tools for competency implementation
  - CODECAT-EZ for staff and supervisors
  - Supervisory tools and coaching modules

System-level Implementation: 12 Steps for CCISC Implementation

(See Minkoff, K., & Cline, C. (2005). Developing welcoming systems for individuals with co-occurring disorders. *Journal of Dual Diagnosis, 1*, 65-89.)

CCISC implementation involves a system-wide quality improvement partnership in which all components of the system are organized to make step-by-step progress toward a common vision. The partnership is both horizontal and vertical.

The horizontal partnership means that all "subsystems" (e.g., mental health, substance abuse, developmental disabilities, adult and children's systems, county or regional systems), all provider agencies and programs, and all consumer/family advocacy organizations are welcomed as partners into the process, exactly as they are. Whether the subsystem, provider agency, or program is an "excited front-runner," a good partner right in the middle, or nervous about the changes, everyone is welcome.

The motto is: **All you have to have is an interest in making things better for the people receiving service, and you have a place at the table.**

In the horizontal partnership, Change Agents represent each participating partner program, agency, or constituency to become a boundary-spanning team across the whole system.

The vertical partnership means that the change process is neither top-down nor bottom-up. The quality improvement process is a partnership among system leadership, system middle managers, agency leadership, agency and program managers and supervisors, front-line staff and, of course, individuals and families receiving service, who are the drivers of the process and the people to whom we are all ultimately accountable.

In the top-down/bottom-up vertical partnership, Change Agents represent the front-line voices of people delivering care, people providing services and supports, and people receiving services.

Individually, within their own programs or settings, Change Agents partner with their own leadership to help them make progress toward multi-occurring capability.

As a team, Change Agents work as empowered partners as a formal constituency within the system, to partner with leadership to transform the system at every level.

The following section describes what are called the *12 Steps of Implementation of CCISC*. These steps organize the implementation process at multiple levels simultaneously. Although they are listed in order, they do not occur sequentially. The earlier steps occur more at the "top of the system," and the later steps more at the front lines of the system; all the activities are coordinated to create change in many places at many levels across the system as a whole.

This model of system transformation by having multiple distinct activities all moving toward a common vision at the same time is called *collective impact.*

CCISC implementation is an example of collective impact applied to behavioral health, health, and human service delivery systems.

The 12 Steps of Implementation listed and discussed below are included again in Appendix C.

1. Integrated System Planning and Implementation Process

CCISC implementation requires a system-wide integrated strategic planning process and quality improvement partnership that creates an empowered partnership among all levels of the system, including consumers, families, and front-line clinicians. This partnership can address the need to create change at every level of the system:

- System philosophy, regulations, and funding
- Program standards and design
- Clinical/service practice and treatment/support interventions
- Staff competencies and training

The integrated system planning process must:

- Be empowered within the structure of the system.
- Include all key funders, providers, and consumer/family stakeholders.
- Have the authority to oversee continuing implementation of the elements of CCISC.
- Use a structured process of system change (e.g., continuous quality improvement).

- Define measurable system outcomes for the CCISC in accordance with the elements listed herein.

Consumer- and family-driven outcomes measure the ability of the system to be designed, with all programs, policies, practices, and persons providing care, to be welcoming, hopeful, strength-based, trauma-informed, culturally competent, and multi-occurring capable, as well as accessible, integrated, continuous, and comprehensive, from the perspective of individuals in service and their families.

The COFIT-100™ was developed to facilitate this CCISC outcome measurement process at the system or sub-system level.

The COMPASS-EXEC™ is a self-assessment tool for system leadership to determine how well they are organized to oversee implementation of CCISC.

The SOCAT™ is a self-assessment tool for system partnerships (for children or adults, county, regional, or statewide) among multiple agencies (e.g., behavioral health, developmental disabilities, criminal justice, housing, education, health, vocational rehabilitation, and so on) to determine how well organized the system partnership is to implement CCISC principles and system of care principles at every level.

See 15 Steps for Implementation Teams in Appendix D.

Steering Committees and Leadership Teams

Many systems will organize the integrated system partnership by creating a formal transformation leadership team or steering committee, on which all the partners are represented.

Change Agent teams will identify specific representatives to the Steering Committee. These representatives represent the collective voice of all Change Agents across the system, and join representatives of other constituencies (consumers, families, provider leadership, system managers) at the partnership table.

2. Formal Consensus on CCISC Implementation

The system must develop a clear mechanism for:

- Articulating the CCISC process, including principles of treatment and goals of implementation.
- Developing a formal process for obtaining consensus from all stakeholders.
- Creating a formal Charter Document that "charters" the action steps and objectives in the quality improvement partnership and process.

- Describing the implementation steps and responsibilities for system leadership, as well as implementation steps and responsibilities for each participating program partner (12 Steps for Agencies/Programs).
- Disseminating this consensus for action to all providers and consumers within the system.

Change Agents participate as partners in the development of the charter, in the dissemination of the charter across the system, and the implementation of the agreed-upon steps for change within their own agencies.

3. Funding Plan within Existing Resources

CCISC implementation involves the recognition that *each* funder or funding stream within the system—with every dollar spent—can promote welcoming, hopeful, strength-based, trauma-informed (recovery-oriented) multi-occurring-capable services within the full range of services provided through its own funding stream—whether by contract or by billable service code—in accordance with CCISC principles and in accordance with the specific tools and standards described below. Integrated service delivery is supported within each single-funded event, rather than every person with multiple issues requiring multiple providers and multiple funding streams. Further, every dollar in the system is used to support the vision of transformation.

Using funding instructions and incentives to support inter-program partnerships and blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone is only a small component of the collective impact of CCISC.

CCISC supports:

- Developing the flexibility across a whole system to more creatively use limited resources to design services that are more accurately matched to the needs of complex populations.
- Using available incentives to support providers engaged in the transformative quality improvement process.

Change Agents are advocates in their own programs and as a team across the system for creative "out-of-the-box" approaches to care that use resources more effectively because they are better matched to what people receiving services really need.

4. Strategic Prioritization and Population-based Planning

Strategic Alignment of Initiatives

CCISC encourages alignment of all "initiatives" in a common transformation vision, and building energy for change from existing strategic opportunities or priorities, including funding increases or reductions. Examples of initiatives that can be aligned or folded into a CCISC implementation process include:

- Primary health/behavioral health integration
- Recovery-oriented systems of care
- Trauma-informed systems of care
- Children's systems of care
- Positive behavioral supports
- Criminal justice diversion and re-entry (Sequential intercept)
- Housing and homelessness planning
- Child welfare system redesign
- Cultural competency development
- Development of a managed care continuum (ASAM, LOCUS)
- Crisis system redesign

The Four-quadrant Model

In addition, the system should organize a population-mapping plan for individuals and families with multi-occurring needs that present in various types of systems and settings. Using the national consensus Four-quadrant Model, the system develops a plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care.

The two Four-quadrant Model examples below are applied to mental health and substance use disorder services, and to behavioral health and developmental disability services. The Four-quadrant Model has also been adapted to provide a framework for population mapping for behavioral health and primary care integration.

Four-Quadrant Model for Mental Health and Substance Use Conditions	
Quadrant IV Psych High - Substance High Serious & persistent mental illness* with substance dependence	**Quadrant III** Psych Low - Substance High Psychiatrically complicated substance dependence
Quadrant II Psych High - Substance Low Serious & persistent mental illness* with substance abuse	**Quadrant I** Psych Low - Substance Low Mild psychopathology with substance abuse
**Serious & Persistent Mental Illness (SPMI) is a term for adults; can be replaced by Serious Emotional Disturbance (SED) for children & adolescents.*	
Four-Quadrant Model for Intellectual/Developmental/Cognitive Disabilities and Behavioral Health Conditions	
Quadrant IV Behavioral Health High (SPMI/SED) Developmental Disability High	**Quadrant III** BH Low DD High
Quadrant II BH High (SPMI or SED) Cognitive Impairment Low-Moderate	**Quadrant I** BH Low DD/Cognitive Impairment Low

In the MH/SA four-quadrant model, programs in the mental health system provide acute and continuing care to adults, children, and families with high-priority mental health conditions (SPMI/SED), who may also have multi-occurring substance abuse or dependence, as well as a variety of cognitive impairments that do not meet developmental disability criteria. Programs in the substance abuse system mostly serve individuals with more serious substance use disorders (e.g., substance dependence) with lower-severity mental health conditions, including trauma, as well as a range of cognitive impairments, usually below the threshold of formal developmental disability or serious brain injury.

In the BH/DD four-quadrant model, programs in the developmental disability system support individuals and families with more severe well-defined developmental and intellectual disabilities, some of whom may have more severe mental health conditions and many of whom have less severe conditions, including trauma. As noted above, the behavioral health (MH and/or SA) programs commonly serve individuals with more significant behavioral health conditions who occasionally have a developmental disability, but more commonly have cognitive impairments that are lower in severity.

In both cases, each system helps the other develop its internal capability, not primarily through referrals, but through consultation, education, in-reach and support, so more people can get what they need in a single door.

Motto: **It is easier for service providers to move around so that clients don't have to.**

Change Agents are key partners in developing relationships with one another's programs, to provide consultation, education, in-reach and support that spans the boundaries of the whole system and makes it more likely that individuals with complex needs will *not* fall through the cracks.

5. Development and Implementation of Multi-occurring-capable Programs

A crucial element of the CCISC model is the expectation that all child and adult programs in the service system meet basic standards for person-/family-centered, hopeful, strength-based (recovery- or resiliency-oriented) multi-occurring capability, whether in the mental health, developmental disability, brain injury, or addiction system. There needs to be consensus that each program can begin its own quality improvement process to achieve multi-occurring capability. Note that even though each program is working on multi-occurring capability, each program in the system will have a different "job," based on its primary mission and resources, to provide multi-occurring-capable services to the population that it already is likely to be serving.

COMPASS-EZ™ (ZiaPartners, 2009) is a program self-assessment tool for mental health and substance abuse providers working on multi-occurring capability that can be helpful in initiating the program quality-improvement process.

COMPASS-ID™ is a similar tool for intellectual disability, developmental disability, and brain injury providers.

COMPASS-Prevention™ is a similar tool for prevention and early intervention providers.

COMPASS PH-BH™ is a similar tool for primary health programs, developmental disability programs, or behavioral health programs working on improvement of primary health/behavioral health integration capability.

Using these tools in their own quality improvement activities, programs throughout the system make progress at their own pace in relation to their own goals toward multi-occurring capability, and anchor change into their own policies, practices, and paperwork. As programs make progress, the system can develop multi-occurring

capability standards; over time, those standards can be built into regulatory, funding, and licensing requirements.

Change Agents play a critical role in helping their own programs make progress toward multi-occurring capability. This will be discussed in the Organizational-level Continuous Quality Improvement section (see page 207).

6. Inter-system and Inter-program Partnership and Collaboration

CCISC implementation involves creating routine structures and mechanisms for collaborative partnerships among developmental disability programs/providers, brain injury programs/providers, addiction programs/providers, mental health programs/providers, and representatives from other participating systems (e.g., corrections) to develop local (county or regional) system processes whereby all the providers work together to share responsibility for their common population and share clinical planning for complex cases whose needs cross traditional system boundaries.

Over time, the system will develop formal policies and procedures that define how the various types of providers develop and demonstrate that they are participating actively in those partnerships, both by joining local system collaborations and by creating partnership relationships with collaborative programs in their communities.

Change Agent teams work collaboratively as the "front-runners" in inter-program and local system partnerships. Change Agents build relationships across different programs in the same community to become the starting place for local system development and inter-agency collaborations.

7. Development and Implementation of Multi-occurring-capable Practices and Practice Guidelines

CCISC implementation requires system-wide transformation of clinical/service/support practice in accordance with the CCISC principles. This can be realized via continuous quality improvement (CQI) processes through dissemination and incremental developmental implementation of consensus best-practice service planning guidelines that address welcoming, engagement, integrated screening, integrated longitudinal strength-based assessment, integrated stage-matched and skill-based intervention and service planning, positive behavioral support, rehabilitation programming, program matching for multiple types of services and levels of care, psychopharmacology, transition planning, and peer support.

This manual provides a wide range of screening, assessment, and service planning tools and materials to guide this process, all based on CCISC principles. Existing practice guideline documents are adapted for this manual from national sources (visit http://www.bhrm.org) to facilitate this process.

Clinical practice implementation does not occur simply by training staff. Clinical practices must be supported by changes in policy, procedure, and paperwork, by regulatory changes (both to promote adherence to guidelines and eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor adherence. Quality improvement processes at the system and agency level to facilitate welcoming, access and identification, and to promote empathic, hopeful, integrated continuous relationships, are a particular priority.

Change Agents are front-runners in the implementation of clinical practice across the system. Change Agent teams receive training in the application of the CCISC principles and in using the materials in this manual to support the implementation of those practices in their own settings. This information provides a front-line and service-recipient perspective that allows systems and programs to implement new approaches in a way that is matched to the experience of people receiving and providing care and support.

8. Facilitation of Welcoming, Access, Integrated Screening and Identification of Multi-occurring Conditions

This step reflects the first priority for system and program improvement, based on the first CCISC principle that describes welcoming expectation for people with complex and multi-occurring needs.

Implementation of this step requires a quality improvement partnership that:

- Addresses welcoming and "no wrong door" access in all programs.
- Eliminates arbitrary barriers to initial access and evaluation.
- Improves clinical and administrative practices of screening, clinical documentation, Management Information System reporting, and appropriate next-step interventions for people with multi-occurring conditions, disorders, and disabilities.

Each program will usually prioritize welcoming, access, and integrated screening as the first steps in its quality improvement process toward multi-occurring capability. The system as a whole will support similar priorities, through such activities as developing a system-wide welcoming policy, creating mechanisms for improving routine integrated screening, increasing data reporting of individuals with various

combinations of MH, SUD, DD, BI, and trauma, and developing policies that remove arbitrary access barriers based on things like presence of multi-occurring conditions, length of sobriety, level of IQ, and type of medication.

Change Agents are often the champions of welcoming, engagement, and access for individuals and families with complex needs who might otherwise be experienced as "misfits." Change Agents model welcoming with all partners in the system, and champion welcoming with their peers, within their programs, and across the system as a whole.

9. Implementation and Documentation of Integrated Services

Empathic, hopeful, strength-based integrated treatment/support relationships are the core of the second principle of CCISC, and are a critical component of both short-term and ongoing success for individuals and families with complex needs.

Implementation requires creating a quality improvement process in which service staff, supervisors, and managers partner in developing and documenting an integrated support, service, treatment or recovery plan in which the person or family is assisted to make progress toward hopeful goals by simultaneously following issue- and stage-specific recommendations for each primary multi-occurring condition or issue.

This expectation must be supported in a variety of ways within each program and within the system as a whole. Examples of organizational supports include policies and protocols describing appropriate integrated person-centered documentation and service plans, clear definition of the expected "scope of practice" for how each type of service provider can provide and document integrated interventions, and standards of practice for documentation of reimbursable interventions that are acceptable to funders—in developmental disability, mental health and substance settings—for individuals who have multi-occurring conditions.

Change Agents frequently work in partnership with each other and with system and program leadership to develop the protocols and policies described above. Some Change Agents may work in the part of the system that performs quality oversight for charting and billing; they work with their service provider Change Agents and consumer/family Change Agents to develop improved instructions for how integrated services can and should be provided and documented to support hope and progress for individuals and families with complex and multi-occurring needs.

10. Development of Multi-occurring Competencies for All Persons Providing Service and Support

A significant characteristic of the CCISC process is creating the expectation that all staff, regardless of level or type of training and licensure, including those with no certification or license at all, can make progress toward developing universal multi-occurring competency, including attitudes and values as well as knowledge and skills. Available competency lists for multi-occurring conditions, such as the 12 Steps for Direct Service Staff, can be used as a reference for beginning a process of consensus building regarding the competencies (see discussion later in this chapter, page 45).

Mechanisms can be developed to:

- Establish competencies in existing human resource policies and job descriptions.
- Incorporate them into personnel evaluation, credentialing, and licensure.
- Measure and support attainment of competency.

Competency self-assessment tools for front-line staff and supervisors (e.g., CODECAT-EZ™) can be utilized to facilitate this process.

Change Agents often function as peer supports for each other in learning new competencies and then bringing those competencies back to colleagues in their own programs, as well as working with their program leaders on how to anchor those new competencies into place. Further, Change Agent teams commonly work with system leadership to develop system-wide competency instructions and scopes of practice. Some Change Agent teams have worked with state licensure boards to include a definition of multi-occurring competency within the scope of practice supported by licensure or certification.

11. Implementation of a Change Agent Team

In the CCISC quality improvement process, development of program multi-occurring capability and staff multi-occurring competency occur through a top-down/bottom-up partnership in which front-line clinicians and consumer/family Change Agents work with leadership to effect change. Change Agents in a system ideally become an empowered team that represents the principles and values of front-line service delivery and service recipients in the system planning and implementation process. ZiaPartners has developed this Change Agent Manual for systems to provide orientation and structure to help Change Agents with their growth and development.

Even though Change Agent team development is "Step 11," because a lot of the other structures have to begin before the Change Agents have a "place" within the system

process, Change Agents are usually recruited early in the process since they perform a vital role in the evolution of all the steps.

12. Development of a Plan for a Comprehensive Program Array

The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency in providing person-/family-centered, multi-occurring capable services for people with multi-occurring conditions, within the context of available resources. This plan should also identify system gaps or key areas of system mis-design that require longer-range planning and/or additional resources to address, and strategies for promoting appropriate redesign and more effective resource utilization in the long term. Four important areas that must be addressed in each CCISC process are:

Welcoming, Integrated Continuum of Crisis Access and Engagement with an Integrated Continuum of Levels of Care

Crisis Redesign

Most systems have a continuing mismatch in the design of crisis evaluation, intervention, and stabilization services for individuals or families with mental health and/or substance use and/or developmental conditions. The common areas of mis-design include:

- The crisis response continuum is designed as if individuals presented with single problems, rather than on the expectation of multi-occurring conditions.
- There are parallel crisis continua for each type of problem (e.g., MH crisis teams, crisis beds, and psychiatric units; SUD referral centers and residential/outpatient detoxification programs; DD respite centers), which are both inefficient and lead to battles about which setting is the best match for individuals with multiple issues.
- The crisis evaluation system is often designed mostly to determine appropriate disposition after a single assessment, when individuals with complex conditions may need continuing crisis assessment and intervention.
- The crisis system is often expected to transition individuals to continuing routine care after a relatively brief period of stabilization, when these individuals might not fit well into "routine intake" processes, and need extended (up to 3 months), flexible, and integrated community-based engagement and intervention.
- Most systems are designed so that the majority of entry points for ongoing care are for routine intake, although the majority of individuals and families entering the system are entering in crisis.

- Further, most systems have funded expensive "workarounds" to their existing crisis system to engage a limited number of people with complexity, but it is ultimately not cost-effective to continually spend scarce resources to work around the existing system, rather than reorganizing the core capability of the crisis system.

CCISC helps systems redesign the crisis system with better use of limited resources, by helping all parts of the existing system become multi-occurring capable and join in an integrated partnership to create welcoming and integrated engagement for individuals and families with complex needs based on existing principles.

Integrated Continuum of Levels of Care

CCISC also facilitates the system regarding all intermediate-length-of-stay or continuing-care programs as part of a single continuum of multi-occurring capable services with different levels of care, rather than a parallel array of distinct and competitive services. The basic components include:

- Outpatient services at various levels of intensity
- Intensive outpatient/day treatment/psychosocial (re)habilitation
- Residential treatment and supports
- Hospital diversion programming (including detox capacity)
- Hospitalization

Further, in CCISC, this continuum of levels of care can often be operationalized in managed care payment arrangements and may involve more sophisticated level-of-care assessment capacity that is built into the utilization management guidelines provided by all types of payers. (See Minkoff and Pollack, *Managed Mental Health Care in the Public Sector: A Survival Manual*).

Peer Supports that are Multi-occurring Capable

The implementation of formal and informal peer supports has been an emerging best practice in person-centered/family-centered/recovery-oriented systems of care serving individuals and families with all types of multi-occurring conditions. This includes the following types of interventions, all of which can be designed to be multi-occurring capable.

- Certified Peer Specialists
- Recovery coaching
- Family or parent partners

- Youth peer mentors
- Culturally specific peer support
- Promotores
- Health and wellness coaches
- Dual Recovery Anonymous sponsors

In addition, the system can identify dual-recovery self-help 12-Step recovery programs (e.g., Double Trouble in Recovery, Dual Recovery Anonymous, Dual-Anon) and establish a plan to facilitate creation of these groups throughout the system.

Change Agent teams very often include peer specialists and parent partners as key members.

Integrated Continuum of Person-centered Multi-occurring-capable Residential Supports and Services

Building initially upon existing resources, the system should begin to plan for a comprehensive range of programs that address a variety of housing or residential needs, by redesigning services with the recognition that multi-occurring conditions are an expectation. This range of programs should include:

- Universal multi-occurring-capable and targeted multi-occurring-enhanced addiction **residential treatment** (e.g., modified therapeutic community programs) or other types of residential rehabilitation for individuals with more severe psychiatric or cognitive impairments.
- **Abstinence-mandated (dry or sober) supported housing** for individuals with psychiatric or cognitive disabilities who wish to live in sober settings.
- **Abstinence-encouraged (damp) supported housing** for individuals with psychiatric and cognitive disabilities who may not wish to stop using substances, but do wish to live in housing with social support and are open to working on more successful choices regarding substance use in order to be successful in the setting.
- **Consumer-choice (wet) supported housing ("Housing First")** for individuals with cognitive and psychiatric disabilities at risk of homelessness who need to be supported in individual sites of their own choosing.

Strategic Implementation of Evidence-based Programs or Practices and Culturally Specific Programs

CCISC incorporates all available evidence-based and consensus practices in the design of the whole system, provided that all services and practices are provided in a person-centered, hopeful, strength-based (recovery-oriented), trauma-informed, culturally competent, and multi-occurring-capable framework.

CCISC principles define the translation of evidence-based approaches into interventions that can be used in any setting, by any service provider, with any population with complex needs.

In addition, each system should develop a strategic plan for how to implement and organize evidence-based practices or programs that are targeted to specialized populations or specialized needs. Such programs must be designed and matched according to the size of the population that needs such services. All specialized programs must also be multi-occurring capable.

Culturally or linguistically specific integrated teams and multi-occurring capable programs must be included at all levels that match threshold populations in the system.

Examples of evidence-based/specialized programs and practices include, but are not limited to:

- Integrated Dual Disorder Treatment Teams (IDDT)
- Assertive Community Treatment (ACT)
- Intensive Family Wraparound Services (e.g., MST, FFT)
- Opiate Maintenance Treatment (methadone, buprenorphine)
- Specialized programming for Autism Spectrum Disorders
- Illness Self-Management and Recovery/WRAP
- Supported Employment (IPS)
- Trauma-specific Treatment (Exposure Therapies)
- Dialectical Behavior Therapy (DBT)

Program-level Implementation

(See Minkoff & Cline, 2006: Dual Diagnosis Capability: Moving from Concept to Implementation, *Journal of Dual Diagnosis*)

In the CCISC process, *all* programs and services are engaged in a quality improvement process to become welcoming, person-/family-centered, hopeful, strength-based (recovery-/resiliency-oriented), trauma-informed, and multi-occurring capable.

What is Multi-occurring Capability?

In service and support settings, people and families with complex needs are the expectation, not the exception. They often have combinations of issues and conditions such as learning, cognitive and intellectual disabilities; mental and emotional health concerns; substance use issues; traumatic brain injuries; psychological and emotional traumas; sexual and physical abuse issues; health concerns and conditions; housing and homelessness; correctional and court issues; transportation, basic welfare, educational and vocational concerns; and potentially many more. People and families in service are characterized by complexity; these complexities are termed *multi-occurring conditions*. The more complex the issues, the poorer people and families tend to do in systems and services as they are currently designed. Complexity of needs generally results in inefficient use of scarce resources. To more effectively use resources and improve treatment and supports for people and families with multi-occurring conditions, Iowa stakeholders have committed to create a quality improvement partnership across the state. This partnership is represented in ICORN and commissioned to implement welcoming, empathic, hopeful, person-centered and integrated systems and services that meet the needs of complex populations as a fundamental design and achieve this multi-occurring capability over time, together.

For any type of services and supports program, within its mission and resources, multi-occurring capability involves designing every aspect of the program at every level around the assumption that the next person and family coming to the door is likely to have multi-occurring issues and complex needs. They must be welcomed for care, engaged with empathy, hope, and kindness, and provided what they need in a person-specific and integrated fashion in order for them to make progress toward happy, productive lives. Multi-occurring capability means that all services and supports are welcoming, respectful of autonomy and self-determination, and centered on the person's vision of happiness. This dynamic approach to service is attuned to people and families with diverse goals, strengths, histories and cultures. Multi-occurring capability involves looking at all aspects of program design and functioning in order to embed

integrated policies, procedures and practices into regular operations, so each provider can more easily and routinely successfully deliver integrated services and supports.

NOTE: Even though all programs are "multi-occurring programs," each program has a different job, based on that program's core mission and resources, to provide multi-occurring-capable services to the people with complex needs who are already coming to its doors. This is illustrated in the examples below.

Examples of Multi-occurring Capability

Addiction Programs

ASAM PPC 2R (2001) identified a framework for all addiction programs to demonstrate multi-occurring capability in treatment of individuals with low-/moderate-severity cognitive and psychiatric issues.

Components of multi-occurring capability in an addiction setting include:

- Welcoming people with multi-occurring issues who are coming for addiction treatment at any level of care.
- Removing access barriers based simply on diagnosis, IQ, or type of medication.
- Developing hopeful, integrated, recovery partnerships with all clients.
- Developing multi-occurring competency for all staff, including residential aides.
- Implementing integrated stage-matched assessment and treatment/recovery planning.
- Incorporating multi-occurring issues into group programming, so that all groups become multi-occurring groups.
- Providing specific education on trauma, mental health conditions, brain injuries, and cognitive impairment.
- Organizing open discussion and skill-based learning about how to utilize psychotropic medication.
- Using skills training and manuals (e.g., *Seeking Safety*) to teach clients specific skills for managing multiple issues, matched to each person's cognitive and learning style.
- Using positive contingencies to support progress, rather than punishing or discharging people who continue to use.
- Creating a "dual" or "multiple" recovery community in which clients feel comfortable sharing all their issues and struggles as they work toward sobriety.

Mental Health Programs

Components of multi-occurring capability in an adult or child mental health setting include:

- Welcoming people/families with multi-occurring issues who are coming for acute or ongoing mental health treatment at any level of care.
- Removing access barriers based simply on presence of active substance use or level of intellectual disability or cognitive function.
- Developing hopeful, integrated, recovery/resiliency partnerships with all clients.
- Developing multi-occurring competency for all staff, including residential aides.
- Implementing integrated stage-matched assessment and treatment/recovery planning.
- Incorporating stage-matched multi-occurring issues into group programming, so that all groups become multi-occurring groups.
- Providing specific education on trauma, substance use conditions, brain injuries, and cognitive impairment.
- Organizing open discussion and skill-based learning about how to make choices and decisions regarding substance use and gambling.
- Using skills training and manuals (e.g., *Overcoming Addictions: Skills Training for People with Schizophrenia*) to teach clients specific skills for managing multiple issues, matched to each individual's cognitive and learning style.
- Using positive contingencies to support progress, rather than punishing or discharging people who continue to use or who have challenging symptoms or behavior.
- Creating a "dual" or "multiple" recovery community in which clients feel comfortable sharing all their issues and struggles as they work toward recovery.

Developmental Disability/Brain Injury Programs

Components of multi-occurring capability in an adult or child developmental disability or brain injury setting include:

- Welcoming people/families with multi-occurring issues.
- Removing access barriers based simply on presence of active substance use or psychiatric diagnosis.

- Developing hopeful, integrated, person-centered partnerships with all clients.
- Developing multi-occurring competency for all staff, including residential aides and front-line support workers.
- Implementing integrated stage-matched assessment and treatment/support planning.
- Incorporating stage-matched attention to multi-occurring issues into group programming, so that all groups become multi-occurring skill practice groups.
- Providing specific teaching to clients and families about trauma, substance use, and mental health conditions.
- Organizing open discussion and skill-based learning about how to make choices and decisions regarding substance use, gambling, and psychotropic medication.
- Using skills training and manuals to teach clients specific skills for managing multiple issues, matched to each individual's cognitive and learning style.
- Using positive behavioral supports to support progress, rather than punishing or discharging people who continue to use substances or who engage in symptomatic behaviors.
- Creating a multi-occurring supports community in which clients and families feel comfortable sharing all their issues and struggles as they work toward autonomy and self-determination.

Achieving Multi-occurring Capability: 12 Steps for Agencies/Programs Developing Multi-Occurring Capability

These steps are based on the principles for CCISC implementation (Minkoff and Cline, 2004), and can be initiated by any agency (for all of its programs, or by an individual program), within the scope of the agency/program mission and resources. These 12 Steps are also included in Appendix D.

Change Agents play a critical role in multi-occurring capability development in their own agencies and programs.

Just like in the system as a whole, each agency/program needs to develop a horizontal partnership (across all programs or teams) and vertical partnership (across all levels of the hierarchy) in an organized change structure in order to transform its culture and practice.

Change Agents represent the empowered voice of front-line service and support staff, as well as consumers/families, in the vertical partnership. In addition, each agency

needs adequate numbers of Change Agents to create an *internal* Change Agent team to represent all parts of the agency in the horizontal partnership. A smaller subgroup of this team may be chosen to attend system-wide Change Agent meetings representing the agency or program.

The Change Agents in a provider organization meet regularly with each other and with leadership to effect change, and help to inspire their leaders and peers to continue working through the following 12 Steps.

1. *Formal Announcement and Commitment*

Leadership officially announces its formal commitment to achieve multi-occurring capability for all programs, and communicates to all staff about the CCISC implementation process.

2. *Continuous Quality Improvement (CQI) Team*

Leadership organizes a CQI team intended to represent all levels of the agency or program in partnership, and to meet regularly to oversee the change process.

3. *Change Agents*

The organization identifies a team of Change Agents that represents the voice of front-line staff (and, where appropriate, persons and families) in each program. Change Agents are represented on the CQI team and help programs and staff achieve multi-occurring competency in the practice priorities listed below.

4. *Goal of Multi-occurring Competency for All Staff*

The agency or program commits to the goal to work in partnership with all staff to support their development of multi-occurring competency at their level of training and/or licensure.

5. *Program Self-assessment*

Each program uses a structured tool (e.g., COMPASS-EZ™ or COMPASS-ID™) to involve as many staff as possible in a program baseline conversation and self-assessment of multi-occurring capability.

Instructions for using the COMPASS™ tools are found in the user guides in the tools themselves.

6. *Program CQI Action Plan*

Based on the results of the COMPASS™ survey, each program creates an achievable three- to six-month action plan, with measurable objectives, to make progress toward multi-occurring capability. Initial action plan objectives are developed in the following areas.

7. *Welcoming and Access*

The program action plan addresses multi-occurring welcoming policies, procedures, practice, and staff competencies, and identifies access barriers that need to be removed.

8. *Integrated Screening*

The program creates a definition and process to implement universal integrated screening.

9. *Identification and Counting*

The program measures baseline data on the number of multi-occurring persons and families it serves, and develops a CQI plan to improve recognition of the population.

10. *Empathic, Hopeful, Integrated, Strength-based Assessment*

The program CQI plan helps clinicians to demonstrate integrated empathy and hope, and provides support for documentation of hopeful goals and periods of strength and relative success.

11. *Stage-matched Interventions*

The program plan focuses on identification and documentation of stages of change and stage-matched goals for each issue.

12. *Integrated Stage-matched Treatment/Support/Recovery Planning and Programming*

The program plans and develops policies, procedures, and processes for improving integration and stage matching in service plans, and works to improve the use of multi-occurring skill manuals, stage-matched groups, and positive behavior supports for multiple issues, as part of routine service planning and interventions.

Practice Implementation

CCISC principles are each associated with specific practices that can be implemented in any setting, with any population, by any service provider or team.

Practice guidelines for multi-occurring issues have been implemented in a variety of systems at county and state levels. These practices can be summarized as follows:

- Welcoming access and engagement
- Integrated screening
- Integrated strength-based assessment
- Integrated stage-matched service planning
- Stage-matched interventions for multi-occurring issues (motivational interviewing)
- Skill-based practical learning in small steps for each issue
- Positively rewarded, positively supported learning for each issue
- Collaborative partnering, teamwork, and cross-consultation with other types of services and service providers
- Empowerment and utilization of peer and natural supports

Change Agents are the champions of the implementation of these practices. They work in partnership with their leadership to create structures for ongoing practice-based learning, and for development of new policies, practices, procedures, and paperwork to support the routine delivery of multi-occurring-capable services.

Change Agents learn these practices (from ZiaPartners trainings and the content of this manual) ahead of the rest of the system, and bring the information and resources back to their organizations in order to support the program's change process to achieve multi-occurring capability.

Change Agents model new practices for their peers and encourage continued attention to the values and principles in day-to-day teamwork and case discussions.

In order to support Change Agents to have tools and materials that can be used in their own programs or agencies to support these practices, this manual includes a range of specific "practice support" resources. Some of these are:

- Integrated Screening Processes and Tools (see page 75)
- ILSA™ - Integrated Longitudinal Strength-Based Assessment (Overview) (see page 75)

- CCISC Hopeful, Strength-Based Integrated Case Presentation Format (see page 77)
- Integrated Service/Support/Recovery Plan Template (see page 82)
- Example Psychopharmacology Practice Guidelines for Multi-occurring Conditions (see page 343)
- References for Motivational Interviewing and Stage-Matching (see page 117)
- References for Skills Training Manuals (see page 137)
- References for Positive Behavior Supports and Contingency Management Interventions (see page 129)
- References for peer-led programs, such as DTR and DRA (see page 139)

Staff Competency Implementation

In the CCISC process, as part of working toward multi-occurring capability, *all* programs and services work to engage *all* staff providing service in a partnership to become welcoming, person-/family-centered, hopeful, strength-based (recovery-/resiliency-oriented), trauma-informed and multi-occurring competent.

Change Agents play a significant role in facilitating multi-occurring competency development, both individually within their own programs and settings, and as a team working collaboratively across the whole system.

What is Multi-occurring Competency?

Multi-occurring competency for all staff includes attitudes and values, as well as knowledge and skills.

For any person delivering care to individuals and families with multi-occurring conditions or other complex concerns, multi-occurring competency involves developing core attitudes/values and knowledge/skills so that the care provider becomes a helpful, hopeful, and skillful partner to the individuals and families with multi-occurring issues. These attitudes/values and knowledge/skills are core competencies of the person's job, applied in the program in which he or she works. Further, these core competencies are applied in accordance with that staff person's level of training, licensure, and experience. An individual providing care to individuals and families with multi-occurring issues does not need to have multiple licenses or special certification to become multi-occurring competent; multi-occurring competency is achievable by individuals with one license, two licenses or no license at all, including peer specialists,

residential aides, case managers, and support staff who may be working directly with individuals or families with multi-occurring issues.

How is Multi-occurring Competency Developed?

Avoid the Training Trap

Best-practice approaches for competency development involving attitudes, values, knowledge and skills do not primarily involve "sending staff to training." We call this approach "the training trap." In the training trap, staff attends training events but do not have the right level of structure and support to translate the new concepts into practice, leading to frustration or lack of implementation, or both.

Competency Development is Part of Program Quality Improvement

The best approaches to developing staff competency include:

- Engaging staff in partnership to help inspire people to learn new approaches and to make successful progress in small steps.
- Developing programmatic structures and processes to support new competencies in a continuing way. Change Agents play an important role in each of these processes. These processes include:
    - Program-level commitment to working on multi-occurring capability, regular change team meetings, and so on.
    - Regular structures within the program for continuing learning, mentorship, and supervision, where staff routinely practice new attitudes and skills.
    - Empowering staff to work in partnership with leadership to develop program supports (e.g., new policies, procedures, or paperwork) that help them to be successful.
    - Involving non-clinical and non-service staff as partners (e.g., receptionists, maintenance staff) when possible.
    - Involving consumers and families as learning/teaching partners with staff.
- Reinforcing learning in small steps by continuing to practice using new procedures or practices. The 12 Steps for Direct Service Staff, included in this manual (see page 45) are an illustration of what those "small steps" can look like.
- Providing training in small increments to the extent that the content can be absorbed and translated into next steps of practice.

- Embedding competency development as a goal into job descriptions (e.g., staff job titles like "integrated change partner, multi-occurring supports coach"), human resource policies and evaluation criteria.
- Providing big rounds of applause for each staff person as he or she makes small steps of progress in learning new approaches to be successful with the people and families in his or her caseload.

At the system level, states and counties are approaching competency development in a number of ways. Numerous states have developed consensus clinician competencies to guide training plans and human resource development. Many states have organized the development of curricula and Change Agent initiatives. States such as New Mexico and South Dakota have developed language to define the multi-occurring scope of practice for clinicians in either field. These scopes have been adapted and used in numerous CCISC projects (See: Scope of practice guidelines for addiction counselors treating the dually diagnosed. *Counselor, 4*: 24-27; Minkoff, K., & Cline, C. 2006; Scope of practice guidelines for rehabilitation professionals working with individuals with co-occurring mental health and substance disorders. Minkoff, K., & Cline, C. *Rehab Review*, 2:22-25.)

CODECAT-EZ™

The CODECAT-EZ™ is a simple tool that provides opportunities for staff and supervisor self-assessment of principle-based competencies (attitudes and values, knowledge and skills) targeted for multi-occurring capability development.

These competencies are aligned with the *12 Steps for Direct Service Staff Developing Multi-occurring Competency* (see next page).

It is recommended that this tool be used *only* after the program has organized the first 7 or 8 steps of the multi-occurring capability development process (after about 6-12 months of progress). The tool is used to facilitate an open and honest conversation with all staff about their strengths and improvement opportunities, and to engage the program in a competency development plan that helps supervisors, Change Agents, and front-line staff (including peer support specialists, support staff, etc.) to make progress in partnership implementing the practices based on CCISC principles.

For instructions on using the CODECAT-EZ™, see the user guide in the tool itself.

12 Steps for Direct Service Staff Developing Multi-occurring Competency

These steps are based on the principles of CCISC listed above, and can be practiced by any person providing service or support within the scope of his or her existing job or caseload. These 12 Steps are also found in Appendix D.

1. Welcoming

Welcome individuals who have multi-occurring conditions or disabilities, thank them for coming, and let them know you are glad to get to know them as they are.

2. Hope

Ask every one about their goals for a happy life, and inspire a belief that you will work with them to help them to achieve that vision.

3. Integrated

Screen for problems in multiple life domains (MH, SA, cognitive disabilities, trauma, court, housing, health, etc.) in the course of conversation, and practice using one screening tool.

4. Empathy

Ask clients and families to describe in detail their experience with the issues in the "other" domains, and empathize fully with what it feels like.

5. Strengths

Ask clients to identify a period of recent success in relation to their problem, describe in detail the specific strengths they used to be successful, and what they were experiencing that they had to overcome to make progress (e.g., mental health issues during a period of sobriety, what they were and how they were managed; mental health issues for a person with DD who is trying to work, etc.).

6. Quadrant

Review each case in the caseload, and determine: Are they multi-occurring (yes, no, maybe)? What quadrant are they in? (High severity vs. low severity cognitive disability, substance dependence vs. abuse; SPMI/SED vs. less serious mental health issues.)

7. *Integrated Primary Problem-specific Treatment*

For any client, list each problem or issue, and list a specific day-at-a-time set of recommendations to help that person succeed. Discuss with the client and/or family how they use their strengths to attempt to follow each set of recommendations on any given day. Include recommendations in other areas, like medical issues, probation, etc.

8. *Stage of Change*

For each identified problem that may affect the person's goals for happiness, identify stage of change. Write down, in the client's or family's own words, a stage-matched goal for each problem. Practice establishing empathy with clients who are in earlier stages of change.

9. *Skills and Supports*

For any identified problem during a period of success, identify in detail with the client the specific skills that the client used to be successful, including skills asking for help or using supports.

10. *Skill-based Learning*

Use one manual for teaching multi-occurring skills, and/or practice one skill exercise with a client that is connected to their life. For example, work with the client in an addiction setting on managing mental health symptoms on any day; work with a mental health client on refusing drugs from a friend; work with a DD client on how to ask for help when hearing voices, or how to say no when offered cigarettes.

11. *Positive Rewards*

Identify small steps of progress for any problem in any client, and provide strong positive reward ("positive behavioral support") for those small steps, such as a "round of applause for one day of sobriety."

12. *"Recovery" Support*

Identify a place where the client (or family) can receive "recovery" support for each problem, whether from peers, family, or others, and discuss in detail how the client can improve asking for help from these supports.

Change Agents are peer mentors for their colleagues regarding these competencies. While some Change Agents prefer to do brief formal trainings or presentations on these competencies, many do not. *All* Change Agents try to demonstrate openness to continued learning, and to model the step-by-step improvement of these competencies in their own work, in team meetings, in case discussions, and in program philosophy and practice.

Conclusion

This section of the manual outlines all the places that you, as a Change Agent, will have the opportunity to support the transformation of the system. Welcome aboard…there is a lot to do!! But don't be overwhelmed or put too much pressure on yourself. You are already making a difference just by being identified as a Change Agent, and joining others to become a member of the team.

As a Change Agent (or Change Agent team), remember that "Changing the World" is slow going. Work with all your colleagues (system leaders, agency and program managers, front-line staff, consumers and family advocates) as the great partners they have the potential to be, and help everyone feel successful and rewarded for taking the next small step that makes sense for them to achieve the vision of the system, and in moving through the 12 Steps above.

And don't forget:

Every piece of progress deserves a huge Round of Applause!!!!

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Part 5:
Modules on Improving Practices

Overview

These modules are resources for Change Agents and trainees on relevant topics. Change Agents are able to access this information in order to answer questions and solve problems together and in their own organizations. Some aspects of each module's content will be included in the Change Agent meetings/ trainings, but other materials Change Agents will access independently, as needed, for implementing training plans in their own programs or agencies.

Modules

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Module 1: Welcoming

Introduction to Welcoming

As we begin to work on multi-occurring competency and capability together, let's begin with one of the most fundamentally important aspects—welcoming. Welcoming is a simple concept that relates to many aspects of how services are designed and delivered—from the posters on the walls, to the things we say when we meet people for the first time, to the way we are with people in our caring relationships. The impact of focusing on welcoming as a starting place for improvement is much greater than one might anticipate. It is also important to recognize that the more we delve into welcoming as an improvement opportunity, the more we see that can be improved! The case stories below are provided simply to begin the conversation. Let's begin.

Case Story: Welcoming People in Crisis (Mr. A and Ms. B)

Discuss your feelings about the person (Mr. A or Ms. B). What is your view about how each person should be treated? Specifically, what do YOU do next?

Presenting Crisis

Mr. A

Mr. A is a 50-year-old Caucasian man referred to Community Day Treatment from Drywall State Prison on parole from a three-year sentence for possession and sale of cocaine. Historical information sent from the prison is sparse, but includes the following information. He is divorced and has an 18-year-old daughter with whom he has no contact. He was discharged from the armed services ineligible for veteran's benefits, and in his thirties worked for 10 years as a steelworker. He has a history of bipolar disorder with psychotic features dating back 15 years and a lengthy history of alcohol and crack cocaine dependence. He has Hepatitis C. During his prison term, he was assaulted and suffered a traumatic head injury. It was noted that he became more impulsive and had difficulty following the daily instructions that were no problem for him before the injury. He was maintained on Haldol injections and Depakote while in prison, along with Klonopin, and was referred on these medications to live in a mental health group home plus attend community day treatment, where he also is to receive medication follow-up. He has been assigned to a case manager whom he has never met, as well as to a parole officer.

He began day treatment two weeks ago, and after the first day, in which he met YOU (his primary clinician) and was oriented to the program, he has attended sporadically. He initially appeared relatively calm and non-psychotic, but was edgy and irritable, not wanting to attend groups. He did make sure to come in for his initial medication appointment, but reported he did not need a prescription at that time. Today he presents in the late morning, dirty, disheveled, and reeking of alcohol. He is irritable and appears somewhat paranoid, reporting that staff at the group home are watching him on the street, and "I'm going to get someone but good, if they don't cut it out." He states that "those no-good bastards" kicked him out of the group home because "I complained about all the assholes stealing my stuff" and "they claimed I was drunk, when I only had a few." He spent the night on the street, lost his meds, and is demanding a place to stay.

Ms. B

Ms. B is a 28-year-old Hispanic woman who presents to YOU for an initial addiction counseling evaluation at a substance abuse outpatient clinic. Her referral sheet states that her three-year-old son was removed from the home by protective services two weeks ago because Ms. B had been arrested for possession and had a positive urine screen for marijuana and opiates. Her two older children are in the custody of her mother because of prior problems with domestic violence issues, unsafe living environment, and Ms. B's inability to care for them adequately; she has inconsistent weekly supervised visits. Her eldest son, 11 years old, has autism and requires significant supervision and assistance. Her middle child, 8 years old, has trouble in school and was held back in second grade. The three-year-old is showing signs of delayed language development.

Ms. B's arms are covered with multiple lacerations (some old, some appearing more recent), which appear to be self-inflicted. Her initial presentation is angry: "Hey, what are you looking at?" (Seeing you looking at her arms) "That's none of your business!" "You're supposed to help me get my kid back, so start helping. I don't have no drug problem. It's all a misunderstanding. I was just holding some shit for my man and I got picked up. Anyway, I ain't no addict. I been clean for a year because I swore I wouldn't let them mess with my kid this time. But I've been depressed. I been depressed, ever since I they took my other two kids. I went to see the doctors down at the mental health clinic and got some medicine, some stuff that starts with a Z, and I took that for a while and it really helped, so I wasn't hurting it so bad, you know, and then my man said he thought I was hooked on that shit, so a couple of months ago I stopped it, and I did fine, but then you know shit happens and I got bummed out, so I picked up, but so what. What I really need is help for my depression, none of this AA bullshit that you people try to hand out. Somebody is always hitting on me in those damn meetings anyway. So

what are you going to do for me?" (Starts crying) "This is so f-in' messed up and unfair; I lost two kids already, and if I wind up losing this one, my baby, I'm going to kill myself, you get it, kill myself (shows you her arms). It wouldn't be the first time I tried it. So what are you going to do?"

Competencies

- Establish a therapeutic relationship by engaging the person in an empathic manner, fostering honest disclosure. Be aware of your own negative attitudes to difficult people in order to prevent these attitudes from interfering with the treatment connection. Emphasize acceptance of the person's viewpoint in establishing initial goals and priorities.
- Remove barriers to access based on arbitrary rules (e.g., regarding commitment to abstinence, needing meds, agreeing to program rules) in order to assess the situation and promote engagement. Develop comfort with identifying two primary diseases, rather than trying to figure out which one is the real problem; convey that comfort to the person. Establish rapport prior to formal history taking and filling out forms.
- Assess acute risk and intervene to reduce risk. Engage the person in discussion of risky impulses in order to establish the person's capacity to be in control and wish/need for containment in a more secure setting. Take impulses seriously, but do not overreact based on your own anxiety; calm evaluation is more likely to promote safety. Obtain consultation from team members.
- Assess cultural and gender issues. Identify how the race, ethnicity, age, and gender of the clinician will affect the interaction with each person. Give the person some control over who s/he feels comfortable with, especially in crisis.
- Assess motivation. Begin by establishing and communicating empathic detachment and acceptance of the person's goals and priorities, even if different from your own. As much as possible, develop initial treatment recommendations based on the person's own goals.

Questions

1. In order to establish safety, the first step in each situation is:

    a. Call police or security or other staff for show of force.

    b. Refer for immediate detoxification.

    c. Immediately offer to bring the person to a crisis center.

    d. Ask the person to contract for safety before continuing the interview.

    e. Simply ask the person if they would like to talk about things further with you.

    Answer: e. In the absence of immediate out-of-control violence or self-harm, the first step is always to attempt to engage the individual in conversation. In addition, simple intoxication is not a medical emergency, nor does it require detoxification. **With Mr. A**, the first step might be to ask him if he would like to sit down somewhere and talk quietly about what is going on, and then ask about his impulse control, and his previous alcohol withdrawal efforts. **With Ms. B**, the first step might be to indicate that there are many things that can be done to help her, but the first step is to figure out what she needs to be safe. Then, ask her to tell you more about her suicidal feelings. Does she feel like she is about to harm herself immediately? Does she need to go to the hospital?

2. What is the best approach to the issue of abstinence?

    a. Tell each person that abstinence is a condition of treatment participation, and failure to be abstinent or commit abstinence means that we can't do anything for you at this point. (Come back when you're sober, or agree to be sober.)

    b. Tell each person that abstinence is a treatment goal, although immediate abstinence is not required. If the person is not prepared to work toward abstinence from all "mind-altering" substances, then treatment in the program will not be possible.

    c. Tell each person that abstinence is a treatment recommendation, and ask each one to indicate how s/he will respond to that recommendation before negotiating a treatment plan.

    d. Be aware that abstinence is both a recommendation and a goal, but ask the person to begin by defining their view of substance use as an issue in relation to their presenting problem.

    e. Tell each person that they can drink and drug as much as they want in the treatment program in order to engage them.

Answer: d. It is best to let the person begin to define his/her view of the problem rather than leading with a variety of rules and recommendations. Once the person's view is known, one can relate this view to the person's own stated goals in other areas (housing, child custody) and negotiate a treatment plan. In purely outpatient mental health settings, particularly involving flexible case management models, it is valuable to let the person know that the relationship will be unconditional regardless of substance use. In addiction program settings, or in any structured mental health program (e.g., CDT), program requirements may likely limit one's ability to make such a blanket statement.

3. What is the best approach at the outset to identify the primary disorder that requires treatment?

   a. In general, it is impossible to assess or treat a primary mental illness in the presence of active substance use. Therefore, the person must get sober before anything can be done about mental illness.

   b. In general, it is impossible to address substance use issues in the presence of active mental health symptoms. The person needs to stabilize suicidality, impulsivity, severe mood symptoms, and/or paranoia before one can address the substance use.

   c. In general, mental illness and substance issues are both primary issues that can be addressed simultaneously, using historical information to make presumptive diagnoses of each condition.

   d. In general, establishing a primary disorder involves getting good historical information concerning which disorder came first, with the secondary disorder presumably either precipitated by or actually caused by the primary disorder.

   e. In general, complications and interactions resulting from comorbidity are so complex that neither person can be assessed accurately except by a specialized dually licensed clinician, ideally in a specialized dual-diagnosis program.

   Answer: c. In any setting (mental health or substance abuse), a reasonably competent clinician can make good guesses about initial diagnoses and treatment requirements based on historical information. In the case of **Mr. A**, it is reasonable to initially suppose that his psychiatric diagnosis is accurate and requires continued stabilization with his existing medication regime; in the case of **Ms. B**, one can take her at her word that she may have had a good response to "Z" (probably Zoloft), contact collateral mental health treaters, and restart meds as soon as possible. Both issues are primary, and both can be initially addressed in each treatment setting.

4. What do you do if the person does not want to commit to abstinence-oriented treatment recommendations immediately, even though program rules require it?

   a. Describe program or external contingencies to the person, and ask the person to identify how s/he would like to relate those requirements to his/her own goals.

   b. Indicate to the person that program rules must be maintained because otherwise the program cannot operate, and that you need to set limits at the outset in order to treat the person.

   c. Educate the person about his/her disease of addiction, and the importance of abstinence as a goal because of the nature of the disease.

   d. Firmly confront the person's denial, pointing out in an empathic manner how much trouble the person is already in, and how much that trouble is likely to continue if the person doesn't get sober right now.

   e. Tell the person you will need to contact his or her parole officer/protective service worker if they don't immediately commit to abstinence.

   Answer a. The essence of motivational assessment is to give the person as much room as possible to define his/her own goals, and to introduce external constraints in the form of additional choices the person has to make. In the case of **Mr. A**, he is likely to insist that housing and medication are what he needs, not addiction treatment, and that alcohol is not a problem as long as he doesn't use cocaine. He might be willing to accept housing assistance, case management, and meds from CDT, in return for an agreement not to attend the program while obviously intoxicated. Staff might recommend abstinence, but he needs to discover for himself whether his own plan will work. In the case of **Ms. B**, she may insist that she is not an addict (or that marijuana is not a problem), but may acknowledge that she has to comply with addiction treatment recommendations and maintain abstinence in order to get her child back. Negotiation about treatment recommendations can begin from that premise.

Module 2: Principles, Values and Frameworks

Introduction

There is a great deal of knowledge in the world now about how to be helpful to people and families with multi-occurring conditions and issues. Many times, systems have several valuable projects or initiatives underway at the same time. Often these activities are found to have principles and values that are in alignment, and this alignment plays a powerful role in helping the system make progress in many areas of change without becoming overwhelmed. The table below is a "crosswalk" of principles and values that are shaping care and supports in Iowa. The crosswalk allows change agents to see how the principles and values are aligned and support one another.

Examples of Principles and Values that Shape Systems Development

Crosswalk		
CCISC Multi-occurring Capability Principles	**Trauma-Informed Care**	**Positive Behavioral Supports**
~ Organizational culture shift supports practice shift and is an important outcome in itself. ~		
Welcoming people with complexity and welcoming each other.	Welcoming and safety for *all*; *no* retraumatization.	Always maintain a positive stance.
Hopeful vision for a happy, productive, meaningful life.	Hope for healing from trauma.	Hope that anyone can be successful.
Empowered, strength-based partnerships.	Empowered, strength-based partnerships.	Strength-based partnerships to make progress to more autonomy.
~ Always build on strengths and successes, not on negativity and criticism. ~		
Empathic understanding of person's story and all their issues.	Empathic validation of traumatic experiences.	Empathic understanding of the context for all behaviors.

Crosswalk		
CCISC Multi-occurring Capability Principles	**Trauma-Informed Care**	**Positive Behavioral Supports**
All issues are primary, including trauma.	Trauma is a primary issue that contributes to all other issues.	Positive behavioral supports can support success in any issue.
Integrated best-matched interventions for *each* issue at the same time.	Interventions for any issue must be trauma-informed. *Some* people need trauma-specific treatment.	Positive behavioral supports can support success in addressing any issue.
Stage-matched interventions for each issue—use motivational interventions.	Forcing people to change is a form of retraumatization—use motivational interventions.	Change requires positive supports for next steps in decision-making and learning.
Skill-based learning for each issue.	Learn specific skills for establishing safety (grounding) and healthy relationships.	Practice skills for new, healthy behaviors.
~ Consistent positively rewarded learning. ~		

Other Related National Frameworks and Principles of Interest

Children's System of Care Principles (see Appendix E, page 255)

SAMHSA Consensus Statement on Mental Health Recovery: The 10 Fundamental Components of Recovery

http://store.samhsa.gov/product/National-Consensus-Statement-on-Mental-Health-Recovery/SMA05-4129

Self-Direction

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-centered

There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment

Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear

Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based

Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support

Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect

Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility

Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope

Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier nation.

Resources

http://www.samhsa.gov

National Mental Health Information Center: 1-800-789-2647, 1-866-889-2647 (TDD) or http://mentalhealth.samhsa.gov/

The 12 Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Resources

- Minkoff: CMHS Panel Report (1998): Executive Summary
- CCISC Description (see page 15)
- Cline and Minkoff: SAMHSA Technical Assistance Report
- Minkoff (2001): Development of Standards of Care for Individuals with Co-occurring Issues
- Minkoff (2000): Integrated Model for Management of COD in Managed Care Systems

- Minkoff and Cline (2004): Changing the World article
- Minkoff and Cline (2005): Welcoming Systems of Care article
- Minkoff and Cline (2006): Dual Diagnosis Capability Implementation article
- Minkoff (2009): Dual Diagnosis Enhanced article
- CCISC Toolkit (COMPASS-EZ™, COMPASS-ID™, COMPASS-PH™, COMPASS-EXEC™, COCAP™, CODECAT-EZ™, CO-FIT100™, COMPASS-PH/BH™)
- AACP Position statement: Dual Diagnosis Capability/Dual Diagnosis Enhancement http://www.communitypsychiatry.org/publications/position_statements/ddc-dde.pdf
- Action Plan Format, Categories, and Sample Action Plans (see page 207)
- Drake et al.: Implementation of Evidence-Based Best Practices for Co-occurring Issues (April, 2001) article

Module 3: Mental Illnesses and Substance Use Disorders

Resources on Diagnosis and Treatment

- DSM IV (TR): Short version
- TIP 42 (http://store.samhsa.gov/product/TIP-42-Substance-Abuse-Treatment-for-Persons-With-Co-Occurring-Disorders/SMA08-3992)
- Symptoms: Anxiety (see page 68), Depression (see page 65)
- Geppert & Minkoff: *The Place of Medications in Recovery from Addiction*
- Ekleberry: *Personality Issues and Addiction*
- Burton and Cox: *Cross-Training for Dual Issues*
- Daley and Moss: *Dual Issues, Third Edition*
- Daley: *Coping with Dual Issues, Addiction and Psychiatric Illness*
- SPARC/Florida Mental Health Institute web curriculum http://mhlp.fmhi.usf.edu/training/
- SUPS Table (Appendix F, page 269)

Exercise: Identifying Multi-occurring Conditions

Which of these situations involves multi-occurring conditions/issues and why?

- Person A presents for mental health treatment. He has long-standing schizophrenia and a history of alcohol and cocaine dependence, and is currently using. Two years ago he suffered a stroke that resulted in paralysis of his left arm/hand.
- Person B presents for addiction treatment. She has marijuana dependence and is on medication for major depression. She has a learning disability that affects her reading comprehension.
- Person C in mental health has a history of bipolar disorder and is currently receiving mood stabilizers. He has a history of alcohol dependence, but has been sober for 10 years. *What about 1 year? What about 6 months?*
- Person D has a history of sexual trauma, and is requesting help for depression and PTSD. She has diabetes that is stable. She is currently 28, and has a history of abusing alcohol and marijuana as a teenager, never met criteria for dependence, as

far as you can tell, and has not used for 10 years. *What if she had been abusing drugs without dependence in her earlier 20's (while in a relationship with an active addict), but has not used for 1 year or 6 months or 3 months? What if the latter scenario, with no use for 1 year, but she had a crisis and made a suicide attempt last month, and took an overdose of meds and alcohol?*

- Person E has a history of well-documented bipolar disorder, and was last hospitalized for mania five years ago. He has been actively addicted to various drugs since then, with off-and-on brief periods of sobriety, and on-and-off mood stabilizers, with no meds for one year, and no current significant mood symptoms as he is detoxing.
- Person F has a history of ADHD as a teenager, and was medicated then. He is currently polysubstance-dependent. He is 28 years old, and states that he no longer has ADHD, and has not had meds for 10 years; he has no apparent ADHD symptoms. *What if he looks like he might have symptoms, but is in early sobriety? What if he had stopped meds one year ago, six months ago?*
- Person G is 18-year-old young woman who presents for marijuana dependence. Mental-health screening is negative. She reports she made a suicide attempt after a fight with her boyfriend at age 13, before she was using drugs extensively. *What if it was one year ago, six months ago?*
- Person H presents with clear-cut mental health symptoms, but not psychotic or seriously disabled. The person acknowledges substance use, and it is not clear at intake what the extent of the use might be or whether it constitutes a diagnosable condition, but it is also not clear that a diagnosis can be ruled out. *What if the person is seriously psychiatrically disabled at baseline? What if developmentally disabled? What if age 12? What if age 15? What if age 17?*
- Person I presents with clear-cut substance use disorder, no clear-cut history of a mental health diagnosis, and some reports of mental health symptoms of anxiety and depression. Neither you nor the person is terribly clear whether the symptoms will clear up after 30 days of sobriety, though the person insists he is mentally ill and needs meds. *What if the person insists he is NOT mentally ill and refuses meds? What if the person is psychotic? Seriously suicidal?*
- Person J is 9 years old with SED symptoms. *What level of substance use history would constitute a multi-occurring condition?*
- Person J, again, but clearly has never used substances. Person J's mother is actively alcoholic, though refusing treatment. *What if she is in recovery? What if the above, but he does not live with mother? What if the above, but he does not live with mother, but the*

primary foster caretaker has an active substance disorder? What if there is a suspicion of substance use, based on information from the child, and other sources, but the family denies or minimizes the problem so that no clear diagnosis of the family member can be made?

- Person K is 14 years old in ID support services. Her mother is severely affected by Major Depression.
- Person L is an adult who lives with his parents. He has schizophrenia, is cognitively limited because of a head injury suffered in a car accident when he was 12. His parents are his guardians, and one of them is actively alcoholic. *What if his parent is an alcoholic in recovery? What if there is a suspected substance problem but not clear?*

Mental Health Symptoms and Disorders

Depression

- Depression is a normal feeling.
  - Response to loss, death, grief.
  - Worry about family problems, finances—associated with feeling helpless and hopeless about the problem, trapped.
  - Seasonal changes: less light, winter.
  - Physical and medical problems may be depressing—terminal illness, for example; chronic pain; aging; menopause.
  - Unwanted change—powerlessness about your life, the health system.
  - Kids leave home; kids won't leave home even though they're 35.
  - Realizing that you have a serious chronic incurable disorder, such as addiction.
  - Depression is normal in early recovery: giving up something you love (drugs); you may have physical and chemical changes in your brain; life is a mess and there doesn't seem to be an easy way out; experiencing new feelings and you can't get rid of them.
  - Depression has value: makes you stop, think, rest; makes you realize you need to mobilize energy to solve the problem; recognize that this is something that needs to change.
  - Normal depression is uncomfortable: sad, hopeless, helpless, low energy, confused, worried, loss of appetite, sleeplessness, irritable, isolated, sometimes overeating and oversleeping.

- People may use healthy or unhealthy coping strategies to deal with depressed feelings.
- Healthier people use depression as a signal to solve the problem, rather than just get rid of the depression. People with addiction use drugs and alcohol to get rid of the depression without addressing the issues or solving the problem.
- If you don't solve the problem, the problem gets worse and the depression gets worse; this is normal.
- Usually, each time you use alcohol or drugs to get rid of your depression, your feelings may feel more out of control (biologically) when the alcohol wears off. Also, usually whatever was going wrong that made you depressed in the first place is now worse, so you get to be even more depressed.

- Major Depressive Disorders are disorders in which people experience depression in distressing and unhealthy ways, and struggle to control it.
  - Experience depression in situations where it doesn't belong.
  - Experience depression all the time.
  - Experience depression that is much more severe than the situation would seem to warrant, so much so that you have a harder time being able to solve anything or function.
  - Sometimes people with depression feel so hopeless that they feel suicidal; depressive issues are a serious risk for suicide, and are more of a risk in people who are also using drugs or alcohol.
  - Experience not just feeling depressed, but a whole syndrome that includes low energy, inability to think clearly, changes in sleep and appetite, etc. Depression is often accompanied by anxiety, jitteriness, panic, agitation, and irritability. It can be extremely uncomfortable.
  - Usually caused by biologic changes in the brain.
  - Different levels of severity: **Mild** implies more discomfort than should be present, but still able to function okay; **Moderate** interferes with functioning, but not completely. **Severe**: essentially can't function.
  - People may use healthy or unhealthy coping strategies to deal with normal depressive feelings and symptoms of depressive issues:
    - Healthy strategies: productive activity; engage in something that leads to a feeling of success, hope or higher self-esteem: art/music, pets, reading, entertainment, spending time with friends and family, eating comfort food,

helping others, hobbies, hiking/outdoor activities, better diet, drinking water, relaxation skills, taking prescribed medication, asking for help, talking about the feeling, exercise, various types of ceremonies.

  - Unhealthy strategies: using drugs or alcohol, using nicotine, avoiding the problem totally, isolation, using medications you don't need or taking them improperly, getting angry or blaming, giving up or quitting, cutting and burning, overeating, becoming a couch potato, feeling sorry for yourself, overutilization of healthy activities to the point they become compulsions. Unhealthy strategies are not disorders in themselves, but they may become disorders—using alcohol may lead to alcohol abuse or dependence; avoidance and isolation may lead to losses which lead to further depression; overusing caffeine can lead to anxiety problems; overusing nicotine can lead to health problems.

- Different Types of Disorders
  - **Major Depression**. Disorder characterized by persistence of low mood, reduced energy, negative self-esteem, pessimism, difficulty with decision-making and problem-solving, rumination, along with poor sleep and appetite, or excess sleep and appetite, which persists for at least two weeks, is not related to grief (or similar experience) and is associated with significant dysfunction in some area of life. Mood persists independently of positive events. Depression may feel worse in the morning. Sometimes depression is so severe that it is associated with psychotic symptoms like delusional beliefs regarding poverty, poor health, etc.
  - **Dysthymia**. Milder version of the above, that may last for years.
  - **Bipolar Disorder, Depressed**. Episodes of major depression in an individual who also has a history of periods of mania or hypomania, that is: periods (usually 2 weeks of more) of elevated mood, increased energy, reduced sleep with reduced fatigue, sometimes increased irritability or argumentativeness, inflated self-esteem. Full mania usually involves psychotic symptoms like grandiose delusions and paranoid ideas about being the center of attention. These periods occur independently of substance use (e.g., stimulants).
  - **Post-Traumatic Stress Disorder** is often associated with depression.
- Interventions
  - For depressed feelings and/or depressive disorders:
  - **Education**: Teaching people this material

- **Symptom-management Strategies**: Exercise, engaging in positive and constructive activity, music, meditation, crafts, carpentry, writing in journals, gardening, art. Asking for help.
- **Peer Support**: Encouraging people to talk to each other about managing difficult feelings and disorders.
- **Cultural interventions**: Ceremonies and rituals, etc.
- For Depressive Disorders Only
  - **Modification of Usual Programming**: allowing assignments to be done in smaller steps to reduce feeling overwhelmed and increase a sense of success.
  - **Modification of Skills Training**: teaching each skill in smaller steps, with more practice, more support.
  - **Medication**: Use non-addictive antidepressant medication (e.g., SSRIs such as fluoxetine, paroxetine, citalopram) for major depression, mood stabilizers (such as Lithium, valproate) (possibly with antidepressant) for bipolar depression. Medication is to correct chemical imbalance in a disorder that leads to feeling feelings inaccurately: the goal is to help you to feel your feelings properly. Medication is not a moral issue. Help people get better advice from their doctors, and follow their doctor's prescribed medication regime; don't try to give people medication advice.
  - **Medication Education**: Teaching the above to people.

Anxiety

- Anxiety is a Normal Feeling
  - Crisis (like a car accident): normal to feel worried.
  - Any event that is scary because it's new, like giving birth.
  - Before starting a new job.
  - Sobriety is a new situation involving new skills, activities, and feelings.
  - Anxiety has value: gives you adrenaline to deal with a crisis.
  - Anxiety is a signal that you need to pay more attention, prepare yourself mentally, solve a problem.
  - Normal anxiety is uncomfortable: scared, worried, loss of appetite, sleeplessness, irritable, confused, pacing, can't sit still, heart pounding, sweaty, may start to feel panicky.

    - Panic is a normal reaction to serious danger: earthquake. Symptoms of intense fear, dread, feel like you might die, heart pounding, head rushing.
    - Healthier people use anxiety as a signal to solve the problem, rather than just get rid of the anxiety. People with addiction use drugs and alcohol to get rid of the anxiety without solving the problem.
    - If you don't solve the problem, the problem gets worse and the anxiety gets worse; this is normal.
    - Usually, each time you use alcohol or drugs to get rid of your anxiety, your anxiety may feel worse (biologically) when the alcohol wears off.
- Anxiety Disorders are disorders in which people experience anxiety in unhealthy ways, and can't control it.
    - Anxiety in situations where it doesn't belong.
    - Anxiety all the time.
    - Anxiety that is much more severe than the situation would seem to warrant, so much so that you have a harder time being able to solve anything or function.
    - Panic in situations that are not really dangerous, so much so that it may make it harder to function.
    - Usually caused by biologic changes in the brain.
    - Different levels of severity: **Mild** implies more discomfort than should be present, but still able to function okay; **Moderate** interferes with functioning, but not completely. **Severe**: essentially can't function.
    - People may use healthy or unhealthy coping strategies to deal with disorders:
        - Healthy strategies: relaxation skills, taking prescribed medication, asking for help, talking about the feeling, exercise, various types of ceremonies.
        - Unhealthy strategies: using drugs or alcohol, avoiding the problem totally, isolation, using medications you don't need or taking them improperly, getting angry or blaming, giving up or quitting, cutting and burning. Unhealthy strategies are not issues in themselves, but they may become issues—using alcohol may lead to alcohol abuse or dependence; quitting may lead to losses which lead to depression, etc.
- Different Types of Disorders
    - **Generalized Anxiety Disorder**: feel anxiety almost all the time, even when there is no reason to; normal anxiety situations are associated with such severe anxiety

the person is unable to function effectively; occurs regularly even after 30 days of sobriety; often associated with a history of severe trauma.

- **Panic Disorder**: Experience panic attacks regularly in situations which don't warrant panic; not just associated with specific phobias.
- **Phobias**: Symptoms of severe anxiety and/or panic attacks attached to specific situations, severe enough to potentially affect functioning. Types of phobia: social phobia, agoraphobia, claustrophobia; specific phobias like snakes, mice, doctors (especially psychiatrists).
- **Post-Traumatic Stress Disorder**: History of trauma, persistent anxiety/panic/ hyperarousal, high startle response; associated with flashbacks, nightmares and other experiences connected to the traumatic experience that are intrusive and unable to be controlled.

- Interventions
  - For anxiety and/or anxiety disorders:
    - **Education**: Teaching people this material
    - **Symptom-management Strategies**: Relaxation techniques or tapes, music, exercise, showers, meditation, crafts, carpentry, writing in journals, gardening, art. Asking for help.
    - **Peer Support**: Encouraging people to talk to each other about managing difficult feelings and issues.
    - **Cultural Interventions**: Ceremonies and rituals, etc.
  - For anxiety disorders only:
    - **Modification of Usual Programming**: sitting outside the sweat lodge.
    - **Modification of Skills Training**: teaching each skill in smaller steps, with more practice, more support.
    - **Medication**: Use non-addictive medication. Medication is to correct chemical imbalance in a disorder that leads to feeling feelings inaccurately; the goal is to help you to feel your feelings properly. Medication is not a moral issue. Help people get better advice from their doctors, and follow their doctor's prescribed medication regime; don't try to give people medication advice.
    - **Medication Education**: Teaching the above to people.

Module 4: Screening and Integrated Assessment

Screening

Mental Health and Substance Use Screening Measures: FAQs

Adapted from: Connecticut Department of Mental Health and Addiction Services, Statewide Implementation of Standardized Mental Health and Substance Use Screening Measures, Frequently-asked Questions
http://www.ct.gov/dmhas/lib/dmhas/cosig/ScreeningFAQs.pdf

- **What is the purpose or benefit of screening for co-occurring disorders?**

  By implementing screening, your program is establishing a system of care where there is "no wrong door" for people with co-occurring disorders.

  The use of these screening measures can help to:

  * Facilitate the identification of people at immediate risk.
  * Assist in the early and accurate identification of multiple disorders.
  * Create a more welcoming environment for people with co-occurring disorders.

- **What is screening?**

  Screening, using standardized screening measures, is a recommended best practice, and it is one of the many steps to make our system more responsive and effective for people with co-occurring disorders. It helps focus our system to be highly responsive to the multiple and complex needs of people and their families experiencing co-occurring disorders with trauma.

  Integrated Screening (i.e., screening for both disorders) is a recommended practice by the federal Substance Abuse and Mental Health Administration's (SAMHSA) Co-occurring Center for Excellence (COCE). Integrated screening addresses both mental health and substance use, each in the context of the other disorder.

  Screening is a formal process of determining whether an individual does or does not warrant further attention at the current times in regard to a particular problem. Screening is *not* an assessment; it does not replace your biopsychosocial assessment, and does not result in a diagnosis.

  Screens are first-line identifiers and as such, are imperfect. They may either under-identify or over-identify a condition they are designed to detect. Standard screens

help avoid these problems, and follow up assessments are key to identifying and incorporating co-occurring disorders into a comprehensive treatment plan.

- **How can these screens be administered?**

  It is important to develop a comprehensive introduction to the screening process (either verbally or written) that explains why these questions are being asked, and that informs individuals of their right to refuse to answer any questions they do not feel comfortable answering.

  All programs should establish a written protocol for screening, including:

  * The use of these standardized measures.
  * How the measures will be administered and by whom* (e.g., in-person interview or self-administered). *Note: The interview method allows the staff person to clarify ambiguous items, define words as needed, and generally make sure that the person understands what is being asked.
  * The next steps if a person screens negative or positive on one or both of the measures, or answers *yes* to the questions regarding suicidal thoughts.
  * What other screening information should be collected (e.g., toxicology).

- **How long does the process take?**

  During the pilot, and based on over 3,000 completed sets of these mental health and substance use screens, it took an average of 11 minutes to complete both screening instruments (MHSF-III and Modified Mini).

- **What does a "positive" score mean?**

  A positive score means that a person should receive a comprehensive assessment for the areas that they were positive on. It does *not* mean that they have a mental health and/or substance use disorder. It only means that they show signs of a possible problem that should be comprehensively assessed by the appropriate staff.

- **How can I make sure that the trauma questions are asked in a trauma-informed manner?**

  Question 7 on the MHSF-III and questions 14-15 on the Modified Mini are screening questions related to a history of traumatic or distressing events and their reactions to those events. Circle or make notes regarding which symptoms are being endorsed to collect as much information as possible. Please note that these are not complete lists of either traumatic events or possible reactions to them, and individuals may not identify with some of the language. The limitation can be addressed through a

separate trauma screening or the comprehensive biopsychosocial assessment. (Scroll down to Screening Resources for a variety of trauma screenings.)

Screening Considerations For Tobacco Use

For people who report use of tobacco**:** *Any* current tobacco use places a person at risk.

Advise *all* tobacco users to quit. For more information on smoking cessation, see *Helping Smokers Quit: A Guide for Clinicians* at http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm.

Screening Considerations For Alcohol Use

Question the person in more detail about frequency and quantity of use: If the answer is *None*, advise the person to stay within these limits:

- For healthy men under the age of 65: No more than 4 drinks per day AND no more than 14 drinks per week.
- For healthy women under the age of 65 and not pregnant (and healthy men over age 65): No more than 3 drinks per day AND no more than 7 drinks per week.

Recommend lower limits or abstinence as medically indicated; for example for people who take medications that interact with alcohol, have a health condition exacerbated by alcohol, are pregnant (advise abstinence).

Encourage talking openly about alcohol and any concerns it may raise, re-screen annually.

One or more times of heavy drinking (≥ 5 for men; ≥ 4 for women), the person is an at-risk drinker.

Please see NIAAA website "How to help patients who drink too much: A clinical approach" at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm for additional information to assess, advise, assist, and arrange help for at-risk drinkers or people with alcohol-use disorders.

Reminder: Many people don't know what counts as a standard drink (e.g., 12 oz. beer, 5 oz. wine, 1.5 oz. liquor). For information, please see http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide13_p_mats.htm

Screening Considerations For Intravenous Drug Use

Recommend to people reporting any prior or current intravenous drug use that they get tested for HIVH and Hepatitis B/C.

If the person reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.

- If the person responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
- If the person responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to people reporting any current use of alcohol or illicit drugs that they get tested for HIVH and other sexually transmitted diseases.

Examples of Screening Tools (Some included in Appendix G)

- Substance disorder screening tools: CAGE, SMAST, DAST, DALI, MIDAS, CRAFFT
- Mental illness screening tools: Mental Health Screening Form III, MINI
- Traumatic Brain Injury Screening tools: (see links in Appendix H)
- Stage-of-change assessment tools: Substance Abuse Treatment Scale, URICA, SOCRATES, Readiness to Change Scale
- Substance disorder severity scales: Clinician Alcohol (and Drug) Usage Scale, ASI (subscales)
- Peters: Screening and Assessment in the Criminal Justice System
- Level-of-Care Assessment: ASAM PPC 2R, LOCUS 2.001

Integrated Assessment

Integrated Longitudinal Strength-Based Assessment (ILSA™)

ILSA™ is a part of the implementation tool kit for the Comprehensive Continuous Integrated System of Care (CCISC) (Minkoff & Cline, 2004).

It has the following features:

- ILSA™ is not a typical tool that simply asks a list of questions. Rather, it is a format which organizes *a process of assessment* that is fundamentally designed to develop the life story of a person with complex needs, in order to achieve a more effective approach to care fully aligned with the individual's own goals.
- ILSA™ supports the development of an empathic hopeful working partnership between the person and the care provider.
- ILSA™ begins with "welcoming," and provides a structure for emphasizing person engagement as a priority over simply collecting data.
- ILSA™ organizes the assessment with a focus on achieving person-centered goals and hopeful outcomes.
- ILSA™ provides a framework for incorporating various screening and other information-gathering tools as they are appropriate for the actual person being interviewed, rather than "one-size-fits-all" screening.
- ILSA™ is strength-based, longitudinal, and integrated in that it is formatted to encourage the detailed narrative chronologic description of periods where the person did *well*, and to integrate discussion of elements of the person's (and family's) functioning, and treatment and supports during those periods.
- ILSA™ incorporates a multi-dimensional formulation adaptable to individuals presenting with any combination of issues that is useful in serving individuals with multi-occurring conditions.

Five Great Places to Start in Understanding the ILSA™

1. **Welcome the person to the process. Focus on the beginning of a hopeful empathic partnership.** Because of the high prevalence of multi-occurring disorders, routine assessment in all settings should be based on the assumption that any person presenting with needs is likely to have a complex story that reveals itself over time. For you to have a chance to know how to be helpful, the person must feel that engaging in what you have to offer makes sense for him-/herself or the family. Direct communication to the person that such complex

needs are both welcome and expected will facilitate engagement and disclosure of areas of concern, around which you will begin to build a helpful response. It is important to remember that welcoming is most difficult when you are personally confronted by issues that challenge your own attitudes, values, knowledge and skills. This is exactly when welcoming is most important and the skills of empathy and engagement are most necessary.

2. One of the most important skills in the assessment process is listening to the person in order to be able to understand what he or she wants. Being able to understand a person's goals allows you to find a hopeful connection that may be the very thing that inspires a person to tell their story and stay engaged with care. In addition, you have to understand something about what makes a person fundamentally happy and what contributes to their sense of wellbeing before you can figure out with them how to achieve it.

3. Once you have welcomed the person and have some understanding of what he or she wants help with, you may move to a screening process that identifies immediate risk issues and establishes safety, detects problem areas in multiple domains and past recommendations to manage these problem areas. This information can be gathered directly or in the flow of the interview, depending on the person's presentation and always in a manner that is respectful of a developing partnership and supportive to people in distress. Screening should always be viewed and conducted as an opportunity to engage with a person.

4. Describe a time when the person did well, according to his or her own definition. Ask the person about periods of time when things were going relatively well compared to the current situation, and obtain detailed information about the characteristics of that time. Focus on demonstrated strengths, skills and capacities.

5. Identify multiple issues and stages of change (see page 118) for each.

ILS™ Documentation Template

(Provided as made available to the Change Agent team.)

ILSA™ Coaching Exercise

(Handouts will be made available to the Change Agent team.)

ILSA™ Coaching Exercise for Supervisors

(Handouts will be made available to the Change Agent team.)

Module 5: Person-Centered, Strength-based Integrated Treatment and Recovery Planning

Alternative Case Consultation Format: Integrated Strength-Based Recovery-Oriented Case Conferencing

Why Do This?

This exercise is a departure from the traditional case presentation format. It is intended to demonstrate a repositioning from talking with each other about people we care for in a problem-oriented and often reactive way to a more hopeful and proactive way, the end result of which is a much better understanding of the human being, his or her wants, needs and desires, and how we can be helpful.

Format

This is a group format. The group is comprised of a team of care providers from an agency—or ideally partner agencies—who have different perspectives, skills, and experiences. Prior to the team meeting, one person is selected to present. The presentation should be written if possible and the oral presentation should be about 20 minutes. This is followed by a team conversation about problem solving and sharing perspectives, as well as discussing what was learned by using the alternative format.

Introduction to Case-based Learning

One of the most important learning opportunities we all have is to sit together and problem-solve with each other using the real stories of people we care for. A beginning place in our conversations is to consider *how* we talk about people in relationship to values such as being welcoming, empathic, and hopeful, person-centered, strength-based and recovery-oriented, to name a few. It is in our orientation around these values that we can then discuss with each other how to be most helpful to the person and to organize the next steps of any proposed interventions, how they are applied to be most helpful, and where the interventions best takes place.

Starting Places

Welcoming, Empathy and Hope

Describe to the team who the person is, what it is that brought him or her to you and what it is that the person wishes for in their life to be happy. Describe what you related to about the person and his or her goals and how you positioned yourself as a partner with the person.

Story-based

Frame your presentation to the team as if you are telling the story of the person's life, very much as if he or she were the main character in a novel. The point of story-based presentations is to help the listeners feel as if they know the human being, not just their presenting problems and conditions.

Most Recent Stable Baseline

Begin the story-based presentation with a period of recent stability. Find a time in the near past where the person did relatively well, and be descriptive—where did he or she live and with whom, how did he or she support him- or herself, what helped maintain the stability, any treatment, how did it work, why or why not, what was the support network like, what skills did he or she use, what were the signs and symptoms of the various conditions during this timeframe. This is a powerfully informative process. Beginning with a period of stability helps the listeners get a picture of the person at baseline, they can see what worked in the past, and the information is integrated as it is in the person's real life. This period of recent stability is also diagnostically rich. You have access to the interplay between symptoms of multiple conditions. Further, you can begin to describe the early features that contributed to the loss of stability that may be opportunities for further skill-building or support-building. During this period, describe how the person perceived their issues—this gives you insight into stages of change and phases of recovery. Work your way from this period to the current day, being descriptive of events and the person's perspective.

Immediate Risk Survey

Present to the listeners any immediate risk issues:

- Is there indication of immediate risk of self-harm?
- Is there indication of immediate risk of violence?
- Is there a significant alteration in mental status?
- Is there indication of immediate inability to provide for age-appropriate self-care?

- Is there indication of severe mental health symptoms that are associated with out-of-control behavior or inability to effectively participate in the assessment?
- Is there indication of severe substance use associated with inability to communicate adequately, or with possible risk of withdrawal?
- Is there indication of immediate risk of harm or abuse/neglect from a person in the environment?
- Is there indication of immediate risk of homelessness?
- Is there indication of immediate risk of criminal activity that will result in incarceration, or immediate risk of incarceration?
- Is there indication of any immediate medical danger?

Current Life Domain Survey

Present to the listeners any issues the person has in the major life domains:

- Medical
- Mental health
- Substance use/gambling
- Trauma/victimization
- Cognitive/learning/developmental disability
- Independent living skills
- Housing stability
- Criminal justice involvement
- Financial, employment, and disability issues
- Family/social/parenting or custody issues

Fill in the Life Story

Go back in time and put together for the listeners the picture of what the person's life was like during key historical periods—early childhood, school years, work, marriage, kids, major episodes of care and treatment, and other key episodes of the person's life. Be selective and be descriptive. Remember to illustrate how the person perceives him- or herself and look for the evolution of problem areas in the person's life and how the person responded to these issues. For example, does the person respond to being at risk by asking for help or does he or she try to do it all by him- or herself?

Summary

This is a beginning framework. You will not have covered every detail and the team may want to ask questions of you. This is fine, but your goal in this exercise is simply to see if you can convey to the team of listeners who the person is by telling his or her story, specifically telling his or her story in such a way that the team relates to the person first, then the issues he or she faces, then how to be most helpful to foster recovery of the person to gain or regain pride, self-worth, hope and dignity.

See the next page for a one-page summary of this hopeful, strength-based, recovery-oriented, integrated case presentation format.

CCISC Hopeful, Strength-based (Recovery-oriented) Integrated Presenting Format

The [age]-year-old [man/woman/boy/girl] I am presenting is an amazing/cool/special person because:

I like or feel connected to the person I am presenting because:

His or her vision for a happy, meaningful, proud, successful life is:

Over the past several weeks/months, in the face of multiple challenges:

List all the challenges (e.g., continuing mental health issues, substance issues, cognitive/learning issues, health issues, past and current trauma, relationship challenges, housing issues, criminal justice issues, etc.)

1.

2.

3.

This person has amazingly made progress toward his/her goal of happiness by doing the following things:

List the positive things that he/she has been doing in general, and specifically to make progress for each challenge. STAY WITH A STRENGTH-BASED FOCUS (e.g., "He/she has amazingly made 75% of appointments or taken meds 60% of the time."), rather than "He/she does not keep appointments and is med non-compliant."

Also note the STAGE OF CHANGE he/she is in for each issue, reflecting progress in a way that is "stage-matched." (e.g., "He/she has just started to trust us enough to talk about substance issues in spite of bad experiences with talking about these issues with caregivers in the past, and is moving into the contemplation stage.")

1.

2.

3.

Based on the above, I would like some help from the team identifying smart next-steps of progress (skills, etc.) that the person and I/the team can work on in partnership together, for each of the challenges that he/she is facing, in order to help him/her make progress toward the vision of a happy life.

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Adult Service Plan Template

Program:	**Date:**
Person:	**Team Members:**
Person's Goals for a Happy Life:	
Strength-based discussion: Describe recent or relevant periods of success:	

Goals and Objectives	**What Do We Do? (Stage-matched Interventions)**	**- Responsible Persons - Milestones of Progress - Opportunities for Rounds of Applause**	**Target Date for Completion**
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			

Signed by: ☐ Person ☐ Family ☐ Program Manager ☐ Staff ☐ MD ☐ Other (specify)

Child/Family Service Plan Template

Program:	**Date:**
Person (Person/Family or Caregiver):	**Team Members:**
Child's Goals for a Happy Life:	
Family's/Caregiver's Goals for a Happy Family:	
Strength-based discussion: Describe recent or relevant periods of success:	

Goals and Objectives	**What Do We Do? (Stage-matched Interventions)**	**- Responsible Persons - Milestones of Progress - Opportunities for Rounds of Applause**	**Target Date for Completion**
Child Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			

Signed by: ☐ Person ☐ Family ☐ Program Manager ☐ Staff ☐ MD ☐ Other (specify)

Stage-specific Treatment Plan Samples

If someone asks you what stage of change a person is in, the correct answer is ALWAYS "For which problem?".

Pre-Contemplation

"I have no problem, or if I do, I am not interested in changing."

- Goal
  - To begin to enter the contemplation stage: "I am willing to talk with you about how I decide whether or not I have a problem, and whether or not I should do something about it
- Challenge
  - How to frame the goal in the person's own words, in a way that promotes empathic connection, and reduces defensiveness. *This is a core approach of motivational interviewing*.
- First Step: Establish Empathy via Empathic Outreach
  - **Substance Abuse**

    "I have no problem with marijuana, because I need to use it every day to go to work."

    "I have no problem with alcohol, because I only drink wine, and I have cured my DUI problem because I no longer drive."

    "I have no problem with drugs because I only smoke pot."

    - Examples of Empathic Positioning

      "If you need to use marijuana every day to go to work, how do you decide exactly how much marijuana is the right amount for you to use?"

      "How do you become the most successful marijuana user you can be, in your context?"

      "If you only drink wine, how do you decide how much wine is the right amount of wine for you to use? How do you decide if you ever want to drive again?"

- Goal (in the person's words)

  "I want to learn as much as I can to be able to have a successful plan for how to use substances in my life."

- Objectives

  The person agrees to come up with a method to keep track of what he is using on any given day, and share it with clinician.

  The person agrees to develop a list of helpful and unhelpful results from current use patterns, and to share it.

  The person agrees to learn one to three ways in which her substance of choice is helpful to folks in general, and unhelpful, and discuss the ways in which those apply to her, or not.

  Based on the above, the person identifies a plan for daily use that will be most successful for him, and to identify specific outcomes he is hoping to achieve.

  Clinician and the person come up with a method to see if the person can follow the plan successfully, and/or to achieve the stated objectives. If not, they can begin to "develop discrepancy" that might begin to address the need for some possibility of change. For example, if the person finds that two joints a day is useful, and three is too many, how would she develop a plan to stick to two joints? How would she evaluate long-term risks vs. short-term benefits?

- Interventions:

  Individual and group motivational interventions.

  Sit with the person and develop a method to keep track of daily use.

  Educational interventions to evaluate short- and long-term risks and benefits.

  Decisional analysis exercise in individual or group sessions to figure out how much is the "best amount" for the person.

* **Employment**

  "I can't work and I'm too sick to work."

  "I'm retired."

  "I can't work until I get my life in order."

- Examples of Empathic Positioning

  "Given that you are retired, how do you want to spend your time in the way that feels most productive and enjoyable?"

- Goal

  How do I design my life so I feel like I am spending my time in the way that leads me to feel happy, proud, and valuable?

* **Mental Illness**

  "I don't have a mental illness, I have a back problem. I called the FBI about my back problem."

- Contemplation

  "I am considering whether my substance use might be a problem, and whether or not to make any change, but I am not ready to do that at this point in time."

- Preparation

  "I have identified something I would like to change, and am ready to start developing a plan of action for how to change."

- Action

  "I am working on the problem and trying to do something different to address it."

- Goal

  To achieve a successful change, and/or enter the maintenance phase, or to continue in the maintenance phase in the face of serious changes or challenges.

- Challenge

  To engage the person, from an empathic, motivational interviewing perspective, in recognizing how much work and how much support are necessary to be successful, and helping him or her to engage in a partnership to figure out how to identify and develop the skills they need very concretely.

* Example: "I am working on developing the skills I need to be able to not use substances on any given day." Not just "I need to get new friends," but also "What skills do I need to deal with my existing friends, and to begin to develop new supports?" Not just "I need to live in a different setting," but also "What skills do I need to be able to be successful in any living setting?"

"I need to enter a treatment program."

"I am going to start going to AA meetings."

"I have stabilized the problem, but my circumstances are changing, and I need to develop new skills in order to stay stable."

Example: "I have been sober with no job, now I have a job."

- Goals and Objectives

  Client develops and practices (role-play)—in individual and group work—a set of skills to deal with substance-using co-workers.

  Client identifies sobriety supports that will be less available when working, and identifies strategies to replace them and monitor that those strategies are working.

  Client discusses the experience of having money, and discusses risks and strategies for managing those risks.

* Example: "I have been sober and stable for bipolar in a supportive living situation, but now I will be moving to more independent living."

  - Goals and Objectives:

    Identify community resources and demonstrate familiarity with how to access those resources.

    How is he staying sober now, and how would he be using those skills in a less supportive setting.

    Increase self-awareness of cues that may put him at risk for using substances.

    Increase self-awareness of cues that may indicate mood instability.

    Demonstrate that he knows his dose and frequency of meds, and can demonstrate how he would take meds independently, before he moves out.

    Develop a plan for what he will do when he is at risk.

    Practice and rehearse the things that you will do that are in the plan

  - Interventions:

    Individual and group active treatment interventions.

    Review healthy skills list to choose daily skills plan.

    Role-play discussions with co-workers, with other people in the living situation.

Identify risky situations that may emerge: money in the pocket, substance use in the environment.

Identify strategies to manage those situations, or manage money differently.

Identify strategies to actively seek and maintain recovery supports, and to ask for help in risky situations.

Practice strategies, and develop a mechanism to find out how those strategies are working.

Identify recovery supports, and increase use of supports during the transition to work, during the transition to independent living.

Keep a log of substance-related activities to share with counselor.

Daily check-ins with counselor for first four weeks of work to commit sobriety and to discuss strategies for each day.

Similar activities for increasing attention to skills for taking meds regularly, for tracking bipolar symptoms and reporting those to clinical support staff and prescribers, etc.

For people who want to be more independent: The more independent you are, the more work you need to do—on your own—to keep yourself stable. The less work you want to do or are able to do, the more that others wind up taking over for you in order for you to succeed.

Sample Treatment Plan Series: Addiction Residential Program

Problem: Major Depression

- Introduction

  This treatment plan sample describes routine goals, objectives, and interventions for an individual with major depression who is taking antidepressant medication, is reasonably stable, but still exhibits some symptoms of depressive illness.

- Goal

  "I want to keep my depression under control while I'm in treatment, and not relapse when I feel depressed after I leave treatment."

- Objectives

  * The person can identify as having the diagnosis of major depression, and describe characteristics of that disorder.

- The person can describe medication regime, and consistently takes medication as prescribed.
- The person will identify expected positive effects and side effects of medication, and can report them consistently.
- The person will identify reasons for current or possible non-adherence to prescribed medication, including inability to pay for medication.
- The person can identify unhappy feelings that are related to life circumstances and are not going to be "fixed" by medication.
- The person can identify specific strategies for managing either unhappy feelings or symptoms of depressive illness without using substances.
- The person demonstrates utilization of at least one of those strategies in one-on-one or group format.
- The person develops skills to remain on medication in the context of attending self-help programs where some peers may advise medication discontinuation.
- The person develops skills for talking about having a depressive illness and being on medication when talking to recovering peers.
- The person develops skills for improving self-esteem and reducing depressive feelings by engaging in positive activities that result in feelings of pride, self-worth, and self-confidence.

- Interventions
  - The person reads pamphlet on "Major Depression" and completes assignment describing symptoms, and identifying which symptoms she has.
  - The person attends education sessions with psychiatric nurse or other staff and reports to primary counselor what has been learned.
  - The person attends weekly education group on mental illness.
  - The person reviews weekly with nurse and/or counselor her medication regime for depression. The person follows self-medication protocol.
  - The person attends monthly medication reviews, and accurately reports side effects to doctor.
  - The person negotiates with doctor a medication regime that she can actually take (afford) following discharge.

- The person does written assignment describing expected unhappy feelings in her life, distinguishing from symptoms of depression, and reviews assignment with counselor.
- The person attends _____ groups, and discusses unhappy feelings and depressive symptoms with group, asking for suggestions on how to manage them.
- The person completes worksheet on "managing depression and sadness," and selects one or more skills to practice this week.
- The person role-plays discussing her mental illness in specific groups and AA meetings.
- The person engages in role-play activity where another peer tells her to stop medication.
- The person identifies activities that will improve self-esteem and selects one such activity to work on this week.
- The person and counselor identify issues that contribute to depressive feelings (e.g., longstanding trauma history) that will not be treated in this setting or addressed at this time, and identify where and when psychotherapy will take place. Referrals are made.

Sample Treatment Plan Series: Outpatient Clinic

Problem: Court-ordered Pre-Contemplative Pregnant Adolescent with Bipolar Disorder, Conduct Disorder, and Methamphetamine Abuse in an Outpatient Clinic

- Problem 1: Emotional and behavioral instability
- Problem 2: Polysubstance abuse
- Problem 3: Court involvement
- Problem 4: At-risk pregnancy
- Problem 5: Family issues

- Goals
  - "I want to have a healthy baby and be a good mother."
  - "I want to have no hassles from the court."

- "I want to live with my mother, without her hassling me."
- "I want to feel less out of control of my emotions: anger, depression, loneliness, anxiety; OR I want to find healthy strategies to manage my emotions, and have fun, without getting into trouble."
- "I want to stay away from substances while I am pregnant."

- Major Issues in Treatment Planning
  - **Major issue for the person in treatment planning**: This person does not easily connect the achievement of her goals to any of the activities that we label as treatment.
  - **Major issue for staff in treatment planning**: Before we begin, we need to be very clear about where we can and will draw the line to enforce expectations, and where we will/must let go (detach empathically).
  - **Major issue for everyone in treatment planning**: Attending to the incremental sequence of:
    - Deciding if something is a problem.
    - Deciding if change is desired.
    - Deciding, if change is desired, what that change will be.
    - Deciding what strategy will be used to effect change.
    - Deciding how to evaluate whether that strategy is working.
    - Deciding whether help is needed to effect change or evaluate change.
    - Deciding what that help should be.
    - Deciding to actually get the help that is desired.
    - Deciding how to evaluate the effectiveness of that help, and modify if needed.
- Goal 1: Pregnancy-related Objectives
  - Person will identify three things she needs to do to have a healthy baby.
  - Person will identify three things she needs to do to become a good mother.
  - Person will make a list of things she is currently doing that she feels contribute/do not contribute to having a healthy baby.
  - Person will make a list of things that she is currently doing that she feels contribute/do not contribute to being a good mother.

- Person will identify specific emotional issues or behavioral issues that relate to having a healthy baby or being a good mother.
- Person will identify patterns of substance use that relate to having a healthy baby or being a good mother.
- Person will describe the pros and cons of receiving recommended prenatal care.
- Person will indicate understanding of the behavioral and substance-use criteria which will lead to protective services involvement when the baby is born.
- Person will identify one or two behaviors that she might want to change for having a healthy baby or being a good mother (or to reduce likelihood of protective services involvement).
- Person will discuss the merits of trying to engage in these activities in her current living environment, and factors that contribute to success vs. no success in that environment.
- Person will discuss recommended interventions to change those behaviors, and discuss the pros and cons of following those recommendations.
- Person will discuss recommendation for residential setting for pregnant teens, and the pros and cons of attending that setting (e.g., any setting that provides more help will also have more restrictions: tough choice).
- Person will agree to consider one recommendation that might be helpful for changing each activity.
- Person agrees to a set of objective criteria that would help her decide whether she is making enough progress or demonstrating enough success to stay in the community, and determining whether she should decide on residential.
- Person's mother will endorse the goals and issues identified by the person, and support participation in a process to figure out what help she needs to be successful.

- Goal 2: Court Involvement
  - Person's probation officer will describe as clearly as possible the specific minimal expectations for the person, and the actual consequences for not meeting those expectations.
  - Person will indicate that she understands the expectations as defined.
  - Person will list three ways in which court expectations may connect to helping her achieve her own goals, and how she can use them in that fashion.

    - Based on this, the person will decide whether or not she chooses to meet the expectations, and if so:
        - Person will identify her preferred strategy for meeting the expectations defined by the court.
        - Person will identify her preferred method for monitoring those expectations.
        - Person will identify a list of rewards for success, and small-step consequences for non-adherence with expectations.
        - Person will agree to a contingency management plan to assist her in meeting the expectations defined by the court.
        - Mother will explain understanding of the court expectations, connection to the person's goals, and support the contingency plan.

- Goal 3: Family Issues
    - Person identifies positive and negative aspects of current relationship with mother.
    - Person identifies positive and negative aspects of living at home.
    - Person identifies three things that she wishes mother could do to be more helpful to her in achieving her goal.
    - Person recognizes three things she actually could do that might be perceived as helpful by her mother.
    - Person connects these activities to emotional, behavioral, or substance issues, and can identify one or more specific problems that might contribute to problems getting what she wants from her mother.
    - Person identifies one or more treatment activities that might help her to be more successful in these areas.
    - Person agrees to meeting with mother to discuss how to live together more successfully.
    - Mother agrees to a structure for meeting (in person or by phone) that would be successful.
    - First meeting takes place, and each identifies one activity that can be successful for each of them in being more helpful to one another.
    - Person identifies how to use some treatment activity to help her achieve success in this area.

- Goal 4: Emotional/Behavioral
  - Person defines her view of her emotional and behavioral problems.
  - Person exhibits understanding of how these problems are perceived by mother, school, and court.
  - Person describes how she relates her view of her problems to others' perceptions.
  - Person indicates that she is aware of her diagnosis (diagnoses), what they mean, and what the treatment recommendations are.
  - Person identifies pros and cons of taking prescribed medications, and agrees to consult with obstetrician regarding what meds might be safe while pregnant.
  - Person identifies two helpful strategies for managing problem feelings, and practices using each strategy once.
  - Person agrees to two monitors for recognizing when feelings or behavior are out of control, and contracts for a safety strategy regarding asking for help when that happens.
  - Person demonstrates ability to use that safety strategy in three practice sessions.
- Goal 5: Substance Abuse
  - Person describes her goal regarding using substances when pregnant and after delivery.
  - If goal is not abstinence, the person describes strategy for not having child removed by protective services, and is able to acknowledge why that strategy is not likely to be successful.
  - For any goal, the person identifies daily activities, including treatment participation, which will help her succeed.
  - Person agrees to include this plan in report to probation.
  - Person agrees to monitor urines as a measure of success, and to increase daily activities if not successful.
  - Person and mother agree to a plan for providing weekly positive contingency rewards for defined success (clean urine, completes 80% of daily activities, etc.), including positive report to probation officer.
  - Person agrees to a plan that reduces consequences or provides reward for reporting a slip prior to being caught with a dirty urine.

    - Person identifies one peer support activity that will help recovery, and attends one time, reports on experience and pros and cons of attending that activity at least once per week.

- Interventions
    - Weekly individual integrated counseling, with intermittent phone contact and meetings with mother (can be done in either mental health or substance abuse setting).
    - Psychiatric evaluation, and periodic follow-up to assess meds, including need to start meds while pregnant.
    - Contact with primary care/ob-gyn to identify recommended prenatal care, and access to any support services for pregnant teens.
    - Contact with probation officer, once and then ongoing, to discuss with court contingencies for compliance and noncompliance.
    - Offer of weekly adolescent substance abuse group, with information about adolescent after-school intensive outpatient treatment, and residential services, if outpatient not successful.
    - Offer of weekly adolescent group to help with emotions and develop healthy peer support skills.
    - Counseling strategies include motivational interviewing with the person and mother, contingency contracting, identifying and practicing emotional and substance safety skills, as well as more traditional counseling.
    - Counseling can be aided by access to worksheets regarding teen pregnancy and prenatal care, teen pregnancy and substance use, parenting skills for teens, diagnosis worksheets regarding bipolar disorder, feelings management worksheets and skill sheets, pamphlets and booklets regarding teens and abstinence.
    - Actual plan would match specific interventions to each of the objectives listed above.

Sample Treatment Plan Series: Chronic Psychotic Illness and Substance Use Disorder

Problem: Individual with Chronic Psychotic Illness and Substance Use Disorder who is Pre-contemplative

- Problem 1: Chronic Psychotic Disorder
- Problem 2: Substance Use: Engagement Phase – Person won't discuss substance use or acknowledge a problem.

  "My case manager disagrees with me about whether I have a substance use problem."

- Goal

  "I want to be a more successful substance user, so that I can drink and drug as much as I want and not get into as much trouble."

  "I want to make sure that the amount of substances I am using is right for me."

  - During the next six months, the person will begin to discuss his use of substances, and how he makes choices or decisions about substance use, even without yet admitting that it's a problem or that he wants to change.

- Objectives
  - Person will identify at least one substance (including nicotine) that he makes choices about, and identifies three benefits of that substance and three problems with that substance.
  - Person will describe what he currently has decided to do about that substance (amount and pattern of use), and discuss whether he is happy or not happy with that decision.
  - Person will identify whether he has been successful in consistently implementing his decision.
  - Person will agree to attend one group in which people discuss decisions like this, and either learn about how to do better or be able to teach others about what has worked.
  - Repeat for other substances and other choices as indicated.

- Interventions
  - One-on-one with staff to review substance decision sheets. Identify a reward for the person for successful completion of a sheet.
  - Person reads pamphlet on the chosen substance.
  - Person fills out sheet with staff help.
  - Person maintains daily log of use of chosen substance, and compares to choice.
  - Person attends group on "healthy decisions and choices," or similar type of group.
  - Substance Abuse Treatment Scale (SATS) rated quarterly to monitor progress.

Example Integrated Scope of Practice for Singly Trained Care Providers

- Convey a welcoming, empathic attitude, supporting a philosophy of dual recovery.
- Screen for multiple issues, including trauma history.
- Assess for acute mental health/detoxification risk, and know how to get the person to safety.
- Obtain assessment of the conditions, either one that has already been done, or a new one, if needed.
- Be aware of and understand the diagnosis and treatment plan for each problem (at least as well as the person understands them).
- Support treatment adherence, including medication compliance, 12-step attendance, etc.
- Identify stage of change for each problem.
- Provide one-on-one and group interventions for education and motivational enhancement, to help people move through stages of change.
- Provide specific skills training to help people follow recommendations for each issue (e.g., help people to take meds exactly as prescribed).
- Help the person manage feelings and mental health symptoms without using substances.
- Help the person advocate with other providers regarding treatment and support needs.

- Collaborate with other providers so that the person receives an integrated experience.
- Educate the person about the appropriateness of taking their psychiatric meds and participating in mental health treatment while attending 12-step recovery programs or participating in other addiction treatment support systems.
- Modify (simplify) skills training for any problem to accommodate a person's cognitive or emotional learning impairment or disability, regardless of cause.
- Promote self-help group participation and natural supports.

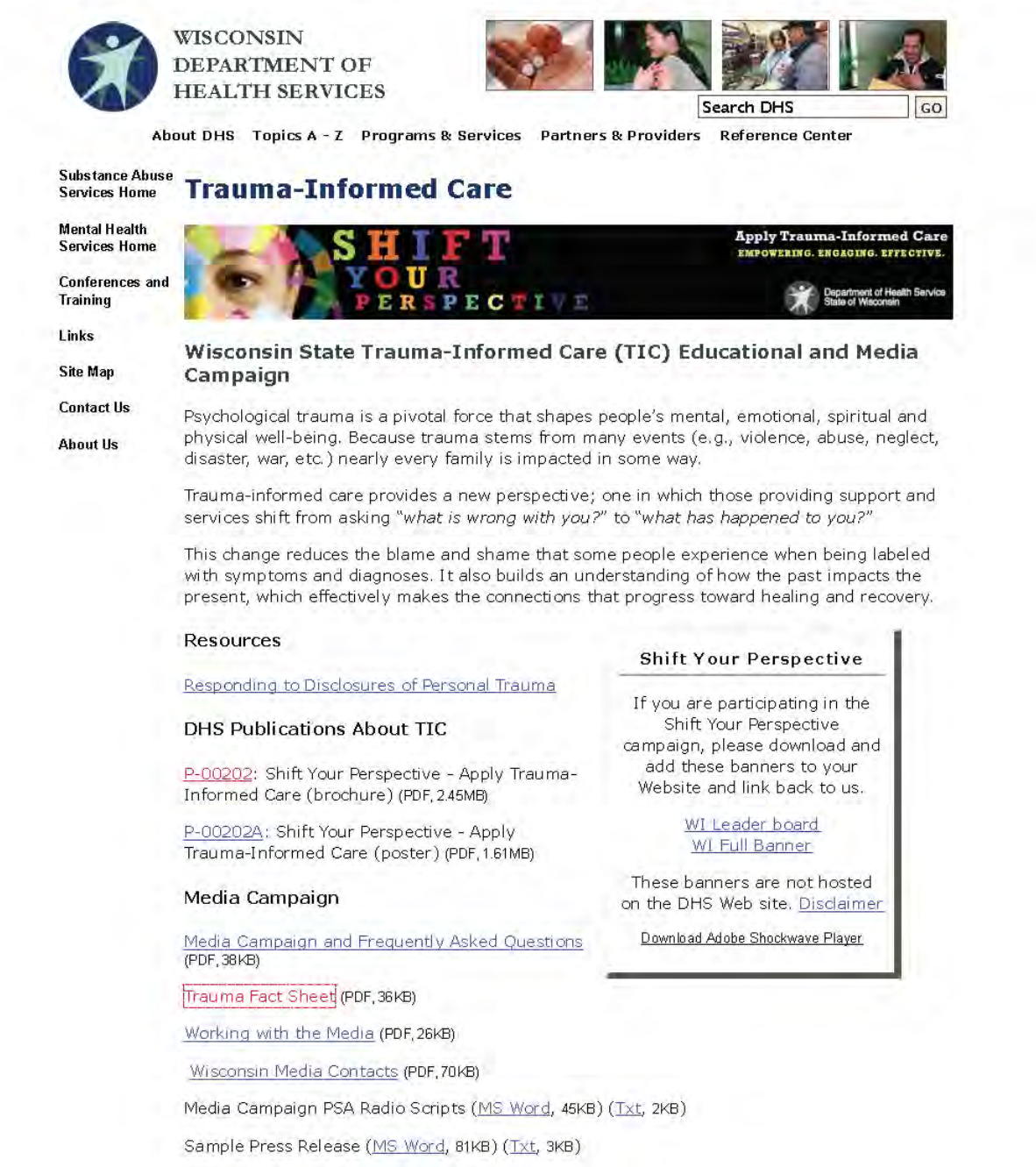
Module 6: Trauma-informed Services for Individuals and Families with Multi-occurring Conditions

Included in Module 6 are materials from the State of Wisconsin; San Mateo County, CA; and the State of Connecticut that are used in those state and county-level trauma-informed initiatives. These materials are included to give Change Agents real working examples of what other systems are doing to organize trauma-informed care as a core feature of working with individuals and families with multi-occurring conditions or complexity.

Resources

- Covington, S. (2008). Helping Women Recover: A Program for Treating Addiction. San Francisco: Wiley.
- Covington, S. (2008). Helping Women Recover: A Program for Treating Substance Abuse, Special Edition for Use in Criminal Justice System. San Francisco: Wiley.
- Finkelstein, Markoff, and others: Articles from the SAMHSA Cross Center Study on women (and children) with COD who were victims of violence and trauma.
- Harris, M. & the Community Connections Trauma Work Group (1998). Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups. New York: Free Press.
- Institute for Health and Recovery. Developing Trauma-Informed Organization: A Tool Kit. Cambridge, MA.
- Institute for Health and Recovery. Template for Developing a Trauma Integration Strategic Plan. Cambridge, MA.
- Najavits, L. (2002). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press.
- Brown, Vivien: Materials from the SAMHSA Women who are Victims of Violence with COD Project

Wisconsin Department of Health Services: Trauma-informed Care Web Page



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Trauma-Informed Care

Wisconsin State Trauma-Informed Care (TIC) Educational and Media Campaign

Psychological trauma is a pivotal force that shapes people's mental, emotional, spiritual and physical well-being. Because trauma stems from many events (e.g., violence, abuse, neglect, disaster, war, etc.) nearly every family is impacted in some way.

Trauma-informed care provides a new perspective; one in which those providing support and services shift from asking "*what is wrong with you?*" to "*what has happened to you?*"

This change reduces the blame and shame that some people experience when being labeled with symptoms and diagnoses. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing and recovery.

Resources

Responding to Disclosures of Personal Trauma

DHS Publications About TIC

P-00202: Shift Your Perspective - Apply Trauma-Informed Care (brochure) (PDF, 2.45MB)

P-00202A: Shift Your Perspective - Apply Trauma-Informed Care (poster) (PDF, 1.61MB)

Media Campaign

Media Campaign and Frequently Asked Questions (PDF, 38KB)

Trauma Fact Sheet (PDF, 36KB)

Working with the Media (PDF, 26KB)

Wisconsin Media Contacts (PDF, 70KB)

Media Campaign PSA Radio Scripts (MS Word, 45KB) (Txt, 2KB)

Sample Press Release (MS Word, 81KB) (Txt, 3KB)

Shift Your Perspective

If you are participating in the Shift Your Perspective campaign, please download and add these banners to your Website and link back to us.

WI Leader board
WI Full Banner

These banners are not hosted on the DHS Web site. Disclaimer

Download Adobe Shockwave Player

State of Wisconsin, Department of Health Services: "Shift Your Perspective" Brochure

One Human Service Provider's Perspective

I work in a community support program. Every day we see people who have been traumatized. It is tough to heal from the prolonged, repeated abuse that can happen in families. When I think about it, most of the people we work with are trauma survivors, and not just of one experience, but of many. I see how some of the things we do–the processes and procedures that have been around for decades–are a sort of barrier between *us* and *them*. Sometimes our approach creates a situation where we're not only *not* helping, but we're making support less accessible.

I learned about trauma-informed care several years ago. I talked with staff and we started to think through how this shift in our perspective could make a difference. We looked at our policies and procedures–and we changed quite a bit. We started listening to the people we serve and have worked to integrate their voices and choices into our everyday practices.

True collaboration is hard work, but making the effort has made all the difference. Trauma-informed care is the right thing to do for everyone!

– Kathi, *Jefferson County*

"Every human service provider should consider 'Shifting Their Perspective' because we know that trauma-informed care can lead to social inclusion and healthier communities."

– Karen Timberlake, *Wisconsin Secretary of the Dept. of Health Services*

National Resources

Child Trauma Academy
www.childtrauma.org

International Society for Traumatic Stress Studies
www.istss.org

National Center for PTSD
www.ptsd.va.gov

National Center for Trauma-Informed Care
mentalhealth.samhsa.gov/nctic

National Child Traumatic Stress Network
www.nctsnet.org

Sidran Foundation
www.sidran.org

Trauma-Informed Models
www.theannainstitute.org/MDT.pdf

"Trauma is the Common Denominator, Healing is the Common Goal"
www.witnessjustice.org/health/trauma.cfm

State Resources

Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services
dhs.wisconsin.gov/mh_bcmh/tic/index.htm.

Trauma Services Coordinator Elizabeth Hudson:
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Department of Health Services
State of Wisconsin

SHIFT

YOUR PERSPECTIVE

Apply Trauma-Informed Care

EMPOWERING. ENGAGING. EFFECTIVE.

One Consumer's Perspective

"Wow!" That's all I could say after I left the new program. "Wow!" I wasn't labeled. I wasn't talked down to. I wasn't "less than" anyone else. . . and maybe for the first time in my life I actually felt like I mattered. I hope they know how much that means to me.

For years I've been in and out of programs. "Co-occurring disorders" is what most people called my depression and drinking. I was "treated" and I only felt worse. Then I find this program that is "trauma-informed." I felt safe and respected from the moment I walked in.

In this program people asked "What happened to you?" I hadn't really thought about that. Nobody ever asked before. But I had a really horrible childhood that I still have a hard time talking about. It's starting to make sense now–how my depression links back to what I went through as a kid and how I drink when those memories are too much to take. The people I work with in the trauma-informed care program talk about how understanding my trauma will help me to heal and find peace–and I'm seeing now how that can happen.

– Melissa, *Milwaukee County*

What is Trauma-Informed Care in Human Services?

Psychological trauma is a pivotal force that shapes people's mental, emotional, spiritual and physical well-being. Because trauma stems from violence, abuse, neglect, disaster, terrorism and war, nearly every family is impacted in some way. Trauma-informed care provides a new perspective where those providing the support shift from asking "What is wrong with you?" to "What has happened to you?" This change reduces the blame and shame that some people experience when being labeled. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing and recovery.

Trauma-informed care takes a collaborative approach, where healing is led by the consumer and *supported* by the service provider. Together, in a true partnership, people learn from each other. There's greater respect, progress toward healing, and greater efficacy in services.

Trauma-informed care in organizations impacts all the many aspects of service delivery–from how services are provided, to how the physical space is laid out. While the shift in perspective and organizational change doesn't happen over night, it will start to take root with dedication. With organizational management on board and some thoughtful discussion about what change needs to take place, it won't take long before staff and clients start to see positive change.

Ten Values of Trauma-Informed Care

- Understand the prevalence and impact of trauma
- Pursue the person's strength, choice and autonomy
- Providers must earn trust
- Healing happens in relationships
- Provide holistic care
- Share power
- Communicate with compassion
- Promote safety
- Respect human rights

- Wisconsin Trauma-Informed Care Advisory Committee

Your colleagues in Wisconsin believe Trauma-Informed Care is...

- Positive
- Respectful
- Compassionate
- Hopeful
- Effective
- Helpful
- Energizing/Reviving
- Motivating
- Making a difference
- Exciting

Wisconsin Trauma Fact Sheet

Wisconsin Trauma Fact Sheet

Veteran Statistics

- **26,419**[1] Wisconsin residents have been deployed in either Iraq or Afghanistan (April 2009)
- **Nearly 20%**[2] of service members who have returned from Iraq and Afghanistan report symptoms of Post-Traumatic Stress Disorder (PTSD)
- **328,278** wartime veterans were living in Wisconsin (2008)

Wisconsin Crime Statistics[3] (2008)

- **146** reported murders
- **9,070** reported aggravated assaults

Sexual Violence Statistics[4] (2008 study of reported sexual assaults)

- **4,668** cases of sexual assault that year
- **96%** of the assailants knew their victims
- **Over 70%** of the victims were **under the age of 18**

Domestic Violence Statistics

- There was an average of three DV homicide deaths per month in Wisconsin[5]
- **28,293** incidents of domestic abuse were reported in 2004[6]

Child Abuse Statistics

- In 2007, Child Protective Service agencies received a total of **55,895 referrals; 27,233 were screened-in.**
  - 3,531 substantiated neglect cases
  - 1,135 substantiated physical abuse cases
  - 1,1814 substantiated sexual abuse cases[7]

[1] U.S. Department of Defense: "Legal Residence/ Home Address for Service Members Ever Deployed as of April 30, 2009, Source: CTS Deployment File as of April 30, 2009"
[2] http://www.rand.org/multi/military/veterans/
[3] Wisconsin Office of Justice Assistance: "Preliminary Crimes and Arrests in Wisconsin: 2008"
[4] Wisconsin Office of Justice Assistance, "2008 Crime Statistics Report"
[5] Wisconsin Coalition Against Domestic Violence, "Wisconsin Domestic Violence Homicide Report, 2008"
[6] WI Dept. of Justice, "WI Dept. of Justice Domestic Abuse Incident Report, 2004"
[7] WI Dept. of Children and Families, "Wisconsin Child Abuse and Neglect Report, 2007"

Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services
Trauma Services Coordinator Elizabeth Hudson: elizabeth.hudson@wisconsin.gov or 608-266-2771

San Mateo County (CA) Health System Co-occurring Initiative

Trauma-informed care resources at http://www.smchealth.org/cod

'Becoming Trauma-informed' in San Mateo County

I. The Need for Growth: Pre- Trauma-informed

Pivotal Moments that clearly identified a need (gap in services) and inspired action

- **Trauma was the number one identified need (gap)** in provider skills and requested for training in the coming year according to a broadly distributed survey
- **What was missing?** Recognizing and understanding traumatic symptoms as adaptive responses to overwhelm **Case consultation/collaboration:** Engaging with providers around shared clients w/o acknowledging prior lived experiences of trauma as the root of the problem and current symptoms in order to more accurately and sensitively guide interventions and overall treatment
- **Consequences:** an entire system that feels overwhelmed and helplessness as how to contain and address these issues. Essentially, (by avoiding the root of the problem because we did not know how to competently address it) we were a system that was being vicariously traumatized along with the clients and experiencing the very same effects that define trauma

II. Planting Seeds : Threefold Mission (emerged) based on 3 inquiries

1. **What already exists so as not to recreate the wheel? Increase awareness and highlighting trauma as the root of the issue by demonstrating prevalence of trauma;**
   - Create T-I webliography: to get informed and connected: discovered state initiatives and projects position papers, national efforts (NASMHPD, NCTIC, NCTSN), Ann Jennings' work and listserve (SPSCOT), Community Connections publications ~ beacons of light offering supportive guidance and framework
   - Distribute needs assessment

2. **How can we integrate trauma-informed services into the existing infrastructure? Support recognition of what is trauma and traumatic symptoms by increasing provider competency and the system as a whole;**
   - Consultation: advised not to create a separate initiative, but ride on the coattails of an already established, well recognized countywide effort to become co-occurring capable in order to minimize resistance
   - Saturate the system of care culture with information rich emails including trauma-informed resources, webinars, trainings and conferences via multiple listserves
   - Identify a universal, routine screening tool

3. **How are we communicating the needs of our complex clients and co-occurring families? Create a shared lens and common language amongst diverse providers and services operating within a system of care;** (criminal justice, Child Protective Services, primary care, mental health, AOD, educators, employment, housing, etc.)

III. Nurturing Growth: Systematic Approach to Culture Change (2008)

Create structure and ongoing forums to capture and collectivize the emerging enthusiasm and interest of our consumers and providers to speak openly about trauma and what to do about it as a consumer, provider, program, organization and system of care;

1) **Formed Trauma Informed Workgroup** that has been consistently meeting monthly since Oct. 2008
   - first 1.5 years; identify and learn from the experts among us
   - more recently; share and bolster trauma-specific skills and shape policy in our organizations and system of care using Roger Fallot and Maxine Harris Trauma-Informed Self-Assessment and Planning Protocol as a guide

2) **Created Trauma Learning Collaborative** providing a broad based understanding of trauma by designing Trauma 101: A foundation for understanding trauma for a trauma-informed system of care; stressed the importance of laying the groundwork for recognizing traumatic symptoms and understanding the lived experiences from a place of compassion "being" and really listening FIRST (in an effort to prevent retraumatization) and thereafter learning and building the "doing" skills

3) **Organized Annual Trauma Conferences** featuring leading experts in the field such as Stephanie Covington, Ph. D. and Janina Fisher, Ph.D. to give credence to the work that was being done and to set the tone going forward

IV. Harvesting Fruit: Signs of Progress/Culture Change

Keys to Success: broadcast consistent message/mission, flexibility, perform continuous and ongoing efforts congruent with the mission, carry out a long term vision step-by-step, inclusion ~ say 'yes', cultivate possibility attitude, allow for choice and timing/readiness, sheer persistence and insistence to never give up

- Explicitly stating the intention to become trauma-informed and capable as a system of care by identifying in the Systems Vision for Transformation Charter Document Strategic Action #4, which reads; "Promoting A Shared Vision: to achieve countywide recovery oriented, culturally responsive, trauma-informed and co-occurring capable services."
- Increasing number of diverse system of care service organizations are inspired to request Trauma 101 presentations for their interns, clinical teams, all staff: (Alcohol and Other Drug Services, youth and families, TAY services, housing, intensive case management and residentials)
- It was crucial for 'becoming trauma-informed' to grow and spread based on **self-identified** needs rather than a top-down approach of mandating, forcing or flooding. The latter approach creates resistance whereas the former engenders receptivity, empowerment and choice ~ the very same principles from which trauma-informed services originated
- Now, sitting in meetings and case consultations where there is a discussion re: the needs of the clients being served hearing trauma used more frequently to encapsulate and refer to the injustices and abuses of the lived experiences of our clients

We will know that we have accomplished our mission when every organization within our system of care has fully integrated trauma-informed services into their service provision, policies and procedures evidenced by trauma-informed materials made readily available to clients, consistently applied trauma-informed lens when discussing clients and implementation of routine program procedures such as trauma screening, trauma-informed assessments and stage matched interventions.

State of Connecticut: Commissioner's Policy Statement on Trauma

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

M. JODI RELL
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

MEMORANDUM

To: State Operated CEOs
OOC Staff

From: Patricia A. Rehmer, MSN
Commissioner

Date: June 9, 2010

Subject: ***COMMISSIONER'S POLICY STATEMENT ON TRAUMA***

The Trauma Guide Team is very pleased to present the Commissioner's Policy Statement on Trauma. The development of this Policy has been the result of many years of hard work by numerous champions of the trauma movement; especially driven by the people in recovery, who through their grass-root efforts, have made us all aware that trauma matters.

Special thanks go to the Trauma Guide team, the people in recovery who provided their knowledge, experiences and keen insight into the creation of this policy. We want to thank the many DMHAS trauma champions who, over the years, spent much time and effort encouraging us all to this move this policy forward. In addition, special mention should be made to Valerie Leal, who served as the Trauma Project Lead for many years and who sadly passed on a year ago. Valerie's passion regarding trauma and its fundamental importance to the quality of care delivered was inspiring and motivational.

We hope that this Policy leads the way to values-based cultural change; where true transformation happens, new models of care and practices emerge and that the characteristics of the DMHAS system of care continue to strive to embrace, safety, trust, collaboration, choice and empowerment.

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STATE OF CONNECTICUT
Department of Mental Health & Addiction Services

dmhas Department of Mental Health and Addiction Services

Commissioner's Policy Statement and Implementing Procedures

SUBJECT:	Trauma Services Policy
P & P NUMBER:	Chapter 6.5
APPROVED:	Patricia Rehmer, Commissioner Date: April 15, 2010
EFFECTIVE DATE:	April 15, 2010
REVISED:	New
REFERENCES:	
FORMS AND ATTACHMENTS:	

STATEMENT OF PURPOSE: The purpose of this policy is to foster a health care system that employs and practices principles that are trauma sensitive and trauma-informed to individuals served by the Department of Mental Health and Addiction Services and funded agencies.

POLICY: Trauma sensitivity shall be a governing principle of DMHAS. Services within this system must meet the needs of individuals who have experienced trauma by establishing an environment that is safe, protects privacy and confidentiality, and eliminates the potential for re-victimization. DMHAS shall promote recovery by understanding trauma and its effects on individuals and their families. DMHAS providers shall be sensitive and respectful towards individuals while encouraging autonomy and hope. Individual strengths shall be a major focus in guiding individuals with a history of trauma towards recovery.

DEFINITION AND EFFECTS OF TRAUMA: Trauma refers to extreme stress that overwhelms an individual's ability to cope. Trauma involves events or experiences that confront the person directly or as a witness to a real or perceived threat of death, human suffering, severe bodily harm or injury, coercive exploitation or harassment, sexual violation, violence motivated by ethno cultural prejudice, gender, sexual orientation, or politically based.

Psychological trauma has a direct impact on the brain through associated physical, neurological, and stress response systems. These experiences directly and indirectly affect mood, memory, judgment, and involvement in relationships and work. The psychobiological impact of trauma leads to a sense of fear, helplessness, horror, detachment, and/or confusion. It also impacts an individual's perception towards self, others, and the world. The potential for reactivity to safety concerns in the treatment environment must be consciously and thoughtfully planned in order to create an environment conducive to healing and recovery.

Experiences of trauma (such as childhood physical or sexual abuse or neglect, or adult domestic violence) are a betrayal of basic human values and often cause lasting and severe post-traumatic impairment in the survivor's basic sense of self, trust in others, involvement in society, culture, health and integrity of his/her body.

A high percentage of individuals with severe and persistent behavioral health difficulties have experienced the direct or indirect effects of trauma. Many suffer from post-traumatic symptoms exacerbating other behavioral health problems, impairing psychosocial functioning and interfering with the quality of their lives.

TRAUMA INFORMED SYSTEM:

A trauma sensitive system of care has developed approaches which are both trauma-specific and trauma-informed. Providers must have an understanding of trauma and the effects and symptoms displayed by the individuals within the system. The system must be designed in such a way to allow individuals to participate in their own recovery without possibility of re-traumatization. The goal of an integrative approach is to recognize and be cognizant of the fact that mental illness and substance abuse often coincide with trauma, thereby necessitating that all aspects of an individual's needs be treated concurrently.

Trauma-specific services include techniques which are designed to assist individuals with a history of trauma in managing dissociative symptoms; desensitization therapies which help render painful images more tolerable; and behavioral therapies which teach skills for the modulation of powerful emotions (Harris & Fallot, 2001).

GUIDING PRINCIPLES: DMHAS shall:

- Recognize that the majority of individuals seeking services and/or are currently involved in services have at one point in their life experienced trauma. Trauma sensitive services must be applied universally to every individual.
- Identify and screen for individuals who have experienced trauma. Universal trauma screening should be appropriate to the service setting and should be performed upon intake. An appropriate assessment of trauma exposure, history and symptoms as well as linkage to trauma-specific services that are developed specifically to an individual's desired outcome.
- Education shall be provided to all staff members:
    - on the potential effects and impact on therapeutic relationships and employee wellbeing.
    - on personal and professional boundaries and on understanding behaviors of individuals with a history of trauma.
    - on cultural competence and gender sensitivity
    - on the promotion of a system that is both trauma informed and sensitive
- Provide adequate supervision and training to prevent employees from experiencing compassion fatigue and/or vicarious traumatization.

- Provide clear and specific services to individuals. Individuals receiving services must be informed of their rights, who they will be working with, what goals they wish to achieve, and the expectations of their participation. Boundaries should be made clear and be consistent in order to achieve trustworthiness.

- Focus on individual choice as a way to maximize autonomy and empowerment. Individuals should have a right to choose the services they receive and who provides them. Recovery is achieved by giving individuals control in making their own decisions and choosing goals that are relevant to their progress.

- Increase collaboration and shared power between the individual and the service provider. Individuals will have a role in evaluating the agency's services. Individuals will be present in service planning, goal setting and in all other facets of treatment. Individuals will be seen as the expert on his or her recovery.

- Empower individuals and teach skill building as an integral part of the services being provided. There should be an emphasis on individual growth and a focus on individual strength. Contact with providers should give individuals the opportunity to complete a task and learn a new skill.

COD E-Circular: CA Department of Alcohol and Drug Programs

COD E-Circular

A Project of the Co-Occurring Disorders (COD) Unit, California State Department of Alcohol and Drug Programs

Volume I, Issue 3 **September 2008**

In this issue...

Trauma: The Red Thread Connecting Substance Use and Mental Illness

***Trauma*: Recent research provides extensive evidence on the role trauma plays in the development of COD—that is, both mental illness and substance use issues. Because of its connection to both disorders and its prevalence, trauma is of significant interest among COD populations.**

Understanding trauma can help us find opportunities for reducing its impact. This *COD E-Circular* focuses on the interplay of trauma and the social and individual hardships that can lead to it. Trauma can affect anyone, but it has distinct effects on youth, military personnel, women, and older adults.

Throughout California service providers are working to help shape effective county Prevention and Early Intervention (**PEI**) programs for Mental Health Services Act (**MHSA**) funding. An examination of the PEI Priority Populations reveals that the youthful populations at high risk for mental illness are those facing the **traumas** of school failure, juvenile justice involvement, or family stress, including domestic or external violence. Such **traumas** also put these same populations at high risk for substance use problems.

Increasingly, military personnel return from active duty in which violence is both routine and terrifying. The news carries stories about crises in their lives involving substance use and mental illness. Often these issues are connected to veterans' post-traumatic stress disorder (**PTSD**).

At women's substance use disorder treatment facilities, awareness of **trauma** is critical to successful recovery. Women clients are frequently survivors of domestic violence and/or early sexual abuse, often leading to PTSD. "**Trauma**-informed" services (see page two) are critical for all PTSD clients, so that treatment does not re-traumatize clients. **Trauma**-informed services also increase retention and improve outcomes.

As baby boomers age, awareness is emerging about the impact of the **traumas** of old age. Depression and substance use disorders both find their roots in the **traumas** of grief, social isolation, illness, and the loss of physical capacity. Additionally, the elderly may experience elder abuse, poverty, and homelessness as their retirement incomes fall short of the means to secure a home in a "good neighborhood."

Nationally we also see the terrible, yet predictable, outcomes of the widespread **trauma** of home foreclosures and economic cutbacks. While the news focus may be on dramatic and tragic occurrences, the many lives impacted by substance abuse and mental health issues are largely unseen.

Across the country the aftermath of extreme weather events traumatizes increasing numbers of people. In California, the wildfires throughout the state will have predictable impacts, causing more trauma and more COD.

COD treatment must incorporate awareness of protective factors as well as causes, impacts and effects of **trauma**. This *COD E-Circular* includes resources and references to address the pervasive and powerful effects of trauma on human lives.

COJAC Endorses DDCAT

At its July 2008 meeting the Co-Occurring Joint Action Council (**COJAC**) decided to recommend the Dual Diagnosis Capability in Addiction Treatment (**DDCAT**) tool for assessing COD treatment capability.

Details and link in the next COD E-Circular.

Prevention and Early Intervention and Trauma

In early July, the Department of Mental Health (**DMH**) provided information about the direction of the MHSA. DMH Information Notice Number 08-17 states, "We ... intend to develop the conceptual design of a three-year plan which integrates the MHSA into the larger public mental health system."[1] While the rest of this Notice goes on to discuss Community Services and Support, the integration of MHSA into California's mental health system has important implications. *(Continued on page 6, **PEI** & Trauma)*

COD E-Circular

September 2008

The Special Needs of Traumatized Clients: The Varied Faces and Forms of Trauma

Present or past trauma—whether sexual, physical, psychological or emotional—is common in the lives of people with COD. Certain populations are at high risk for trauma. The great majority of COD clients are impacted by past trauma. The following pages present a brief overview of a few key populations, their particular trauma-related concerns, and the importance of empathy when working with those suffering from trauma. When not otherwise stated, citations are from resources on the Substance Abuse and Mental Health Services Administration (**SAMHSA**) Web site: http://www.samhsa.gov/.

Women and Abuse

Incidence—Research has found that between 51 and 97 percent of women with serious mental illnesses report some form of physical or sexual abuse (Goodman et al., 1997). Additionally, women with COD are more likely to experience abuse than those with a mental disorder who are not drug dependent (Alexander, 1996).

Forty-one to 71 percent of women in treatment for drug or alcohol disorders report incidences of sexual abuse as children or adults; and 38 percent are victims of violent crimes (Alexander, 1996). Women who experience any form of sexual abuse as children are three times more likely than other women to report drug dependence as adults (Zickler, 2002).

Associated Mental Illnesses—Overall, sexual or physical abuse is associated with PTSD, anxiety, depression, psychotic symptoms, personality disorders, and correlated with suicidal tendencies, risky sex and drug practices, and substance abuse (Goodman et al., 1997).

Learn about *trauma-informed treatment*:

Get a range of information at SAMHSA's National Center for Trauma-Informed Care (NCTIC): http://mentalhealth.samhsa.gov/nctic/trauma.asp

Additionally, the NCTIC offers free or minimal cost technical assistance and training to publicly funded health/human service systems and programs.

Also, see the link for "Trauma-Informed AOD Treatment for Survivors of Domestic Violence" near the bottom of this webpage: http://www.adp.ca.gov/TA/TA_af_am.shtml

October is Domestic Violence Awareness Month

CONFERENCE CORNER

Annual Rose Jenkins Conference Focuses on MHSA & Evidence-Based Practices

How well can you document the outcomes of your treatment services? Are your methods effective? Proven? Do you use evidence-based practices (**EBP**s)?

If you care about quality treatment, you are thinking about these questions. If you have read about Prevention and Early Intervention funding under the MHSA, you are already familiar with them! And if you attend this conference you will learn about the latest developments in:

- Brief Treatments
- Lessons Learned from EBP Implementation
- Prevention Strategies
- Outcome-Driven Services
- Public Health Approaches
- Co-occurring Mental Health and Substance Use

The conference is in **Sacramento, California, from Thursday, October 23, to Friday, October 24, 2008**. Hotel and registration discounts apply through September 30. For more information and details go to http://elearning.networkofcare.org/cimh/ .

For additional information on COD-related forums, conferences and trainings, see: http://www.adp.ca.gov/COD/conferences.shtml

COD E-Circular September 2008

Suicide Increasing for War Veterans

Among the most serious issues that military veterans face related to COD is suicide. The causes for the increase in veterans' suicide rates are not well understood. Mental health professionals, however, say the biggest underlying factor is PTSD. Whatever the cause, the cost is high.

Based on U.S. Census data for 2000, of the approximately 25 million veterans in the nation, California is home to the largest population. In California, 2006:

- 666 veterans committed suicide;
- the 2.1 million California veterans represented **only six percent** of the State's 37.1 million residents;
- veterans accounted for **21 percent** of the 3,198 suicides in California (California Department of Public Health statistics).

The sharp rise in suicides appears to be primarily among veterans that served in Iraq and Afghanistan. However, the Veterans Administration (**VA**) has not disclosed what proportion of suicidal veterans served in Iraq and Afghanistan.

Concerned about the rising suicide rate, veterans groups have sued the VA. The suit seeks an order to force the VA to take stronger action to:

- promptly screen and treat those at risk of suicide,
- set timetables for handling claims for medical benefits.

Testimony in this lawsuit indicates that returning troops are taking their own lives in greater num-bers. Expert witnesses and plaintiffs stated there is a steady increase in the veterans' suicide rate since 2001. They claim a comparatively high rate among veterans ages 20 to 24. Witnesses testified the suicide rate for those veterans was anywhere from 2 to 7.5 times the rate among the general population.

A National Institute on Drug Abuse Special Report found high rates of COD and PTSD reported among combat veterans. An inquiry done by the National Association of State Alcohol and Drug Abuse Directors in August 2008 placed California among the 16 states doing the least for returning veterans. The same inquiry found that about half of the states require their providers to screen for, and provide, referrals for clients with potential cognitive disabilities or traumatic brain injuries.

TIP 42 on Empathy*

Empathy is a key skill for the counselor, without which little could be accomplished.... An empathic style:

- **Communicates respect for and acceptance of clients and their feelings**
- **Encourages a nonjudgmental, collaborative relationship**
- **Allows the clinician to be a supportive and knowledgeable consultant**
- **Compliments and reinforces the client whenever possible**
- **Listens rather than tells**
- **Gently persuades, with the understanding that the decision to change is the client's**
- **Provides support throughout the recovery process**

*From SAMHSA's *Treatment Improvement Protocol (TIP) 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Chapter 5: Strategies for Working With Clients With Co-Occurring Disorders, "Use Supportive and Empathic Counseling". Document at http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.74538

COJAC Shares New COD Screening Tool

This issue of the *COD E-Circular* has a number of articles touching on the fact that individuals exposed to trauma are at increased risk of developing mental illness and/or substance abuse problems. Furthermore, those who work with COD realize that one of the biggest problems in treatment is inadequate diagnosis. Aware of these two issues, the Co-Occurring Joint Action Council (**COJAC**) created the new COJAC Screening Tool (**CST**).

> **A good COD screening tool identifies those who would most likely benefit from further assessment for mental illness and/or substance abuse.**

Screening should be quick and simple. A good COD screening tool identifies those who would most likely benefit from further assessment for mental illness and/or substance abuse. Assessment is a lengthy process, normally performed by appropriately trained staff.

The need for a simple COD screening tool was an early focus for COJAC. COJAC is an advisory body to the Department of Alcohol and Drug Programs and the Department of Mental Health. COJAC members provide comments and assistance on COD

(Cont on page 7, COJAC Screening Tool)

COD E-Circular September 2008

Women, Domestic Violence, and COD

Domestic abuse is a frequent source of trauma for women. It includes physical violence, verbal abuse and emotional abuse. Verbal and emotional abuse can be more devastating than physical violence; however, all abuse is traumatizing. Victims typically conceal abuse for as long as possible.

Few mental health or substance use treatment providers incorporate domestic violence screening. Does yours?

Domestic violence is a high risk factor for mental illness – especially PTSD, substance use disorder, and COD.

Because of these factors, screening for domestic violence among women in COD treatment should be part of intake protocol. However, because of the sensitive and even dangerous nature of domestic violence, special staff training is crucial. Staff should know how to appropriately screen and refer clients without further traumatizing them. With proper training, service providers who incorporate screening improve outcomes.

Staff should know how to appropriately screen and refer clients without further traumatizing them. With proper training, service providers who incorporate screening improve outcomes.

A study[1] presented at the International Family Violence Research Conference found that clinic staff adequately trained on screening and responses identified more instances of domestic violence. The women clients appreciated being asked about current and past abuse. In the study, the screened women also felt better able to protect themselves and their children after disclosure of domestic violence to the service workers.

Domestic violence, like alcohol and other drug (**AOD**) abuse, is a generational issue.[2] Providing counseling and referrals to help interrupt the cycle can aid future generations, as well as those currently involved in domestic violence situations.

Simply discussing the problem can be beneficial to those experiencing domestic violence. As stated by the National Center for Trauma-Informed Care, the screening questions for trauma —

> …determine whether he or she has experienced violence, abuse, neglect, disaster, terrorism, or war. These questions not only help to obtain the information needed to plan an appropriate safety and recovery plan, but *they also confirm to consumers/ survivors that their trauma histories matter*[3] [emphasis added].

Although domestic violence may contribute to substance use disorder, substance abuse treatment for survivors and victims does not necessarily stop the violence. In fact, AOD treatment and subsequent abstinence by the victim/survivor of abuse can cause the batterer to feel a loss of control and lead to an increase in violence.[4]

Addressing domestic violence helps contribute to COD recovery. At the same time, service providers should be prepared to respond to the complex and longer-term service needs of the entire family, including the children. According to one authority,

> It is increasingly apparent that many of the millions of children who are involved with the child welfare system at any one time have mothers who are victims of domestic violence.[5]

(Continued on page 7, Domestic Violence)

[1] Magen, Randy H., Kathryn Conroy, and Alisa Del Tufo, "Domestic Violence in Child Welfare Preventative Services: Results from an Intake Screening Questionnaire," presented at the 5th International Family Violence Research Conference, University of New Hampshire, Durham, New Hampshire, 1997, pages 13-15, (http://hosting.uaa.alaska.edu/afrhm1/iwacan/PPRS.pdf).

[2] Center for Substance Abuse Prevention of Substance Abuse's (CSAP's) Prevention Pathways Online Courses, 2003. "It Won't Happen to Me: Alcohol Abuse and Violence against Women" (Fact Sheet). CSAP of SAMHSA, retrieved July 2008, (http://pathwayscourses.samhsa.gov/vawc/vawc_fs_05.htm).

And Women's Health.gov, 2007. "Violence against Women: Domestic and Intimate Partner Violence." Office on Women's Health in the U.S. Department of Health and Human Services, retrieved July 2008, (http://www.4women.gov/violence/types/domestic.cfm).

[3] National Center for Trauma-Informed Care, 2007. Susan Salasin, "Necessary Steps in the Transformation to Trauma-Informed Care." SAMHSA's National Mental Health Information Center, Center for Mental Health Services, retrieved July 2008, (http://mentalhealth.samhsa.gov/nctic/newsletter_08-2007.asp).

[4] Office for the Prevention of Domestic Violence, 1996. Theresa M. Zubretsky and Karla M. Digirolamo, "The False Connection between Adult Domestic Violence and Alcohol." New York State, retrieved July 2008, (http://www.opdv.state.ny.us/health_humsvc/substance/falsecx.html#impact)

[5] National Council of Juvenile and Family Court Judges, 2008. Ann Rosewater, "Building Capacity in Child Welfare Systems: Domestic Violence Specialized Positions". Reno, NV, retrieved July 2008, page 7, (http://thegreenbook.ncjfcj.org/documents/BuildingCaps.pdf).

COD E-Circular September 2008

Poverty and Trauma

"Poverty is the worst form of violence."
Mahatma Gandhi (1869-1948)

Whether or not we agree with Gandhi, it is apparent how poverty creates an environment for many kinds of trauma. Almost any problem can be heightened to the point of trauma when individuals and families lack the resources to respond quickly or sufficiently to needs. Sometimes the connection between poverty and violence is very direct: Low-income neighborhoods are prone to higher crime rates and, in, California's larger urban areas, increased crime frequently extends to gun violence.

Trauma, however, need not be that dramatic to adversely affect lives. Traumatic experiences can occur in various situations that may be connected to lack of financial resources: inadequate or unreliable childcare, family relocations, including evictions or foreclosures, health problems, and general family stress.

In today's economy we are likely to see the incidence of income-related trauma expanding. In a radio discussion in early 2008, Elizabeth Warren of Harvard Law School asserted the following:

> A generation ago, one paycheck would buy housing, health insurance, pay taxes, transportation and still have 50 percent left over to spend on all the discretionary expenses. Today, it takes two-thirds of two paychecks to buy those ... and of course, now child care is thrown in. I think families are under a lot more squeeze than they were just a generation ago... .47 million people without health insurance, half of all Americans haven't saved a single dollar towards their pension.[1]

Poverty can be related to social and racial inequities, which may also lead to other kinds of traumatic experiences. One such trauma is "generational trauma," in which an historic trauma continues to affect individuals and their reactions to experiences. One example is the near-elimination of Native Americans.

Complex generational and social interconnections link economics, history, and culture with individual experiences. Such connections underscore the importance of cultural competence and cultural awareness in trauma-informed treatment, as well as in all COD treatment.

When poverty becomes more extreme it can lead to homelessness, which is associated with an entire array of additional problems. According to a project report from the Homelessness and Extreme Poverty Working Group of the National Child Traumatic Stress Network, families now make up 40 percent of the country's homeless population.[2] The report goes on to explain:

> The experience of homelessness results in a loss of community, routines, possessions, privacy, and security.[3]...The experience of homelessness puts families in situations where they are at greater risk of additional traumatic experiences such as assault, witnessing violence, or abrupt separation.[4]

These problems affect more than 1.3 million children who are homeless at some time each year and may result in further trauma.

As the report explains, homeless children are subject to a wide range of additional problems, such as increased illnesses and school failure. These problems affect more than 1.3 million children who are homeless at some time each year[5] and the negative experiences may result in further traumatization. In an upcoming issue the *COD E-Circular* will focus on the situation of youth, including homeless youth.

Upcoming issues of the* COD E-Circular *will focus on –

- ***Foster & Transitional Age Youth***
- ***Veterans***
- ***Women***

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[1] Marketplace, American Public Media, January 11, 2008. "Middle Class Roundtable," retrieved August 2008, (http://marketplace.publicradio.org/display/web/2008/01/11/middle_class_roundtable).

[2] Bassuk, Ellen L., MD; and Steven M. Friedman, PhD, "Facts on Trauma and Homeless Children." National Child Traumatic Stress Network, 2005, retrieved August 2008, page 1, (http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf).

[3] Ibid.

[4] Op cit, page 2.

[5] Op cit, page 1.

COD E-Circular September 2008

PEI and Trauma *(Continued from page 1)*

With this announcement DMH makes clear that the MHSA is incorporating two key concepts into all of California's public mental health (**MH**) services. One is the "recovery" paradigm, which supports meaningful lives for all clients. Most alcohol and other drugs service providers are already committed to "recovery" in treatment. The other important concept, emphasized by this announcement, is that the MHSA components and concepts of PEI should be an ongoing part of our public MH system.

Unlike prior DMH funding approaches, PEI programs use MHSA funds for services to individuals who **are not** considered "seriously mentally ill" (**SMI**). Because many COD clients experience mental illnesses below SMI levels, PEI programs are especially important to those providing COD services. (For a more detailed discussion of PEI and COD, please see the PEI-focused issue of the *COD E-Circular* on the web page, http://www.adp.ca.gov/COD/documents.shtml .)

Trauma is a fundamental focus of PEI. Another MHSA document describes the lengthy and inclusive stakeholder-input process for developing the guiding policies for PEI statewide.[2] It explains,

> Out of this comprehensive process came joint policies—based on each organization's principles and ongoing stakeholder input—that emphasize: **PEI Key Community Mental Health Needs...** [and] **PEI Priority Populations.**

The PEI program's "Key Needs" criteria acknowledge the importance of appropriate response to trauma to prevent or minimize later MH and AOD problems.

Under Mental Health Needs there are five "Key Needs":

> **Psycho-Social Impact of Trauma** PEI efforts will reduce the negative psycho-social impact of trauma on all ages." And under Priority Populations, at least four of the six groups involve trauma or likely trauma.

Children/Youth in Stressed Families Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-Exposed Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at Risk for School Failure Due to unaddressed emotional and behavioral problems.

Children/Youth at Risk of or Experiencing Juvenile Justice Involvement Those with signs of behavioral/emotional problems who are at risk of or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Services and Supports.

The PEI program's "Key Needs" criteria acknowledge the importance of appropriate response to trauma to prevent or minimize later MH and AOD problems.[3] One article explains the new understanding of trauma in this way:

> What we have learned is that it is necessary to serve trauma survivors in an environment that is immediately and directly supportive, comprehensively integrated, and that strives to be empowering for consumers/survivors. We now know that our service systems must be designed, from the first contact, to respond proactively to the special vulnerabilities and "triggers" of past trauma for consumers/survivors.[4]

PEI can help provide funding for programs that incorporate the integration of trauma-informed AOD and MH services called for in this evolving understanding of trauma.

Through October 6, the California Mental Health Directors Assoc. (CMHDA) is seeking applications for membership in the new Social Justice Advisory Committee (SJAC): Visit the SJAC webpage to download the SJAC Membership Application.

[1] DMH Information Notice Number 08-17, California DMH, July 9, 2008, page. 1, (http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-17.pdf).

[2] Proposed Guidelines: PEI Component. Enclosure 1, DMH Information Notice #07-19, California DMH, September 23, 2007, pages 4-5, (http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure1.pdf).

[3] Ibid.

[4] National Center for Trauma-Informed Care, 2007. Susan Salasin, "Necessary Steps in the Transformation to Trauma-Informed Care". SAMHSA's National Mental Health Information Center, Center for Mental Health Services, retrieved August 2008, (http://mentalhealthsamhsa.gov/nctic/newsletter_08-2007.asp).

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Domestic Violence

(Continued from page 4)

In order to reduce the impact of trauma, providers should be prepared to integrate or make referrals for children's services.

One research project found that providing services for children involved in domestic violence allowed greater access to such services for the mothers as well. When women claimed to go for services "mandated" for their children, the women could also access services for themselves. Thus, the strategy of child centered intervention may have lessened the batterer's suspicions of the mother's therapeutic activities.[6]

Providers can improve services greatly by starting with doable steps. Implementing trauma-informed treatment (see link in box, page 2) is key. Developing referral resources and screening procedures can also improve programs' COD capability.

Integration of these services may be challenging, just as integration of COD treatment can be. In COD treatment, providers of mental health and AOD treatment services struggle with making *both* diagnoses the primary diagnosis. Correspondingly, as noted in a 2002 working paper:

> Although providers from all three sectors do recognize the convergence of domestic violence, substance abuse, and trauma-related mental health issues, often one issue, depending on the setting, is seen as central, and the others are viewed as secondary problems that will resolve once the primary issue is addressed.[7]

Nonetheless, providers can improve services greatly by starting with doable steps. Implementing **trauma-informed treatment** (see link in box, page 2) is key. Developing referral resources and screening procedures can also improve programs' COD capability.

[6] *Op. cit.*, Magen, page 15.

[7] Domestic Violence and Mental Health Policy Initiative, 2002. Carole Warshaw and Gabriela Moroney, "Mental Health and Domestic Violence: Collaborative Initiatives, Service Models, and Curricula." Domestic Violence and Mental Health Policy Initiative, Chicago, IL, retrieved July 2008, (http://www.dvmhpi.org/Library.htm#Documents), page 12.

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THE COD WEB SITE CARRIES VALUABLE INFORMATION AT HTTP://WWW.ADP.CA.GOV/COD/

COJAC Screening Tool

(Continued from page 3)

issues to the Department directors. (For further information on COJAC, see the COJAC webpage at http://www.adp.ca.gov/cojac/ and page 5 of the April 2008 issue of the *COD E-Circular* at http://www.adp.ca.gov/COD/pdf/Vol%20%201,%20Issue%202%20-%20COD%20E-Circ.-%20Housing.doc .)

One of the five COJAC subcommittees, the Screening subcommittee, worked diligently to develop a short and easy tool to screen for COD. A key realization of the Screening subcommittee was that an underlying factor in the development of COD, especially for women, is the trauma of sexual abuse and domestic violence. The CST consists of nine questions, including three questions on these often undisclosed intimate violence issues, as well as three questions each on substance use and mental health.

The subcommittee carefully selected questions from other validated and "public domain" (available for public use at no charge) screening tools. The resulting specific sequence and selection of questions is now being scientifically validated.

Validation is the process of testing a tool by administering it to selected populations who, at the same time, complete other validated screening instruments. Generally, the tool being validated is tested on specific age, ethnic, and gender population groups. The tool being tested should successfully predict similar results as the established tool(s). If it does, the validity of the tool is substantiated for the tested groups.

The CST consists of nine questions, including three on intimate violence issues as well as three questions each on substance use and mental health.

If the CST proves valid, the field could benefit from a reliable, user-friendly, simple and short screening tool. It could be used in a wide variety of settings, including at emergency care facilities, criminal justice intake, school counselors' offices and battered women's shelters. Identifying individuals with COD is an important first step towards improving treatment.

COJAC performed pilot tests of the usability of the CST. The pilot tests indicate that the CST is useful in identifying COD in different settings—emergency rooms, etc.—and with different populations.

The CST questions are in the public domain. Some AOD treatment providers are using the CST. You can download the tool and further background information (a slide show) at http://www.uclaisap.org/slides/psattc/cod/2008/K_The_Cojac_Screener.ppt#478,7,Slide 7 or at http://www.adp.ca.gov/cojac/screening.shtml .

Module 7: Stage-specific Treatment/ Motivational Enhancement

Resources

* TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment: Selected Materials (http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA08-4212)
* Mueser et al: Integrated Treatment for Dual Issues.
* Miller and Rollnick: Motivational Interviewing, 2nd Edition (2002)
* Ziedonis and Trudeau
* Carey et al (2007)

Stage of Change Answer Categories (Minkoff and Cline)

In relationship to my "happy life" goal, for each problem or issue, which sentence best fits my position on the issue?

Precontemplation	You may think it's an issue, but I don't, and even if I do, I don't want to do anything about it, so don't bug me.
Contemplation	I am willing to discuss it, think about it, and consider whether to change, but I have no interest in changing, at least not now.
Preparation	I am ready to start changing, but I haven't started, and need some help to begin.
Early action	I have already begun to make changes and need some help to continue, but I am not committed to maintenance.
Late action	I am working toward maintenance but haven't gotten there, and need some help to get there.
Maintenance	I am stable and I am trying to stay that way as life throws challenges at me.

Stages of Change and Stages of Treatment

(Adapted from material at http://www.centerforebp.case.edu/)

Stage of Change	Stage of Treatment	Stage-matched Intervention
Pre-contemplation	**Engagement**	**Outreach** ♦ Provide outreach in community-based settings. **Trusting Relationship** ♦ Gain permission from people to share in their process of change. ♦ Ask what is important to people; Listen to and respect their priorities. ♦ Get to know the person for who they are. **Practical Support** ♦ Provide daily living support (food, clothing, housing, medicine, safety, crisis intervention). **Assessment** ♦ Assess continuously for personal histories, goals, and readiness-to-change.
Contemplation and Preparation	**Persuasion (Early & Late)**	**Motivational Interventions** ♦ Commit yourself to understanding people's goals. ♦ Help people understand the pros and cons of personal change. ♦ Help develop discrepancy between goals and lifestyles. ♦ Help people begin to reduce substance use and take medications. ♦ Help consumers recognize and take pride in their strengths and successes **Ambivalence is Normal** ♦ Assure people that ambivalence to change is a normal human response (change may occur slowly over time). **Pay-off Matrix** ♦ Use a pay-off matrix to help consumers tip their decisions away from ambivalence and toward positive action. **Education** ♦ Teach people about alcohol, drugs, mental illness, and activities that promote health and wellness. ♦ Offer skills-training opportunities. ♦ Reach out and provide education and support to families.

Stage of Change	Stage of Treatment	Stage-matched Intervention
Action	**Active Treatment (Early & Late)**	**Skill-building** ♦ Teach illness-management skills for both issues (e.g., refusal skills, managing triggers and cravings, recognizing symptom onset, communication skills, etc.). **Social Support** ♦ Encourage positive peer supports (e.g., self-help groups). **Cognitive-behavioral Interventions** ♦ Assist people with transforming negative thoughts and behaviors into coping skills for both issues.
Maintenance	**Relapse Prevention**	**Planning** ♦ Develop a relapse-prevention plan. ♦ Support people to maintain lifestyle changes learned in active treatment. **Recovery Lifestyle** ♦ Help people set new goals for enhancing their quality of life. **Social Support** ♦ Reduce the frequency, intensity, and duration of relapses by increasing positive peer relationships and supportive clinical relationships.

Evaluating Substance Abuse in Persons with Severe Mental Illness

(From the Evaluation Center at HSRI Toolkit: http://tecathsri.org/materials.asp)

Specific Clinician Rating Scales

Our clinician rating scales were originally developed for case managers to use in monitoring people; some are now incorporated as part of standardized data collection across the New Hampshire mental health system. We subsequently began to use these scales for research purposes and have repeatedly demonstrated their reliability and validity.

- Alcohol and Drug Use Scales

  The Clinician Rating Scales (CRS) for alcohol and drug use were developed to enable clinicians to assess and monitor substance use in persons with severe mental illness. The scales were based on DSM-III-R criteria, but can be modified in accordance with changes in diagnostic criteria in subsequent revisions of the DSM. Case managers who follow people closely in the community have access to

multimodal assessment data about their use of alcohol and drugs, including self-reports, observations across different situations, collateral reports from significant others and friends, and medical evaluations from different treatment settings. Case managers can easily be trained to incorporate these data into their CRS ratings in order to monitor people's substance use issues over time. Because of the problems of self-report and poor validity of standard instruments with this population, reviewed above, clinicians' ratings that incorporate multiple perspectives are usually superior to assessments based on the person's self-reports alone.

The CRS encompasses a simple classification system that corresponds to DSM-III-R criteria and also to severity in terms of clinical distinctions that are considered meaningful for this population. Thus, the categories of abstinent, use without impairment, abuse, dependence, and dependence with institutionalization comprise the CRS. An unusually large proportion of people with severe mental illness abstain from alcohol or drug use, particularly those people with poor premorbid functioning and more severe symptoms (Ritzler et al., 1977; Mueser et al., 1990; Dixon et al., 1991; Arndt et al., 1992). This isolation may be due to their severe social isolation and lack of awareness of social norms, including potentially destructive norms, which renders them less likely to be exposed to substance use and less able to maintain a pattern of regular use (Cohen & Klein, 1970). Non-problematic use is documented because these people tend to develop substance abuse if they continue using. Therefore, these people are important candidates for education and early intervention to prevent the development of a substance use disorder (Drake & Wallach, 1993).

Abuse, according to DSM-III-R criteria (American Psychiatric Association, 1987), is defined as a pattern of substance use that leads to significant impairment or distress in vocational, social, emotional, or medical functioning, or results in recurrent use in situations that are physically hazardous. These criteria can easily be tailored to persons with severe mental illness because they typically experience some negative effects of their substance abuse, such as inability to manage funds, maintain housing, or participate in rehabilitation. Dependence involves greater severity of the addiction process and is operationalized in terms of DSM-III-R criteria: e.g., greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of substance use, continued use despite knowledge of substance-related problems, marked tolerance, characteristic withdrawal symptoms, substance taken to relieve or avoid withdrawal symptoms. Other criteria, which are more typical of people with severe mental disorder, should probably also be included in this definition. Evidence from at least two studies indicates that the abuse-dependence distinction may be particularly important for

these people (Bartels, Drake, and Wallach, 1995; Noordsy et al., 1994). Finally, when people have difficulty maintaining themselves outside of institutional or homeless settings because of their involvement with substances, they are rated as severely dependent.

The CRS is reliable, sensitive, and specific when used by case managers who follow their mentally ill people over time in the community (Drake, Osher, & Wallach, 1989; Drake et al., 1990). Test-retest reliabilities over one to two weeks on small samples have been close to 100%. Inter-rater reliabilities, established by comparing ratings of clinical case managers and team psychiatrists, have yielded Kappa coefficients between .85 and .95 for current use disorder (Drake, Osher, and Wallach, 1989). An independent study used the CRS to rate recent and past alcohol and drug use issues, each separately, and found intraclass correlation coefficients ranging between .58 - .82, (Mueser et al., 1995). When CRS ratings were compared to consensus diagnoses generated by a team of experienced psychiatrists using all clinical, research, and treatment data available for each person to establish a current diagnosis of substance abuse or dependence, the CRS achieved a high sensitivity (94.7%) and specificity (100%) (Drake et al., 1990).

The ratings refer to an individual's particular pattern of substance use. Categories of abuse should include not just the usual groups of abused drugs, but also over-the-counter medications (e.g., antihistamines, "diet" pills) and prescribed medications (e.g., benzodiazepines), two types of substances that are often abused by persons with severe mental illness.

- Substance Abuse Treatment Scale

The Substance Abuse Treatment Scale (SATS) was developed to assess and monitor the progress that persons with severe mental illness make toward recovery from substance use disorder. Empirical observations by clinicians and people's self-reports indicated that persons with severe mental illness typically recover from substance use issues in a sequential fashion: First they become engaged in some type of treatment relationship. Second, they develop motivation to moderate or eliminate their use of alcohol or drugs. Third, they adopt active change strategies to attain controlled substance use or, more typically, abstinence. Fourth, they endeavor to maintain specific changes and build supports to prevent relapses. These observations led Osher and Kofoed (1989) to postulate four stages in the recovery process, which they called **engagement**, **persuasion, active treatment,** and **relapse prevention**. Clinicians who have used this four-stage model in New Hampshire since 1989 observed that they were actually able to differentiate early and late aspects of each stage, thus expanding the model to a total of eight stages—pre-engagement, engagement, early persuasion, late persuasion, early active treatment,

late active treatment, relapse prevention, and recovery—that corresponded to progress and treatment needs. These eight stages were defined with operational criteria.

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last six months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. **Pre-engagement:** The person (not client) does not have contact with a case manager, mental health counselor or substance abuse counselor.
2. **Engagement:** The person has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.
3. **Early Persuasion:** The person has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.
4. **Late Persuasion:** The person is engaged in a relationship with case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.
5. **Early Active Treatment:** The person is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.
6. **Late Active Treatment:** The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.
7. **Relapse Prevention:** The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days or problematic use, are allowed.
8. **Remission or Recovery:** The person has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.

Recovery from a substance use disorder is a longitudinal process that takes place over months or years. When clinicians do not understand the longitudinal process, they often bring unrealistic expectations to the interaction, offer interventions for which the person is not ready, and become frustrated. Use of the SATS reminds the clinician of the longitudinal process and permits the identification of treatment options that are appropriate for the person's current stage of recovery. Other advantages of using the SATS to assess and monitor people are that it allows the clinician to evaluate progress before abstinence is obtained and permits monitoring over time of specific people and programs (McHugo et al., in press).

Use of the SATS does not imply that recovery is a linear process. Substance abuse is a chronic, relapsing disorder. People typically backslide and cycle between stages, particularly early in treatment, as a natural part of the recovery process. Nevertheless, at any one point in time, treatment needs to be provided which is matched to the person's current stage of recovery (Drake & Noordsy, 1994). Thus, for example, a person who is homeless and living in a shelter must typically be engaged in a collaborative treatment relationship or working alliance before he or she will be interested in pursuing substance abuse treatment. As another example, once the person is engaged in a treatment relationship, he or she must have some motivation to pursue abstinence before successfully participating in one or more active, abstinence-oriented interventions. Before motivation is present, motivational interventions are more appropriate than strategies designed to reduce alcohol and drug use.

Initial studies of the SATS (McHugo et al., in press) indicate high inter-rater and test-retest reliability, with intraclass correlations typically around 0.9. Clinician ratings of the SATS also correspond strongly to ratings made by researchers, as well as to clinician ratings of substance use, and to the person's self-reports about alcohol and drug use. Correlations are in the 0.3 to 0.6 range on these measures of similar constructs, used to assess convergent validity. As a measure of discriminant validity, SATS ratings are correlated with assessments of progress in other functional domains in the 0 to 0.3 range.

The SATS can be used as either a process or an outcome measure. As a process measure, the SATS yields useful information to clinicians as to their most proximate goals in therapy and the techniques that may aid in helping a person progress to the next stage of treatment. Thus, the most immediate goal when working with a person in the pre-engagement phase is to work towards the next stage, engagement, by establishing an interpersonal helping relationship. Efforts to convince the person to address his or her substance abuse problem before such a relationship is established usually fail and may drive the person away from treatment. As an outcome

measure, the SATS enables clinicians and program evaluators to assess the success (or lack thereof) of treatment for substance use issues. A total lack of change or multiple backslidings over many years, as evident from repeated assessments with the SATS, might be used to question the interventions or programs being used to treat those specific people. In sum, the SATS can be used to guide the clinician's therapeutic work and to inform clinicians and program evaluators as to whether progress is evident in particular people or groups of people.

Necessary Data for Valid Clinician Ratings

We have briefly described in the preceding section the need for information from multiple sources for clinicians to make reliable and valid ratings on the CRS and SATS. This procedure relies on the clinician's actively pursuing, obtaining, and synthesizing information from a wide array of different sources. It assumes that case managers or other clinicians using these scales know their people well, understand the various clinical presentations of substance use issues and the recovery process, and are unbiased in their assessments. These assumptions are supported by previous research we have conducted on the use of these scales by clinicians in a variety of mental health settings. In this section we elaborate on the necessary types of data, including self-report measures, direct observations, collateral reports, urine drug tests, and assessments from other treatment settings.

- Self-Report Measures

  No single self-report instrument has great validity in this population, but such assessments can provide invaluable information about some people's use of alcohol and drugs. To obtain specific information about people's recent substance use, we recommend assessing the pattern of use over the past six months using the Time-Line Follow-Back (TLFB) method (Sobell et al., 1980). The TLFB involves having the person estimate the specific amount of alcohol and different types of drugs consumed each month over the past six months. Although these estimates may be biased towards underreporting, they are nevertheless useful in characterizing the pattern of abuse in people who admit to at least some alcohol or drug use.

  Once a pattern of substance use has been established, specific consequences of use can be evaluated by employing a checklist derived from the DSM. We also recommend supplementing the items on this checklist with additional items that are frequent problems in persons with severe mental illnesses. Self-report information, when combined with knowledge of common consequences of substance abuse in the psychiatric population, is often sufficient to evaluate the severity of a substance use disorder.

- Clinician Ratings Based on Direct Observations

  One of the most critical sources of information about substance abuse is the clinician's own observations of people's behavior at the mental health center or other treatment settings. For example, if people appear for appointments or attend groups when they are intoxicated, there is strong evidence that they have a substance use disorder. Other behavior changes may also provide clues about a possible substance abuse problem, such as missed appointments, unexplained symptom relapses, sudden interpersonal conflicts, or budgeting problems in a person who is ordinarily able to manage his or her money. Although observations of people in treatment settings are useful, information gleaned across different situations and at different times of the day in non-treatment settings is also very helpful. Such information is available to clinicians whose work is not solely clinic-based and who have the flexibility to meet with people in more naturalistic settings (e.g., at their homes, restaurants, parks).

- Collateral Reports

  Clinicians are frequently privy to a limited and biased sample of behavior based on their own contacts and observations of people. This over-reliance on a select sample of behavior can sometimes be overcome by obtaining collateral reports from others who have regular contact with the person. Other treatment providers, as well as shelter workers, housing staff, and family members are the most commonly available people, but reports may be available from others as well (e.g., friends, members of the clergy, law enforcement officials). When obtaining collateral reports about people's substance use behavior, it is useful for the clinician to review with the informant some of the common consequences of substance abuse in persons with severe mental illness, and the specific criteria included in the CRS. This discussion may highlight for the informant critical behaviors characteristic of a substance use disorder, improving their ability to aide in the monitoring of these problem behaviors. An important goal when soliciting collateral reports is to develop a working relationship with others who are familiar with the person's behavior outside of the usual treatment setting, so that ongoing information can be obtained from these same sources.

- Urine Drug Tests

  Urine drug tests cannot inform clinicians about the consequences of substance use, but they can identify which people have been recently using substances. Our experience has been that urine drug screens are more likely to be resisted by the clinicians who must administer them than by the people who provide samples. Therefore, once obstacles within a given treatment setting have been overcome, such

screens can be readily obtained, and they provide a unique insight into people's substance use. We recommend regular testing whenever the clinical situation suggests possible substance abuse and regular testing (e.g., at least every month) for those who are in the process of recovery (Drake, Alterman, & Rosenberg, 1993).

- Assessments from Other Treatment Settings

  Finally, clinicians need to be aware of all information available about people's substance use history in records from other treatment settings. People are often inconsistent about what they tell different treatment providers, and an accurate assessment can only be made when all possible sources of information have been compiled. For example, general medical records may provide information on alcohol-related problems.

Frequency of Clinical Assessments

Substance use issues in both the general population and among persons with severe mental illness tend to be chronic, often lifelong conditions. Because of the severity and persistence of these issues, they tend to improve with treatment at exceedingly slow rates. Stable changes often appear after years, rather than weeks or months, of attempts to change. The short-term picture, i.e., what happens over 30 days following an intervention, is not strongly predictive of stable changes. Therefore, for the purposes of both clinical and program evaluation, assessments need to be conducted on a regular basis over long periods of time. We recommend conducting formal clinician assessments (CRS, SATS) on all people in a mental health program every six months, although on-line clinicians should conduct informal assessments on a more frequent basis (e.g., monthly) in order to best meet people's needs. Furthermore, we recommend that routine assessments be conducted for at least a two-year period on any person who has a history of substance use disorder, even if that disorder is currently in remission. Long-term follow-up assessments are especially important in order to evaluate the success of programs aimed at improving the course of dually diagnosed people. Most of the available evidence suggests that brief programs lasting one year or less tend to produce only transient improvements in substance use disorder in this population.

For example, our studies in New Hampshire show a slow but steady progression toward attaining stable abstinence, so that few people appear to improve markedly over any six-month interval, but significant progress can be observed over two or three years (Drake, McHugo, & Noordsy, 1993; Drake, Mueser, Clark, & Wallach, in press; McHugo et al., in press). These studies document that recovery occurs slowly, in stages, over years. By three years, one-third to one-half have typically achieved substantial abstinence, and many others have moved into active, abstinence-oriented treatment with reduction in their use.

Setting

Substance abuse is an extremely environmentally sensitive disorder (Galanter, Castaneda, & Ferman, 1988; Moos et al., 1990). This means that a person's substance use behavior in one environment may not generalize to another setting. Thus, abstinence in an institutional setting, whether prison or hospital, or in a residential treatment setting, is not predictive of abstinence in less-restrictive settings in the community, as such people often relapse when they return to their usual community-living situations. The implications of this limitation are two-fold. First, assessments of substance use behavior need to be routinely conducted when a person's environment has changed, because there is little generalization of assessments across different settings. Second, intervention for people with substance use issues in highly restrictive environments must also extend the treatment into people's natural settings if treatment gains are to be maintained. The failure to provide a continuity of care from inpatient or residential-based treatments for substance use issues may be one reason why such approaches have not been found to have long-term impact (Drake, Mueser, Clark, & Wallach, in press). Thus, from the perspective of program evaluation, substance use issues require ongoing assessment, especially following a change from a more restrictive to a less-restrictive living arrangement.

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Module 8: Contingency Management and Community Reinforcement

Resources

* Contingency Management Handout (to be provided to Change Agents)
* Contingency Management Article: Shaner and Roberts
* Nancy Petry paper: www.bhrm.org

Contingency Management and Individuals with Multi-occurring Conditions

Definition

Contingency management refers to any strategy designed to promote behavioral learning and behavior change by using positive and/or negative contingencies in an organized manner to create rewards for engaging in the desired behavior(s)and/or consequences for engaging in less-desired behaviors.

With regard to multi-occurring issues, contingency management strategies can be used to promote change with regard to any issue.

Categories

Categories of contingency management can be based on the type of contingency management plan and/or the type of situation in which the contingency management is applied.

Types of Plan	**Single episode**	The contingency strategy is applied on a single occasion to deal with a single situation.
	Program policy	Program policies offer guidance to handle certain situations in a planned manner.
	Ongoing behavior plan	The person participates in an ongoing structure governed by a complex plan.
Types of Situation	**External**	Contingency situation arises completely outside the treatment setting (e.g., arrest, eviction).
	Treatment setting	Contingency situation arises through violation of program policies, or through request for special privilege within the context of treatment-setting policies or practices.
	Voluntary	Client chooses a voluntary plan to help attain specific goals.

Steps to Developing a Contingency Management Plan

Goals

- What does the person want? Identify this from the person's perspective as clearly and specifically as possible.

  Example: Female with paranoid schizophrenia in remission and cocaine dependence is arrested for attempting to buy drugs. She has relapsed after a period of abstinence. She requests a letter from her counselor for the probation officer. Specific questioning indicates that she needs the letter within two weeks, and needs it to state that she is compliant with both addiction and mental health treatment.

Learning Objectives

- What does the person want to learn or change, or what is the person willing to learn or change in this situation, that relates to the specific goal? What do we want the person to learn or change? Learning objectives should be directly connected to a formulation about why the person is in this situation in the first place. List as many activities as possible that would demonstrate change in the desired direction.

  Example: In the above situation, the person's relapse is connected to lack of participation in recommended addiction-relapse-prevention activities. Client is willing to acknowledge that re-engagement in those activities would be a positive step to achieve. Desired activities might include participation in addiction treatment programming, attendance at 12-step meetings, contacting recovering people, living in a sober setting, providing clean urine (or other) screens, maintaining a recovery log, performing writing or reading assignments, taking Antabuse or other addiction treatment medication, if indicated.

Contingencies

- What are the consequences for the person if no intervention occurs? What rewards or contingencies are available to the clinical team? List all that apply, in consultation with the person. Also consult with collateral treaters, family members, etc., who may control contingencies, for confirmation.

  Example: This person is at risk of going to jail (she is already on probation) without such a letter. This is confirmed by communication with the probation officer, who also specifies the necessary content and time frame for the letter. The treatment team controls whether or not the letter is provided, its content, and its time frame.

Contract

- Develop an initial structure that connects demonstration of the objectives to achievement of the contingencies. Consult with the person to establish if this structure appears reasonable. Determine what the response will be if the person does not engage in the desired behavior.

  Example: Client is informed that a letter can certainly be written to the probation officer, but it cannot ratify that she is compliant with substance abuse treatment until she once again demonstrates that to be the case. She agrees that this is fair.

Details

- Begin to flesh out the specific details of the contract with regard to the following parameters:
  - **Balance** (Expectations fit the situation.)
  - **Choice** (The person's choices are defined, and the consequences of either choice are acceptable to the clinician and reasonable for the person.)
  - **Measurability** (Behaviors and consequences are able to be adequately measured and monitored to implement the contract.)
  - **Practicality** (Components of the contract can actually be implemented within the context of the real-world situation.)
  - **Capability** (The person is capable of performing the requested behavior, and the clinical team is capable of providing the necessary responses.)
  - **Loophole Management** (The contract is reviewed to locate and eliminate loopholes.)

    Example: Because the letter has to be written within two weeks, practicability requires that the person demonstrate specific behaviors during that time frame. Balance and capability require that she do things that have been demonstrated to work for her in the past, and not to do more than necessary unless the first level is shown not to work. All the behaviors have to able to be specifically measured for inclusion in the letter. Because the person is risking jail if she chooses not to comply with the requirements, she has to feel that the things she is being asked to do make sense in terms of her own sense of what she needs to do. In this regard, in order to receive a letter saying that she is complying with treatment recommendations, she is asked to enter a dual-diagnosis partial-hospital program (where she has gone in the past, and which has openings), obtain weekly urine screens, and attend at least three 12-step meetings per week, obtaining signed slips. Loophole management requires an analysis of what

happens if the person does only some of the requirements. The answer is that if this happens, the letter will document that she has failed to perform some of the recommended activities, and specify which activities. The probation officer and judge will then make their decisions based on this information; consequently, she will be at greater risk for going to jail if she does not follow through on all recommendations.

Negotiation and Review

- Negotiate the final contract structure with the person and all involved collaterals. Make sure that everyone who has a stake in the contract has had a chance to review and think it through. Write down the final agreement, if at all complicated. Establish a mechanism and time frame for review and/or renegotiation by any party if the contract appears to be unsuccessful.

  Example: The person is told to contact the partial-hospital program and report back with the results within 48 hours. She is informed that at that time there will be an opportunity to review and renegotiate if any of the conditions turn out to have unanticipated implementation barriers, or if other circumstances change.

Principles of Good Contingency Management Planning

- **Learning, not punishment; empathy, not anger.** Good plans are based on a positive caring connection, not an urge to retaliate. The benchmark is the degree to which the person learns, not the degree to which he or she suffers.
- **Positive consequences are at least as valuable as negative.** Learning is supported by the opportunity to gain rewards at least as much as the opportunity to avoid punishment. Try to give the person as much as possible to be helpful.
- **Win/win is better than win/lose.** Even if the person makes the "wrong" choice, learning should be encouraged, and help provided. The idea is not to coerce the person by loading up punishment on the wrong choice side, but rather to facilitate the right choice. Similarly, always try to provide opportunities for redemption—if the person does poorly, how can he or she regain the reward in a reasonable time frame?
- **Less is more.** It is easier to create manageable, replicable, balanced plans if the rewards and consequences are "smaller" and applied more frequently and consistently, e.g., provide opportunities to earn a small reward (points, money) daily or weekly, rather than gain or lose a large reward monthly or quarterly. Managing fewer contingencies more reliably is more likely to be successful than trying to manage every aspect of the individual's behavior.

- **Assume the person will find the loopholes.** Don't base plans on wishful thinking. Anticipate loopholes and close them, or don't implement those aspects of the plan. Similarly, it is worth the time to carefully think through the plan prior to implementation in order to avoid setting in motion a plan that has major flaws.

Program Policies and Contingency Planning

Program policies can be designed ahead of time using contingency-management strategies to promote learning, rather than simply being an exercise in trying to control the person's behavior. In this way, each "violation" of a rule can become welcomed as a learning opportunity. One strategy for doing this is the "menu approach." This approach will be illustrated using the example of a day treatment program or psychosocial rehabilitation program.

Program policy identifies specific behaviors that would constitute violations of program rules. With regard to substance use issues, for example, in a typical psychosocial rehabilitation program, abstinence is not required, but bringing drugs or alcohol on the premises would be considered a violation because it creates an unsafe environment for all people. (Some programs involve a client council in establishing these policies.)

For each violation, Column A of the "menu" identifies a list of possible consequences for that violation (e.g., suspension, additional chores, loss of a privilege or reward). Column B lists possible treatment-related activities that might address learning objectives related to that violation (e.g., attending AA meetings; written assignment regarding substance use and its problems; talking to peers regarding substance use problems; attending treatment groups regarding substance use, etc.). Column C lists possible rewards that might be offered for improvement.

The policy might then specify that for the first violation the person is offered a choice between one of the column A consequences or one of the column B activities. The choices offered would be selected by staff (and/or peers) to suit the individual's needs and strengths. The individual would suffer more consequences for repeated violations, but would also be offered the opportunity to "clean the slate" by successful accomplishment of defined goals. Exceeding expectations might be attached to achieving a reward from column C.

Developing Ongoing Contingency Management Plans

Whether a person is engaged in a coercive treatment situation (as via drug court), or voluntarily decides to seek change, it is frequently helpful to develop ongoing person-specific behavior plans that promote change for that person. Ideally, such plans build contingencies into daily activities that are monitored, with specific rewards and

consequences attached to positive or negative behavior. Rewards and consequences should be designed to be responsive in time to the behavior (that is, quickly applied, and quickly reversed), and renewable (that is, able to be applied recurrently over time). Examples of such contingencies include point systems, provision of money via payeeship, frequency or closeness of monitoring (visits, urines), length or content of social or family activities, etc. The following is an example of how such a plan might be constructed.

> After discharge from residential treatment, the person returns to his apartment with a requirement by probation that he be closely monitored for relapse. The person is afraid of returning to prison, and feels he needs more structure so as not to slip back into bad habits; however, he is very resistant to living in a group setting because he knows that his anger can get him into trouble and precipitate relapse. He is offered an opportunity to use his payeeship status to create a behavioral plan that ties his money to his daily performance on recovery activities. With the help of his counselor he identifies 10 daily activities that can help him maintain sobriety, and agrees to receive 20 cents (up to $2 per day from his disability check) for each activity that he accomplishes each day. These activities include attending a self-help meeting (signed slip), keeping a daily log of substance use and feelings, taking Antabuse, making a telephone call to staff to commit sobriety each day, making a call to a peer at noon each day, taking his psychotropic meds, attending PSR in the morning, attending PSR in the evening, writing a daily meditation from his AA 24-hour book, and reading a chapter of *Living Sober* and writing a paragraph on what he learned.

As an exercise, review the above initial contract for loopholes. Can you identify at least five possible loopholes, and suggest some strategies for addressing each one in the final contract?

Case Example

This case example illustrates a variety of applications of contingency management in a single case. The sequence of interventions begins with admission to the psychiatric inpatient unit for detoxification from alcohol and stabilization of psychosis.

- Promotion of medication adherence

  > Following detoxification from alcohol, the person began refusing antipsychotic medication (olanzapine) and demanding continuation of benzodiazepines. He still appeared quite paranoid and psychotic. He denied significant opposition to olanzapine; he simply stated that he didn't think it would help him that much when he really needed help with his anxiety. He was offered a plan where each time he took olanzapine he would receive an injection of lorazepam. After his paranoia subsided, the lorazepam was able to be discontinued.

- Group participation

  The person continually refused to attend groups, stating that housing was his only problem, and demanding to see his case manager. He was told by staff and by his case manager that receiving housing assistance would be facilitated by his showing that he was working on being able to get along better with other people so that he would not be evicted again. In order to show this, he was told that he needed to attend groups. He was placed on a point system in which he received one point for attendance, and one point for participation. Points could be "traded" for additional walks and smoking time each day. When he accumulated 25 points, his case manager would begin to work on housing.

- Addiction Treatment Referral

  His case manager began to take him out to look at housing, showing him both nice places and much-less-nice places. The case manager told him that landlords in the nicer places would not rent to him because of his previous eviction due to substance problems, but that if he went to addiction treatment he might be able to get better housing. This was supported by direct discussion with two landlords. The person had been opening up in the drug and alcohol education groups, and was more willing to think he had a problem. The plan was set up that if the person went to Turquoise Lodge and completed the program, he could be referred to nicer housing.

- Addiction Treatment Participation

  At Turquoise, the person was initially overwhelmed by the level of expectation, and began to withdraw, and then threatened to leave. His counselor set up an individualized behavior plan where he was able to receive stars each day for achieving small-step objectives. His reading and writing assignments were simplified; he was permitted to sit in group without talking if he felt safer that way, etc. If he received enough stars each week he was credited for program completion, even though he had not done as much as some of the other people. As he felt more successful, he began to participate more effectively and learn more in the groups.

- Aftercare Sobriety Plan

  Once he was discharged, he was eager to live independently, though his treatment team felt he would be at high risk for relapse. He agreed to a daily behavior plan tied to his payeeship to reward him for engaging in positive recovery activities each day. (See above example.) He expressed interest in opportunities to work, and referrals to supported work placements were tied to successful point accumulation on his daily behavior plan.

Module 9: Active Treatment—Skills Training

Resources

- Roberts et al., *Overcoming Addictions* (selections): Liberman Substance Abuse Management Module
- Bellack: *Behavioral Treatment of Substance Abuse in Schizophrenia*
- Healthy Skills for Abstinence (below)

Example Exercise: Healthy Skills for Abstinence

Daily Activity Sheet

The following list of activities is intended to help people be more successful on any given day in working toward the goal of reducing or eliminating substance use. Our philosophy is that we recommend abstinence, and we work with people to achieve that recommendation by identifying strengths and rewarding positive behaviors in preference to establishing negative consequences alone.

- Person makes a phone call in the morning to commit abstinence to case manager, sponsor, or peer.
- Person commits abstinence to caregiver in the morning, verbally or in writing.
- Person keeps daily log of substance activities and provides log to caregiver or case manager.
- Person reads one paragraph or meditation in AA 24-hour-a-day book.
- Person takes psychotropic medication as prescribed.
- Person takes medication for addictive disorder as prescribed: Antabuse, bupropion, naltrexone, nicotine patch.
- Person schedules sober activity in the morning, with or without peers/staff.
- Person attends healthy-living group at day treatment program in the morning.
- Person calls peer/staff for support at one or more prescribed times during the day, with or without supervision.
- Person schedules sober activity in the afternoon, as above.
- Person attends group at day treatment in the afternoon.

- Person attends 12-step meeting.
- Person schedules sober activity in the evening.
- Person reports progress during the day to caregiver. Client is rewarded for honesty even if there is a slip.
- Person provides urine for screening.

Module 10: Addiction Recovery Supports and Treatment

Resources

- Twelve Steps and Dual Issues:
  - Dual Recovery Anonymous (www.draonline.org)
  - Dual Diagnosis Recovery Network (www.dualdiagnosis.org)
- Double Trouble in Recovery (http://www.bhevolution.org/public/doubletroubleinrecovery.page)
- Dual Diagnosis Anonymous Materials
- Daley and Moss, 3rd Edition: Dual Issues: Counseling Clients with Chemical Dependency and Mental Illness
- Evans and Sullivan: Counseling the Mentally Ill Substance Abuser (2nd Edition)
- Eikeberry: Personality Issues and Addiction

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Module 11: Substance Use Disorders in People with Physical and Sensory Disabilities

Introduction

The following material on substance use disorders in people with physical and sensory disabilities is new material from SAMHSA that is included in the Iowa Change Agent Manual as a reference/resource for direct care staff in any setting.

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Substance Abuse and Mental Health Services Administration
SAMHSA
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IN BRIEF
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SUBSTANCE USE DISORDERS IN PEOPLE WITH PHYSICAL AND SENSORY DISABILITIES

Approximately 23 million people in the United States, including people with disabilities, need treatment for substance use disorders (SUDs), a major behavioral health disorder.[1] In addition, more than 24 million adults in the United States experienced serious psychological distress in 2006.[2] People with and without disabilities may face many of the same barriers to substance abuse treatment, such as lacking insurance or sufficient funds for treatment services, or feeling they do not need treatment.

In addition, people with disabilities may face other barriers to SUD treatment, particularly finding treatment facilities that are fully accessible. Vocational rehabilitation (VR) counselors, vocational education providers, and others who work with people with disabilities report that their clients with SUDs have less successful vocational outcomes than clients without SUDs.[3]

To improve outcomes, it is important that clients with disabilities and SUDs receive services for both conditions and that the disabilities do not prevent clients from receiving treatment for SUDs. This *In Brief* is intended to help people who work with people with physical and sensory disabilities—hearing loss, deafness, blindness, and low vision—to better understand SUDs and assist their clients in finding accessible SUD treatment services.

What is an SUD?

Substance use disorder is a broad term that encompasses abuse of and dependence on drugs or alcohol (Exhibit 1). It includes using illegal substances, such as heroin, marijuana, or methamphetamines, and using legal substances, such as prescription or over-the-counter medications, in ways not prescribed or recommended.

SUDs Harm People With Disabilities

It is difficult to estimate the number of people with physical disabilities who have SUDs. Some studies suggest that people with disabilities have higher rates of legal and illegal substance use than the general population, whereas other studies show lower rates.[5] Although debate exists among researchers about the prevalence of SUDs among people with disabilities, there is agreement that active SUDs can seriously

Exhibit 1. Defining Substance Abuse and Dependence

Both substance abuse and substance dependence refer to maladaptive patterns of substance use. ***Substance abuse*** usually refers to using any substance in a way that leads to a failure to fulfill major responsibilities at work, school, or home, or to substance-related legal or interpersonal problems. It also includes using substances in situations that put one's physical safety at risk. ***Substance dependence*** usually manifests as continued use of a substance despite negative physical or psychological effects, inability to cut down or control the use of the substance, tolerance (using more of the substance to get the same effect), and withdrawal symptoms when the substance is no longer consumed. *The Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR)[4] provides fuller definitions of substance abuse and substance dependence.

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harm the health and quality of life of individuals with disabilities. An active SUD can:

- Interfere with successful engagement in rehabilitation services.[3]
- Interact with prescribed medications; alcohol, for example, can interfere with antiseizure medications.
- Impede coordination and muscle control.
- Impair cognition.
- Reduce the ability to follow self-care regimens.
- Contribute to social isolation, poor communication, and domestic strife.
- Contribute to poor health, secondary disabling conditions, or the hastening of disabling diseases (e.g., cirrhosis, depression, bladder infections).
- Inhibit educational advancement.
- Lead to job loss, underemployment, and housing instability.

Women With Disabilities and SUDs

Across all age groups, more women than men are disabled.[6] Women with co-occurring disabilities and SUDs are at high risk for experiencing physical abuse and domestic violence.

One study of people with disabilities and SUDs found that 47 percent of women reported histories of physical, sexual, or domestic violence, compared with 20 percent of men with disabilities reporting abuse experiences. In the same study, 37 percent of women reported sexual abuse, compared with 7 percent of men.[7]

Another study found that 56 percent of women with disabilities reported abuse, with 89 percent of these reporting multiple abusive incidents.[8] What is more, being a victim of physical or sexual abuse is a risk factor for SUD.

SUD Risk Factors and Warning Signs

For some people, drug or alcohol abuse is a direct or indirect cause of their disability, for example, by their becoming intoxicated and then falling or causing a car crash. Without SUD treatment, people who had SUDs before sustaining a disability will likely continue to use substances afterward. Other people may have developed SUDs after using substances such as pain medications or alcohol to cope with aspects of their disability or to cope with social isolation or depression. Exhibit 2 lists SUD risk factors for people with disabilities.

Exhibit 2. SUD Risk Factors for People With Disabilities

- Pain
- Access to prescription pain medications
- Chronic medical problems
- Depression
- Social isolation
- Enabling by caregivers
- Unemployment
- Limited education
- Low socioeconomic level
- Little exposure to SUD prevention education
- History of physical or sexual abuse

Numerous signs may suggest the presence of an active SUD. These include, but are not limited to:

- Dilated or constricted pupils.
- Slurred speech.
- Inability to focus, visually or cognitively.
- Unsteady gait.
- Blackouts.
- Insomnia.
- Irritability or agitation.
- Depression, anxiety, low self-esteem, resentment.
- Odor of alcohol on breath.
- Excessive use of aftershave or mouthwash (to mask the odor of alcohol).
- Mild tremor.
- Nasal irritation (suggestive of cocaine insufflation).
- Eye irritation (suggestive of exposure to marijuana smoke).

- Odor of marijuana on clothing.
- Abuse of drugs or alcohol by family members.
- Many missed appointments with VR, job interviews, and the like.
- Difficulty learning new tasks.
- Attention deficits.
- Lack of initiative.

Some manifestations of certain disabilities may be difficult to distinguish from the signs of SUDs mentioned above. For example, people with multiple sclerosis may have an unsteady gait, slurred speech, and memory impairment. Other signs, such as depression or anxiety, may indicate a different, distinct behavioral health condition.

Screening for SUDs

Screening is not the same as diagnosing; it simply indicates whether further evaluation by an SUD professional is indicated. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) developed a single-question screening tool for alcohol use disorder (Exhibit 3). Clients should also be screened for illicit drug use and prescription medication abuse. VR professionals, physical therapists, and others may benefit from training on how to administer screening and assessment tools.

Exhibit 3. Single-Question Screening Test

Ask men:	"How many times in the past year have you had 5 or more drinks in a day?"
Ask women:	"How many times in the past year have you had 4 or more drinks in a day?"

A response of more than 1 day is considered positive.

Other common screening tools are:

- Alcohol Use Disorders Identification Test, available at http://www.projectcork.org/clinical_tools/html/AUDIT.html
- Michigan Alcoholism Screening Test, available at http://www.projectcork.org/clinical_tools/html/MAST.html
- Drug Abuse Screening Test (including prescription drugs), available at http://www.projectcork.org/clinical_tools/html/DAST.html
- National Institute on Drug Abuse (NIDA)-modified Alcohol, Smoking, and Substance Involvement Screening Test, which includes prescription drugs, available at http://www.drugabuse.gov/nidamed/screening/

Screening is not the same as diagnosing; it simply indicates whether further evaluation by an SUD professional is indicated.

No screening tools have been validated in Deaf populations.[9]

If possible, clients who exhibit warning signs or symptoms should be screened for SUDs. If screening is not possible or if the screening is positive, the client should be referred to an SUD treatment provider for further assessment.

Some clients may benefit from a brief intervention (a discussion of 5 minutes or less) to prevent their substance use from becoming an SUD. Information on brief interventions for alcohol use disorders is available from

The Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment Family Centered Substance Abuse Treatment Grants for Adolescents and their Families (Assertive Adolescent and Family Treatment) was designed to provide substance abuse services to adolescents (including those with disabilities and those from military families) and their families or primary caregivers in geographic areas where services are needed. Grantees implement evidenced-based practices that are family centered and context specific and focus on the interaction between youth and their environments.

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NIAAA at http://pubs.niaaa.nih.gov/publications/AA66/AA66.htm. Clients whose signs suggest a mental health issue should be referred to a professional for further assessment.

Types of SUD Services

SUD services include:

- *Prevention education*—information in various formats that helps people understand the risks of substance use.
- *Indepth assessment*—an evaluation by a treatment provider to determine whether an SUD is present and, if so, what level of care is needed and what treatment options are available.
- *Outpatient or inpatient detoxification*—medically supervised withdrawal from alcohol or drugs.
- *Outpatient treatment*—psychosocial interventions and individual and group counseling on substance use.
- *Medication-assisted treatment and counseling*—methadone, buprenorphine, and other medications for opioid dependence or acamprosate, disulfiram, and naltrexone for alcohol use disorders; medication-assisted treatment works best if combined with psychosocial counseling interventions.
- *Residential programs*—short- and long-term structured living to help people re-enter their community.

In addition, people in recovery often attend mutual-help groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and SMART (Self Management and Recovery Training) Recovery to share experiences and support one another's recovery efforts. Many meetings of AA and NA that are wheelchair accessible are identified in meeting lists. Online meetings are an option for those who are Deaf and hard of hearing, people with visual disabilities, or people who live in locations without accessible meetings. Some AA groups will pay for a sign language interpreter or make use of sign language interpreters who are in recovery themselves.

Accessible SUD Treatment Facilities

Despite requirements of the Americans with Disabilities Act (ADA), studies suggest that many treatment facilities are not fully accessible to people with disabilities.[10, 11, 12, 13, 14] Examples of physical barriers include doors and hallways too narrow for wheelchairs, uneven flooring, nonfunctioning elevators, and a reliance

Barriers to Treatment for People Who Are Blind or Visually Impaired

A survey of VR counselors and SUD treatment providers found that barriers to SUD treatment for people who are blind or visually impaired are formidable. Frequently identified barriers are presented below:

- Negative attitudes and prejudices about people with SUDs. Some VR professionals regarded people with SUDs and disabilities as "not worthy" of SUD treatment, particularly if outcomes are perceived as poor for people with these two co-occurring conditions.
- Lack of staff training. SUD counselors reported a need to learn about working with people who are blind, and VR counselors report a need to learn about SUDs in their clients.
- Inaccessible methods and materials. Many facilities that provide SUD services reported that they are "handicapped accessible" if they provide ramps for clients. But people who are visually impaired require Braille signs and other navigational features and alternatives to sight-based counseling treatment activities like films and booklets to have genuine accessibility to treatment services.

Survey respondents noted it is important to identify which agency will coordinate comprehensive client care. Respondents also commonly mentioned that, because there are no formal mechanisms for shared communication and case management, SUD and VR services providers may not know how to manage cases and work together across fields to provide services for their clients.[15]

Treatment Innovations for People Who Are Deaf or Hard of Hearing

Few fully accessible SUD treatment services exist for people who are Deaf. Specialty treatment facilities for people who are Deaf exist, but the number has declined in the last decade. In 2009, only five providers in the United States offered inpatient SUD services especially for people who are Deaf, and four provided outpatient treatment.[16] A national survey in 2008 by SAMHSA found that 27 percent of opioid treatment facilities offered interpretation services for people who are Deaf or hard of hearing.[17] However, there are numerous barriers to providing fully accessible mainstream SUD treatment to people who are Deaf, including cultural and linguistic barriers, lack of local SUD treatment providers trained to work with people who are Deaf, lack of American Sign Language interpreters, inability of people who are Deaf to participate in group counseling (a mainstay of SUD treatment), increased costs associated with making treatment accessible to people who are Deaf, and more.[18]

One way to fill the treatment gap is to advocate telehealth SUD treatment services for people who are Deaf. Telehealth technology, such as electronic mailing lists and video conferencing, can connect people who are Deaf to appropriate SUD specialists across the country, and it can be adapted for an array of SUD services, from recovery support after treatment to mutual-help groups. Telehealth could also be used to train more people who are Deaf to be SUD counselors. One promising model piloted by Wright State University is Deaf off Drugs and Alcohol (DODA), a program for Ohio residents that supplements local SUD treatment with Internet- and video-based case management, group therapy, individual therapy, and followup. DODA also manages mutual-help/12-Step meetings available 7 days a week, which are conducted via video conferences and open to anyone in the country.[18] More information on innovative SUD services for people who are Deaf is available at http://www.med.wright.edu/citar/sardi/doda.html.

on signage to provide directions, which leaves people with low or no vision without a means to find their way through facilities.

Many other types of barriers exist. Some SUD treatment administrators believe that their facilities are more accessible than they actually are.[14] Of various types of healthcare providers, outpatient SUD treatment providers are among the least likely to report that their services are accessible to people with disabilities or that they have had training on mobility impairments.[10]

Comparatively little information is available on how many people with disabilities have been denied SUD treatment because of physical barriers in the treatment facility itself. One survey of 174 SUD treatment providers in Virginia found that 87 percent of people with multiple sclerosis, 75 percent of people with muscular dystrophy, and 67 percent of people with spinal cord injuries who sought services were denied SUD treatment services because of physical barriers at the treatment facility.[13]

Ways to Help Clients With SUDs

VR counselors, physical therapists, and others who work with people with disabilities are in a good position to understand the importance of identifying and treating behavioral health conditions, such as SUDs, and to advocate for their clients' right to accessible SUD treatment services. To help clients with SUDs:

1. Learn about behavioral health issues, such as SUDs, and promote prevention. A wealth of information about drug and alcohol use, abuse, and dependence and their consequences can be found online.

- Free ADA-compliant publications on SUDs can be downloaded from SAMHSA's Publication Ordering Web page, at http://www.store.samhsa.gov/home
- Information about drugs of abuse is on NIDA's Web site, at http://www.nida.nih.gov
- Information about alcohol use disorders is located on NIAAA's Web site, at http://www.niaaa.nih.gov

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- An overview on SUDs for VR counselors, *Substance Use Disorders and Vocational Rehabilitation: VR Counselor's Desk Reference,* and other information on substance use and people with disabilities is available from Wright State University, at http://www.med.wright.edu/citar/sardi/products.html

2. Don't ignore signs of a possible SUD in clients with disabilities. When there is doubt that disability alone explains a sign or behavior, screen the client for an SUD or refer the client to a behavioral health specialist for further evaluation. SUD is a preventable and treatable condition. A nonjudgmental approach to giving feedback to clients about the potential consequences of their substance use can enhance their motivation to seek further evaluation and treatment.

3. Build a directory of local treatment providers and facilities that work with or would be willing to learn to work with people with disabilities. SAMHSA's online Substance Abuse Treatment Facility Locator includes more than 11,000 U.S. treatment facilities. State-specific information is available at http://dasis3.samhsa.gov.

Online recovery meetings are available in a variety of formats, including text-based chats and discussion forums, audio and telephonic meetings, and video meetings. Information about online meetings is available at:

- Alcoholics Anonymous Online Intergroup
  http://aa-intergroup.org/index.php
- Narcotics Anonymous Chat and Online Meetings for Drug Addicts
  http://www.12stepforums.net/na
- SMART Recovery Online
  http://www.smartrecovery.org/meetings/olschedule.htm

4. Where possible, **help SUD treatment administrators understand how they can make their facilities accessible to people with disabilities.** SAMHSA's Treatment Improvement Protocol (TIP) 29: *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities,* was written to help SUD treatment providers work with people with cognitive and physical disabilities. Appendix D, in particular, is useful for advocating accessibility in treatment facilities. The TIP is available online at http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A52487. A *Quick Guide* based on TIP 29 was created to help SUD treatment administrators comply with ADA requirements and better serve people with disabilities. The *Quick Guide* is available at http://www.store.samhsa.gov/product/QGCT29.

Other resources include:

- Baylor College of Medicine Center for Research on Women with Disabilities
  http://www.bcm.edu/crowd
  Click on "Secondary conditions." From the resulting page, click on "Substance abuse."
- Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals
  http://www.mncddeaf.org
- Wright State University Substance Abuse Resources and Disability Issues (SARDI) Program
  http://www.med.wright.edu/citar/sardi
  Many links are available from the SARDI home page. The "Materials" link offers access to several print resources available free or for a small fee. These include *Substance Use Disorders and Vocational Rehabilitation: VR Counselor's Desk Reference; Substance Abuse, Disability & Vocational Rehabilitation;* and *Blindness, Visual Impairment, and Substance Abuse.*

5. Once a client enters treatment and is ready for VR, **work with the client's primary care physician, SUD case manager, and other treatment professionals to best serve the client.** TIP 29 (Chapter 4) presents ideas on establishing linkages for case management. The chapter can be viewed at http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A52886.

Resources

TIP 29: *Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities,* offers treatment providers guidelines on caring for people with either physical or cognitive disabilities, as well as drug abuse or alcohol abuse problems. The TIP discusses screening, treatment planning, and counseling, and links to other service providers (http://www.ncbi.nlm.nih.gov/books/NBK14408/).

Products based on TIP 29:

KAP Keys for Clinicians Based on TIP 29: Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities
http://www.kap.samhsa.gov/products/tools/keys/pdfs/KK_29.pdf

Quick Guide for Clinicians Based on TIP 29: Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities
http://www.kap.samhsa.gov/products/tools/cl-guides/pdfs/QGC_29.pdf

Quick Guide for Administrators Based on TIP 29: Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities
http://www.kap.samhsa.gov/products/tools/ad-guides/pdfs/QGA_29.pdf

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In Brief

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In Brief
Substance Use Disorders in People With Physical and Sensory Disabilities

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Module 12: Psychopharmacology and Multi-occurring Conditions

Introduction

Psychopharmacology and psychopharm practices are resources available to individuals who have conditions or disorders that need medications and medication management for stabilization, remission or cure of the symptoms of those conditions or disorders. Almost everyone who is in care or supports is either on medicines, thinking about being on medicines, related to someone on medicines or otherwise knows someone on medicines. In all practicality, we are all making medication decisions (or having them made for us, at times), even if our decision is not to take any at all. Everybody should understand the basics of what medications are for, how to use them appropriately, and how not to interfere with another person's decisions and choices regarding their own use of medications. As well, people can be helped to make decisions and choices regarding medications, prior to needing them, such as in the case of advanced directives for psychiatric crisis management.

Learning Illustrations

- Talking about medications in Group: "What do I say in my AA meeting about my meds?"
- Understanding the difference between a medication and a drug.
- Fundamentals of which medications help treat what conditions or disorders.
- Talking to your family about your medications.
- How to track your symptoms and side effects.
- Understanding risks and benefits of medications.
- Talking to your prescriber about your medications and your "other" multi-occurring issues/how to take medications more safely when you are still using substances.
- Medications and brain vulnerabilities: Special considerations.
- Medications and guardianship: Rights and responsibilities.

Psychopharmacology Practice Guidelines

Psychopharmacologic practice for people with multi-occurring disorders is complex. It is not an exact science and requires a partnership between the prescriber, the person, and a team or natural support system to work as well as possible. While it is not exact in nature, prescribing for people with multi-occurring conditions has become more effective and safer over the last decade because of improvements in people being able to get such working partnerships, becoming knowledgeable consumers, having access to safer and more effective medications, and much-improved quality improvement oversight. Another advancement that has helped is the development of organized psychopharm practice guidelines for practitioners to use in shaping complex decisions and supporting each other in activities such as "second opinion" processes. Guidelines are just that; they are not standards, but simply tools to support good clinical judgment.

It is important for every Change Agent to think of him- or herself as being able to be helpful to people and families making medication decisions and as a partner in helping them develop the skills to successfully implement those decisions. There are many opportunities to be helpful, but this requires at least a solid "layperson's" understanding of psychopharmacology and then an awareness of psychopharm practice guidelines. Some Change Agents will be licensed prescribers, and as such, practice guidelines become even more important to know of and begin to use as tools in your practice decision-making. Most Change Agents will not be prescribers, but all Change Agents will have something to do with helping people with multi-occurring conditions who are making medication decisions. A basic knowledge of helpful psychopharmacologic practices and skills to support people with multi-occurring conditions is a core competency for all care providers.

Learning Illustration

- Do we have psychopharm practice guidelines in our clinic or setting? How do they address the needs of people and families with multi-occurring conditions? Are they based in the principles of excellent care for people with complex conditions?
- Do we have an improvement process in our organization to assess the effectiveness and client safety of our psychopharm practices?

Examples of Psychopharmacology Practice Guidelines

In Appendix I, you will find two examples of psychopharmacology practice guidelines for people with multi-occurring conditions:

- Practice Guidelines for Co-occurring Mental Health and Subtance Use Disorders

- Guidelines for the Use of Psychotropic Medications for Individuals with Developmental Disabilities and Mental Health Conditions

Reading through these two sets of example guidelines is informative and gives Change Agents a "resource in hand" when being helpful to the prescribers in their own organizations.

Learning Illustration

- Review and application of the practice guidelines in Appendix I.

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Module 13: Housing and Homelessness

Resources

- Tsemberis: Pathways to Housing
- American Association of Community Psychiatrists (AACP) Position Statement on Housing Continuum
- Housing Grid

  Instructions: Match individual needs to preferences. **Uses**: Individualizing housing; creation of housing services to provide individualized, stage-matched options. Each variable is independent—choose one descriptor from each column.

Lifestyle Composition	Level of Support	Level of Programming	Location of Programming	Level of Substance Use Onsite	Level of Staffing	Level and Type of Childcare
Lives alone	High (On-site individual, medical assistance, food preparation by staff/individual, household main-tenance assistance)	None	On-site (Residential, inpatient psychiatric)	Dry (Abstinence expected and maintained)	High: On-site (Staff of counselors, groups & facilitators, peer specialists, psychiatrist)	None
1 or 2 roommates	Moderate (Both: on-site & off-site individual, medical assistance, food preparation by staff/individual, household main-tenance assistance)	Low (Individual counselor or community or staffed topic group)	Both: On-site & Off-site (Groups on-site, individual counselor and/ or psychiatrist off-site)	Damp (Abstinence attempted & encouraged; open discussion of use encouraged)	Moderate: On-Site & Off-Site (Staff of counselors, groups & facilitators, peer specialists, psychiatrist	Various time frames & hours On-site &/or off-site
Group Living	Low (Off-site: individual , medical assistance, food preparation by staff/individual, &/or on-site household maintenance	Moderate (Individual counselor & community or staffed topic group)	Off-site (Groups, individual counselor, psychiatrist)	Wet (Active use off-site)	Low: Off-site (Staff of counselors, groups & facilitators, peer specialists, psychiatrist)	Half day/ evening On-site &/or off-site
Family-Parent with Child(ren)	None	High (Individual coun-selor, psychiatrist, family group, community support groups & staffed topic groups)	None	None	None	All day/ evening On-site &/or off-site

AACP Position Statement on Housing Options for Individuals with Serious and Persistent Mental Illness (SPMI)

(http://www.communitypsychiatry.org/publications/position_statements/Housing-Revised.pdf)

The problem of providing both housing and housing supports to individuals with serious and persistent mental illness presents significant challenges and controversies to mental health system planners and clinicians. These challenges result from several key issues:

- Access to affordable housing is severely limited in most communities, so that consumer choice is even more severely limited. Furthermore, consumers may consequently experience housing negotiations with the mental health system as coercive, in the sense that provider-imposed requirements become conditions for obtaining any housing at all.
- There is substantial conflict between the preference of many consumers to live in independent, normative housing, integrated into the community, and the desire of mental health clinicians, family members, and the community at large to maximize safety and reduce risk of relapse and dangerous behavior by providing residential settings that are closely supervised and highly structured group living arrangements.
- There is conflict between the view that housing in the least restrictive setting is a fundamental right for individuals with disabilities, even if those individuals refuse treatment recommendations, and the view that providing housing without requiring treatment participation is at best enabling and at worst medico-legally irresponsible.
- Finally, the problem of homelessness among individuals with serious and persistent mental illness continues to increase, most prominently among individuals with co-occurring substance use disorders. There is considerable controversy regarding what types of housing programs and supports should be made available to meet the needs of these difficult individuals, particularly with regard to the question of whether such supports should be offered to individuals (with SPMI) who continue active substance use.

This position statement is intended to address these controversies by identifying key philosophic principles for planning and providing housing supports to persons with SPMI, and then establishing general guidelines for the types of housing options that should be available in any system of care, and suggested methodology for planning these options to meet the person's needs.

Thirteen Principles

1. **Provision of safe, adequate, and appropriately supported housing for individuals with serious and persistent mental illness is a priority.** American Association of Community Psychiatrists (AACP) believes that provision of housing and prevention of homelessness must remain a priority of all treatment systems addressing the needs of individuals with SPMI. Consequently, the range of housing options, particularly for individuals with co-occurring substance use disorders, must be developed with that priority in mind.
2. **Individuals with psychiatric disabilities should not be institutionalized because of lack of housing options.** The Olmstead decision creates a clear imperative to develop a range of housing supports to permit individuals with SPMI access to community-based housing in lieu of remaining in restrictive institutional settings in the public mental health system. AACP believes that there should be the same imperative to provide housing in lieu of inappropriate institutionalization in correctional facilities or nursing homes.
3. **Housing for individuals with SPMI is an issue for the whole community, not just for the behavioral health system.** Treatment systems must take initiative to establish relationships with public and private housing "providers" in the community (such as local housing authorities) in order to develop collaborative strategies for enhancing access to a wider range of housing options.
4. **Housing options should be designed to promote empowerment and recovery, through creating options for normative housing and full community integration.** Housing choices should not be restricted to segregated mental health "ghettos," and consumers should not be expected to remain indefinitely in supervised group homes or other artificial housing environments.
5. **Housing options should be prioritized to be responsive to consumer choice and preference wherever possible.** Consumers are presumed to be competent to make housing choices, even if those choices are in conflict with the recommendations of their caregivers, and are entitled to access to supports in the settings of their choosing. In addition, choices regarding participation in treatment, substance use, and living companions should be respected as much as possible.
6. **Housing support options should maximize opportunities for individualization and flexibility in matching housing to consumer needs and preferences.** Housing services need to move away from attempting to fit consumers into pre-existing "slots" in pre-designed models of care, and move toward flexible wrap-around supports that can be more individually designed. In addition, housing services

should be designed to maximize the consumer's ability to maintain continuous treatment relationships in the context of housing transitions.

7. **Housing support options should be designed in a culturally competent manner, and promote integration into community environments that support consumers' cultural and linguistic preferences.** This follows directly from the prior two principles. Cultural flexibility in housing services is enhanced by emphasizing individual and small-group arrangements in scattered-site apartments with flexible supports, in comparison to more traditional group home models.
8. **Individuals who are transitioning from the child and adolescent system to the adult system are a particular priority population for housing services.** Specific supports are needed to promote the development of independent living skills within a safe context. Other age-based transitions (e.g., those which result from an aging and potentially medically infirm SPMI population) also require specific planning and attention.
9. **For individuals who are not competent to make the full range of independent choices, caregivers must proactively establish the need for protective services and provide appropriate safety and supervision in the least restrictive possible manner.** This can range from payeeships for those whose areas of lack of competence are primarily in the area of money management, to fully supervised environments for individuals with significant cognitive compromise or demonstrable likelihood of dangerous behavior in unsupervised settings.
10. **Individuals should have access to a full range of treatment options in association with housing, and treatment requirements (if any) should be individualized based upon the person's need and preference as much as possible.** Housing options should not routinely require arbitrary participation in pre-arranged treatment. Treatment options should include participation in stage-specific substance disorder treatment, and access to a range of options for medical care.
11. **Within the context of consumer choice, providers should proactively offer assistance to promote safety, prevent relapse, and build recovery.** Simply because consumers are not required to participate in treatment does not mean that assistance should be withheld, or offered only passively. Housing support staff can work actively to encourage consumers to make the best possible choices without rejecting them for making the wrong ones.
12. **Within the context of consumer choice, abstinence from alcohol and drugs is consistently encouraged, but housing options should not be denied because a consumer continues to use substances and/or is unwilling to accept abstinence as a goal.** For this reason, housing options should include abstinence-expected

housing, abstinence-encouraged housing, and consumer-choice housing. These options will be described further below.

13. **Clinical decisions regarding housing recommendations should be based on evidence-based best practice whenever possible.** More research is clearly needed to identify which housing models are most appropriately matched to consumers with particular needs or characteristics. Housing programs should therefore incorporate program evaluation efforts into program design whenever possible.

Dimensions of Housing Variability

Housing supports and housing programs can vary along multiple dimensions. AACP recommends maximizing choices and flexibility along as many of these dimensions as possible:

- Independent vs. group living.
- Wrap-around flexible support (supported housing) vs. staff model support (e.g., group home).
- Consumer lease vs. program-owned.
- Scatter site vs. congregate living.
- Programming optional vs. required/integrated.
- Loosely structured vs. highly supervised.
- Medical care off-site vs. VNA vs. on-site nursing care.
- Self-medication vs. medication monitoring vs. medication administration.
- Consumer choice regarding substances vs. abstinence encouraged or expected.
- Permanent housing vs. transitional vs. temporary (shelter).

The AACP position statement is as follows: In any service area or catchment area, there must be provided a full range of housing options for individuals with SPMI, including those with active co-occurring disorders.

First, a significant body of literature has established that individuals with SPMI predominantly prefer to live independently in normative, scattered-site housing, with few requirements, and access to flexible supports as needed. When such supports are made available with sufficient intensity, these supported-housing models produce significantly better outcomes at lower costs than more rigid group home models.

Consequently, AACP recommends maximizing availability of supported housing, and de-emphasizing development of group homes. Assessment of supported housing

requirements begins with assessment of consumer preferences and their perceived needs for support.

Second, despite the aforementioned literature, there remains a significant minority of individuals with SPMI who **prefer** a group home, or whose level of impairment leaves them unable to care for themselves in an independent setting.

Consequently, AACP recommends that group home models remain available to the extent that the aforementioned needs assessment establishes a cadre of individuals who prefer such settings or who require such settings.

Third, psychiatric housing programs (which provide or support a place to live for individuals with psychiatric disability, in order to prevent homelessness) must be distinguished from addiction (or psychiatric) residential treatment programs (which provide episodes of treatment in a residential setting, usually with defined expectations or requirements). Both are important components of a comprehensive system of care.

In most service areas, the addiction treatment system provides a range of addiction residential treatment programs and sober housing programs (e.g., Oxford House model programs), all of which need to be abstinence-expected programs in order to protect the integrity of the addiction recovery support provided. Individuals who enter these settings seek a sober recovery environment, not merely housing, and expect these requirements to be enforced. Ideally, all such individuals have a plan for housing in the event that they fail to meet program requirements and are prematurely discharged.

The mental health system, by contrast, provides mainly housing support programs for individuals with SPMI. Many of these individuals have co-occurring substance use disorders, but vary in their willingness to define substance use as a problem and/or identify sobriety as a goal, even though they may desire assistance to maintain stable housing. Some of these individuals are simply unable or unwilling to limit substance use, even when all housing supports available require such limits; these individuals frequently become homeless as a result.

Consequently, the range of housing supports and programs for individuals with SPMI (with or without co-occurring issues) who need housing assistance due to psychiatric disability, and who are at risk of homelessness, MUST include the following choices:

- **Abstinence-expected (sober) housing –** usually group living, including both staffed group homes, and supported independent group sober living.
- **Abstinence-encouraged housing** – including both group homes and individual supported housing options.
- **Full consumer-choice housing** – usually individual supported housing or supported shelter placements. (Pathways to Housing in New York City (Tsemberis

et al, 2000) is an example of the former type of consumer-choice housing. Using highly intensive wrap-around supports with persistently street homeless mentally-ill substance users, this program demonstrated significant success in housing retention and improvement in mental health and substance symptoms over five years, but had no requirement that people limit substance use in their own homes unless they chose to do so.)

In many systems, the latter option is unavailable, despite its potential value for preventing or ending homelessness.

Consequently, AACP specifically endorses the consumer-choice housing model as a valuable component of the system of care. Consumers with psychiatric disabilities who need housing support, including those who have "failed" sober group living, should not be left homeless simply because of inability or unwillingness to maintain abstinence.

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Part 6: Group Learning Exercises

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Exercise 1: Introduction to Family Systems Work with Individuals with MH, SUD, ID and Trauma Issues

Application of the CCISC principles to successful intervention. Role-play a team "system of care" approach to a complex family situation: "Joe's Family."

1. Participants will practice skills in working as a team to welcome and engage family members with varying issues and disabilities.
2. Participants will practice using a strength-based approach from the perspective of multiple systems.
3. Participants will identify stage-matched interventions for each family member that can be applied in the context of multiple needs and multiple systems.

Sample Case for Team-based Family Service Planning: Joe's Family

Background on the Family

There are three people living in the home: Joe, age 14; Marie (Mom), age 37; and Frank (Step-dad, whom Joe calls "Dad"), age 50. Their stated goal as a family is as follows:

> "We love each other very much. We want to be able to stay together as a family, and make something better for ourselves. We've all hard pretty hard lives, and we know we need to hang together.
>
> "As parents, we want to provide the best for Joe, and see him grow up healthy and strong, and have a family of his own. We are trying to be the best parents we possibly can be. We don't want him to wind up in institutions and we are terrified he will wind up in jail, so we want all the help we can get.
>
> "As Joe, I want my family to be proud of me, and I want them to be safe and happy. I worry about them a lot, especially my Mom. I wish that I could be like the other kids but it seems pretty hard. I know my parents love me, but sometimes I get so upset with things that I want to explode. I've got to control that but I don't know how. I would like to be able to work as a mechanic some day. I love cars and things. I would also like to have my own family, but I don't know if I ever could."

Joe's Story

Joe is the only child in his mother's care. He knows he had an older brother who was taken away by the state before he was born; he isn't sure why, but he knows he does not want that to happen to him. He has never known his biological father. His stepfather, whom he respects and loves, has been in his life since he was an infant.

Joe is diagnosed with "Autism Spectrum Disorder." He knows that he has "a problem," but he doesn't know how to describe it very well. He knows that he has trouble making friends. The other kids at school think he is strange, and sometimes tease him. He likes to be by himself, and he finds a lot of comfort in drawing pictures of cars, tanks, planes, and so on.

When Joe was younger, he had some trouble at school, but was able to be supported enough to make some progress. His challenges became more severe in adolescence. He got much bigger, and his emotions became more intense. He feels awkward and embarrassed at school (he is in eighth grade), particularly when he cannot keep up with the other kids academically and socially. At school, he does OK when there is a lot of structure in the classroom, but he gets frustrated when things go too fast for him, or when there is a lot of social stuff going on that he does not understand.

When teachers or peers confront him about behaving oddly, he begins to explode with frustration. He doesn't know how to control this very well once it starts, and it makes him feel real bad about himself. He knows the school has tried to help him. There is a very nice counselor that talks to him at the school. The counselor tried to get him an individual plan (IEP), and the teachers tried to make it work. He did OK for a while, but then he had a blowup, and started feeling like a failure. This made things worse, so he wound up being placed in a behavioral residential program for kids with developmental problems last fall, for six weeks. He found this program very helpful. Everyone was very nice and concerned about him. They gave him a lot of structure so he found he could be successful. Every little step was planned out for him so he felt like he knew what to do most of the time. He was getting a lot of praise for small steps of success, and he felt like he could calm down. He knew that his parents and the school were very involved in working with the program. He had some hope that things would be better when he came home.

He began talking more openly to the people in the residential program. He said that he liked it there, but he couldn't wait to get home. "I'm worried about my Mom. I think she is very unhappy. She drinks a little too much, and she tries to hide it. I get so upset at her, because I think she's going to hurt herself, and I love her. She sometimes passes out right after dinner and I have to put her to bed and myself to bed because my Dad works late at his second job. I think she needs me there. I've been afraid to talk about it

because I don't want anyone to do something bad to her." He shared that a lot of the kids at school were drinking after school. He hated alcohol and never wanted to drink. He tried it once, and it made him sick. He also shared that his Dad drank a little too, sometimes with his Mom. "I don't think my Dad has a problem, but it pisses me off that he doesn't make her stop."

He was hoping that when he got home, she would have stopped drinking, but he quickly found that nothing had changed. She was trying very hard to apply the things that she had learned to give him structure to help him, but she would sometimes forget which made him angry. In addition, the school had made some changes too, but still he sometimes felt overwhelmed. He knew the counselor and the teacher were trying to help him, but he still felt like things would go too fast and he would get frustrated. Within a few weeks, he found himself exploding again. "This medicine they put me on isn't working either," he said, and he began spitting it out when no one was looking. Last week, he broke a window at school in a rage, and he was told that charges were going to be filed. He is terrified of going to jail.

Marie's Story

Marie grew up in a rural community in the center of the state, one of the younger daughters in a large family. She remembers her Dad being a violent alcoholic, and her mother being depressed and unable to take good care of the kids. "We had to look after ourselves; it was pretty scary." She could not do well in school, and suffered from anxiety and depression. She ran off with a somewhat older guy on a motorcycle when she was 17. They got into drugs and drinking, and when she got pregnant, the hospital called child welfare and said she was an "unfit mother" and a "drug addict," and they (Child Protection) took her child away. She was so ashamed that she could not engage with anyone to get help. Her child was placed in foster care and then adopted. She feels like a tremendous failure about this. She had a few episodes where she got drunk and cut her wrists, and was hospitalized briefly. She never followed through with counseling. "It's really hard for me to open up and trust people."

She broke up with this guy, but then hooked up with another guy who was also not responsible. She got a job cleaning motel rooms. When she got pregnant again, her boyfriend told her to get an abortion, but she said no. "I need to prove that I can be a good mother and a good person." He told her she was stupid and took off. She stopped drinking and drugging after the first trimester of her pregnancy. She was very proud of that. While she was pregnant, she met Frank. He was a lot older, but he really seemed to want to take care of her. She kept waiting for him to beat up on her, but he never did. Sometimes he would lose his temper because she would do stupid things, and she would feel really afraid. But things would calm down.

When Joe was first born, she was very happy. But she soon was told that he seemed to have some "developmental problems." She felt horrible about this. She began having flashbacks of her own father calling her names. She had nightmares and felt depressed and anxious a lot. She never used drugs again but discovered having a few drinks calmed her down so she could function better. She does not like to talk about this with anyone, because she is afraid people will think she is crazy.

She feels she has worked so hard to make things work for Joe and Frank. When Joe first started having problems, the school made a referral to the Child Protection Agency. They came by to visit to see if they could help her out. She thought the woman seemed very nice, but she was terrified to talk to her because she was afraid she would lose custody of Joe.

When Joe was placed in the residential program, Marie tried to show everyone that she could be the best possible mother for Joe. She took lots of notes and tried to remember everything. The staff seemed to know how hard she was working and that made her feel proud, but it was very stressful. It's even more stressful now that Joe is home. A few drinks at night help her to relax. She thinks she shouldn't drink, but figures she needs to do something to stay calm. She doesn't think anyone notices, and she is ashamed of herself so she pretends it's not an issue. She is also afraid that if she talks about her drinking she will be labeled a drunk and will lose custody of Joe forever. When staff at the residential program mentioned that Joe had said something about her drinking, she said, "You know how kids are. Everyone has a few beers to relax. It's no big deal." And then she would quickly change the subject.

She is feeling devastated that Joe is having a hard time again. She is sure somehow that it is her fault. She is desperate for help, but is also worried that the state will just take Joe away. She wonders if she really can trust the nice woman from Child Protection when she says she knows that Marie is trying to be a good Mom, and that she deserves all the help possible to keep Joe at home.

Frank's Story

Frank is man who is half Native American and half Irish, and was in foster care when he was a teenager because his parents broke up, and his mother was too depressed to care for him. He has been on his own his whole life, and is very invested in keeping his family together. He is a hard worker (he is a carpenter by day and he has a night job as a security guard), and a "caretaker," which helps him feel safe and in control. His deepest fear is that he will be abandoned, as he was as a child, by others who could not care for him.

Frank adores both Marie and Joe, and has tried to do right by them. He knows that Marie is "not quite right," which he blames on her abusive father and her previous boyfriends. He knows that Joe has problems as well, and he tries to help him out, but he often feels confused about what to do. He, like Joe, is worried about Marie's drinking. He doesn't think she is an "alcoholic," but is afraid she will become one. He doesn't know how to discuss it with her, because she becomes very upset and angry when he mentions it, and then she breaks into tears. He feels she is too fragile, and that maybe the alcohol helps her a bit. He tries to have a few drinks with her, figuring that way she won't drink alone, which he knows is bad. He wanted to bring it up and talk about it when Joe was in that program, but he was worried that Marie would be mad, and that the state would take Joe. He was really pleased that Joe did so much better, and was very proud of both Marie and Joe for how hard they worked at the residential program, but he is feeling pretty discouraged now that things have gone backwards at home. The final straw was when Joe erupted at home and started throwing a chair and calling his mother names. He (Frank) was on the verge of losing his temper big time, but he really doesn't want to hurt Joe. "No child should ever talk to his mother that way. I won't stand for it."

The Assignment

The Family Team has been engaged in building a relationship with Joe's family since his discharge from the residential program. They have convened a crisis meeting with the family to come up with a plan to work in partnership with the family to help them address all these issues in a strength-based and stage-matched way so they can make progress. The team has representatives from the local mental health agency, the school, child welfare, developmental disability services, juvenile justice, and the local alcohol and drug agency. The family has a good relationship with the team, but is not sure what to do next.

The team is meeting in part to consider whether Joe should go back to the residential program, which is an option. However, whether he goes or not, the team knows there needs to be a better plan in place to be successful.

Issues include:

- Joe's anger, learning difficulties, social difficulties, and worry about his Mom's drinking
- Mom's drinking, her trauma issues, and her ability to provide Joe with successful structure at home
- Dad's efforts to be a good husband and parent, and knowing how to deal with Marie's drinking and Joe's temper

- The school's efforts to create a successful program for Joe
- What to do about the recent possible charges of malicious mischief

Please sit together as a team, and identify next steps for Joe, Mom, and Dad to make progress, and create a beautiful inspired integrated stage-matched plan in partnership with the family.

Exercise 2: Integrated Stage-matched, Skill-based Learning using Positive Behavioral Supports for Individuals with Multi-occurring Conditions: Case-based Role Play

Introduction

This is a very straightforward role-play exercise that helps Change Agents to build on the understanding of integrated stage-matched skill-based recovery/service planning to actually practice providing the interventions that would be recommended in the plan. Further, Change Agents can easily use this exercise in their own programs or agencies to help colleagues practice and learn similar interventions.

There are three "best practice" approaches in alignment with CCISC principles that are being practiced in this exercise:

- Integrated stage-matched interventions for multiple conditions
- Skill-based learning
- Positive contingency management and positive behavioral support

Basic Instructions

The role-play is based on the case scenario of Diane, and has four different "scenes." To do the role-play exercise, participants should divide into groups of three. In three of the scenes, the role-play involves one person playing the role of Diane, one person being the service provider, and the third person being the observer/coach. The remaining scene (Scene 2, below) involves one person playing the service provider, one person playing the role of Diane and the third person role-playing Diane's boyfriend in order to help Diane to practice her skills, so all three participants are playing roles in that scene. It is suggested that everyone switches roles between scenes.

During the first role-play, participants will need a piece of paper or a treatment planning form on which to write down Diane's hopeful goals and recent strengths and successes, as well as listing her three issues to be addressed in the role-play, and her stage of change for each.

At the end of each of the four scenes, participants will use a "Processing Form" to write down their thoughts and experiences about what they learned during the session. In the

three scenes where one person is the "observer," that person will help to facilitate this conversation.

Case Scenario for Diane

Diane is a remarkable 21-year-old woman with a psychiatric disability and "borderline intellectual functioning," who is working hard with her "service team" to achieve her goals:

> "I want to someday marry my boyfriend, and have a nice house with three rooms. I want to have a job working in a fabric store, because I love making pretty clothes."

Diane's boyfriend of 2 years also has a mental health condition and borderline intellectual functioning. Diane has been receiving services and supports for five years, living at home with her mother, who has an alcohol problem. Diane experienced sexual and physical abuse as a young child, and hears voices saying "bad things about me." The voices are only partly diminished by her medication. She sometimes in the past has cut herself in response to the voices, and has been hospitalized on several occasions for her safety. However, during the past year, she has worked hard with her team, takes her medication regularly without reminders, and has begun a part-time job at the supermarket. She has budgeted her money to be able to move into her own small studio. "I love my mother, but I don't like being around her when she drinks. It's hard for me to leave home because I think she needs me."

Diane was finally able to move into her own apartment three months ago. Her service team manages her disability check for her, and pays her rent and utilities up front. Diane gets a monthly amount for spending money. She has been telling her team that everything is going fine. "I can see my boyfriend whenever I want. I love my apartment. My mother is doing OK too." However, near the end of the last month, Diane came to her team and asked if she could borrow some money. "I ran out of spending money," she explained. "I had to buy a present for my boyfriend." At that time, she seemed to be a bit confused, and she smelled of alcohol.

Her team questioned her gently about where her money went. At first, she was defensive, but with a lot of reassurance that the team wanted to understand what was happening so they could better help her reach her goals, she finally shared that she and her boyfriend had been spending her money on beer and marijuana.

> "I'm old enough to drink now. I have my own place. Why can't I drink beer if I want to? It makes me feel good, and the voices don't bother me as much when I'm drinking. I don't want to stop drinking. How can I afford it? I don't really like the marijuana though. I would like to quit, but I don't know how. It makes

> you eat a lot and get fat. My boyfriend likes it though. He wants me to smoke with him. I don't want him to get mad. I don't know what to do."

When asked about her medication, she says:

> "I'm not supposed to drink on medication. So I don't take it when I drink. But I don't drink every day, so I'm still taking it most of the time. My voices are OK...kind of...well, maybe a little worse. I would like them to stop...but I don't want to go back to the hospital!!!"

Now, the team has to plan stage-matched integrated interventions to help her with three issues:

- Stabilizing her mental health condition
- Addressing her alcohol use
- Addressing her marijuana use

All in the context of helping her achieve her life goals. Interventions have to match Diane's level of cognitive and learning ability and be designed to help her succeed, one step at a time.

Scene 1: Identification of Goals and Strengths, and Stage Identification of Issues

Lesson

Always start with hopeful goals, strengths, and rounds of applause (positive behavioral supports).

Lesson

Always identify stage of change for each issue, before intervention.

Participants

- Diane, service provider, observer

Role-Play

Service provider works with Diane to help her identify her biggest vision of a happy life, and help her to think about all the things she has done right in the last three months in order to make progress. Diane and the service provider should write down on the service planning form her happy life goals and her strengths and steps of success. The

service provider should give Diane a round of applause for her positive progress. (The round of applause is more important now, given that Diane is clearly having a hard time.)

Service provider uses the stage of change "sentence prompts" to help Diane identify where she is in terms of stage of change for each issue. The goal is to come up with one sentence that fits Diane for each of the three issues, and write it down on the service planning form in her own words as a stage-matched goal.

Examples

Contemplation: "I want to keep using (fill in the substance), but I'm willing to talk with you about how to use without getting into trouble."

Preparation: "I really want to quit using (fill in the substance), but I'm not sure what the first step would be."

Late Action: "I'm trying real hard to get in control of (fill in the issue), and I need help to do it better."

After the Role-play

Once this role-play is completed, the observer and the two role players use the "Processing Form" to have a conversation about how the role-play went, and what was learned.

Scene 2: Stage-matched Intervention 1

Moving from preparation to action (for marijuana abuse) using skill-building and positive behavioral supports.

Lesson

Making progress in the preparation stage involves identifying small steps and then learning and practicing the skills needed to take those steps.

Lesson

Skill-based learning can be positively supported by identifying achievable milestones of progress, with positive rewards for achieving each milestone.

Participants

- Diane, service provider doing the intervention, another service provider playing the role of Diane's boyfriend to help Diane with her skill practice.

Background

In her stage-matched objective for stopping her marijuana use, Diane has identified two small-step "objectives" to get started. She knows she can't just quit using right away, because she doesn't want to have problems with her boyfriend, so she has come up with two very small steps forward:

- To tell her boyfriend that she wishes both to stop using marijuana herself AND to no longer spend her own money on marijuana.
- To keep track of her marijuana use with her service team to be able to make a plan to cut down and then stop.

Role-Play

In this role-play scene, the service providers will help Diane with the first of these two objectives.

In the first part of the role-play, the service provider should review with Diane a little script for what she will say to her boyfriend, and help her to come up with some things that her boyfriend might say that would make it hard for her. Diane should then practice the script with the service provider a few times.

In the second part of the role-play, Diane should practice the script with the other service provider, who is pretending to be her boyfriend for the purpose of the role-play. The first service provider should be Diane's coach in this process. The goal is to have Diane practice the "script" two or three times with the pretend "boyfriend." The pretend boyfriend will be saying some of the things that Diane suggested her real boyfriend would say, so she can practice her script with a more realistic set of challenges.

In the third part of the role-play, the service providers should work with Diane to develop "homework" for continuing to practice the script. The goal is to develop a "positive behavioral supports plan" in which Diane agrees to go home and practice her script in some fashion, and then report back to the service provider(s) to get praise and additional coaching. The assumption should be that Diane will need to practice by herself—or with other supports—on several occasions before she is ready to try the script out with her "real" boyfriend.

The service providers and Diane should write down a plan to help Diane through one week of skill practice, with opportunities for positive support for making progress no less frequently than every other day.

Once this is finished, Diane gets a round of applause.

After the Role-play

The group debriefs using the Processing Form.

Scene 3: Stage-Matched Intervention 2

Early action skill building: practicing using a skill manual.

Lesson

Even" simple" skills—like reporting use to staff—need to be practiced.

Participants

- Diane, service provider, observer/coach

Purpose

The purpose of this role-play is to help Diane practice skills related to her second objective listed above—to keep track of her marijuana use with her service team. The starting assumption is that Diane is likely to feel ashamed of using marijuana, so she will have a hard time letting her service provider know when she has used and how much.

Role-play

In the role-play, the service provider and Diane develop a "script" for how Diane will tell the service provider that she used the night before. Diane should then practice the script with the service provider. The service provider should always respond to Diane's efforts with giving Diane positive reinforcement (e.g., a "round of applause") for being honest, asking for help, and for using her skills to make progress, followed by encouragement to talk more about what happened. The coach should help both Diane and the service provider have a successful role-play. The role-play should be repeated three times, with suggestions from the coach for improvement in between each time.

After the Role-play

The group of three debriefs using the Processing Form at the end of the scene.

Scene 4: Integrated Stage-matched Intervention: Alcohol Abuse (Contemplation) and Auditory Hallucinations (Late Action)

Lesson

Working on an issue in an area in which a client is in a "later" stage of change (e.g., late action regarding auditory hallucinations) can help leverage progress in an area in an "earlier" stage of change (e.g., contemplation regarding alcohol abuse).

Lesson

Working with clients in contemplation involves simply opening up the conversation to help the clients make better decisions in relation to the achievement of their goals.

Lesson

Clients on antipsychotic medication should remain on their medication even when using substances. Further, if substance use suppresses a symptom (like "voices"), the symptoms are often getting steadily worse each time the substance wears off ("rebounding").

Participants

- Diane, service provider, observer/coach

Role-play

This role-play involves practicing a conversation that is a bit more complex. Most of the work is done by Diane and the service provider. The coach can jump in at any time to be helpful if things seem to be going off track.

The service provider opens the conversation by saying; "Diane, you've done a great job with working on your marijuana use today. Now, let's talk about alcohol. You've said you want to keep drinking. I hear you. Would it be OK for you and me to try to figure out the right amount of drinking for you to meet ALL your goals?"

Assuming Diane says yes, this should lead into a discussion of how to figure out the right amount of drinking with Diane and for Diane. Diane and the service provider should write down pros and cons of drinking, and things to be figured out to find out the right amount of drinking for Diane. The service provider should be asking Diane about how drinking fits into her budget, as well as what effect she thinks the drinking

might be having on her voices and her medication. The service provider should NOT struggle with Diane or argue with her, but simply engage in the conversation to help her figure out how to make the best decision for herself.

The service provider should try to work the following "teaching points" gently into the conversation:

- "Diane, did you know that if alcohol makes your voices better when you use it, it is usually making your voices worse in the long run? Every time the alcohol wears off, your voices get very slowly worse."
- "For people taking medicine for voices, it is better not to drink. But if you are drinking, it is better to keep taking your medicine than to stop it. People who stop their medicine when they are drinking will cause their voices to get worse, and are more likely to go back in the hospital."

Note: in the role-play, it is up to Diane how much these suggestions influence her decision-making. Diane has said she does not want to stop drinking, and she is not likely to change her mind. However, she does want to do whatever she can to have the voices go away. The outcome of the role-play is that Diane identifies her "drinking plan" and her "medication plan" and works out a way to keep track of her plan with the service provider to see if it is actually working for her (including reporting on her voices, her medication, and her drinking—as well as her marijuana use—regularly). Once this happens, Diane receives positive reinforcement for her work on being a good partner and decision-maker, and for her willingness to learn what works best by working with her team.

After the Role-play

At the end of the role-play, the group of three debriefs using the Processing Form.

Role-play Processing Form

Use one form to debrief after each scene in the role-play.

Scene (circle one): 1 2 3 4

Team Members (optional):

-
-
-

Describe three or more things in the role-play scene that—as a team—you thought went well:

1.

2.

3.

Describe three or more things in the role-play that seemed challenging, or were harder than expected:

1.

2.

3.

Identify two or more things that you (any member of the team) learned in this scene of the role-play:

1.

2.

3.

Describe your thoughts about how to use this role-play scene in helping your own program(s) improve multi-occurring capability and improve staff competency.

Adult Service Plan Template

Program:	**Date:**
Person:	**Team Members:**
Person's Goals for a Happy Life:	
Strength-based discussion: Describe recent or relevant periods of success:	

Goals and Objectives	**What Do We Do? (Stage-matched Interventions)**	**- Responsible Persons - Milestones of Progress - Opportunities for Rounds of Applause**	**Target Date for Completion**
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			
Issue: Stage: Goal: Objectives:			

Signed by: ☐ Person ☐ Family ☐ Program Manager ☐ Staff ☐ MD ☐ Other (specify)

Child/Family Service Plan Template

Program:	**Date:**
Person (Person/Family or Caregiver):	**Team Members:**
Child's Goals for a Happy Life:	
Family's/Caregiver's Goals for a Happy Family:	
Strength-based discussion: Describe recent or relevant periods of success:	

Goals and Objectives	**What Do We Do? (Stage-matched Interventions)**	**- Responsible Persons - Milestones of Progress - Opportunities for Rounds of Applause**	**Target Date for Completion**
Child Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			
Child/Family Issue: Stage: Goal: Objectives:			

Signed by: ☐ Person ☐ Family ☐ Program Manager ☐ Staff ☐ MD ☐ Other (specify)

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Exercise 3: Back to the Basics and Beyond: Aligning Trauma-informed Care, Positive Behavior Supports, and Multi-occurring Capability Development (CCISC)

- Address how the fundamental principles of all three approaches align with and complement each other in helping programs and systems build services that are more responsive to the needs and hopes of individuals and families facing multiple challenges and disabilities
- Relate integrated evidence-based practices for addressing individuals with complex issues and trauma, such as *Seeking Safety*, Dialectical Behavior Therapy, and trauma-focused Cognitive-Behavioral Therapy, with other best practice approaches related to stage-matched interventions, skill-building and positively rewarded learning.
- Illustrate how the same basic principles for direct service, support and care are clearly connected to principles for organizational and system change, including the concept of how organizations use vision-driven change to "recover" from organizational trauma.

Learning Objectives

Participants will:

- Identify principles and practices of trauma-informed care for individuals and families with multi-occurring disabilities.
- Explain how trauma-informed care, positive behavior supports and CCISC have common principles and values that can be applied in an integrated fashion within any program for any population.
- Discuss the basic evidence-based practices that are associated with trauma-informed care, positive behavior supports and CCISC in relation to addressing individuals with trauma.
- Recognize 12 steps that illustrate parallels between clinical principles and organizational change processes to address individuals, families and organizations with trauma and multi-occurring needs.

Crosswalk		
CCISC Multi-occurring Capability Principles	**Trauma-Informed Care**	**Positive Behavioral Supports**
~ Organizational culture shift supports practice shift and is an important outcome in itself. ~		
Welcoming people with complexity and welcoming each other.	Welcoming and safety for *all*; *no* retraumatization.	Always maintain a positive stance.
Hopeful vision for a happy, productive, meaningful life.	Hope for healing from trauma.	Hope that anyone can be successful.
Empowered, strength-based partnerships.	Empowered, strength-based partnerships.	Strength-based partnerships to make progress to more autonomy.
~ Always build on strengths and successes, not on negativity and criticism. ~		
Empathic understanding of person's story and all their issues.	Empathic validation of traumatic experiences.	Empathic understanding of the context for all behaviors.
All issues are primary, including trauma.	Trauma is a primary issue that contributes to all other issues.	Positive behavioral supports can support success in any issue.
Integrated best-matched interventions for *each* issue at the same time.	Interventions for any issue must be trauma-informed. *Some* people need trauma-specific treatment.	Positive behavioral supports can support success in addressing any issue.
Stage-matched interventions for each issue—use motivational interventions.	Forcing people to change is a form of retraumatization—use motivational interventions.	Change requires positive supports for next steps in decision-making and learning.
Skill-based learning for each issue.	Learn specific skills for establishing safety (grounding) and healthy relationships.	Practice skills for new, healthy behaviors.
~ Consistent positively rewarded learning. ~		

12 Steps for Agencies/Programs Developing Multi-Occurring Capability

These steps are based on the principles of the Twelve-step Program of Comprehensive, Continuous, Integrated System of Care (CCISC) Implementation (Minkoff and Cline, 2004), and can be initiated by any agency (for all of its programs, or by an individual program), within the scope of the agency/program mission and resources.

1. Formal Announcement and Commitment

   Leadership makes a formal commitment to achieve multi-occurring capability for all programs, announces it officially to all staff, and communicates to all staff about the CCISC implementation process.

2. Continuous Quality Improvement (CQI) Team

   Leadership organizes a CQI team that is intended to represent all the different levels of the agency or program in a partnership, and to engage in regular meetings to oversee the change process.

3. Change Agents

   The organization identifies a team of Change Agents that represents the front-line voice of direct service and support staff (and, where appropriate, consumers and families) in each program. The Change Agents become represented on the CQI team and help direct service and support staff to achieve competency in the practice priorities listed below.

4. Goal of Multi-occurring Competency for All Staff

   The agency or program includes in its formal commitment the goal that all direct service and support staff will develop multi-occurring competency at their level of training and/or licensure (if any).

5. Program Self-assessment

   Each program uses a structured tool (e.g., COMPASS-EZ™ for MH or SA programs and COMPASS-ID™ for DD or BI programs) to conduct a program baseline conversation and self-assessment of multi-occurring capability involving as many staff as possible.

6. Program CQI Action Plan

   Based on the results of the COMPASS-EZ™ or COMPASS-ID™ survey, each program creates an achievable three- to six-month action plan to make progress

toward multi-occurring capability, with measurable objectives. Areas in which initial action plan objectives are developed are the following.

7. Welcoming and Access

   The program action plan addresses multi-occurring disabilities, welcoming policies, procedures, clinical practice and staff competencies, and identifies any access barriers that need to be removed.

8. Screening

   The program creates a definition and process to implement universal integrated screening.

9. Identification and Counting

   The program measures baseline data on how many multi-occurring clients and families it serves, and develops a CQI plan to improve recognition of the population.

10. Empathic, Hopeful, Integrated, Strength-based Assessment

    The program's CQI plan helps all direct service and support staff to demonstrate integrated empathy and hope, and provides support for documentation of hopeful goals and periods of strength.

11. Stage-matched Interventions

    The program plan works on identification and documentation of stages of change and stage-matched goals for each identified client or family issue needing attention in order to achieve person- or family-centered goals.

12. Integrated Stage-matched Recovery Planning and Programming

    The program works on policies, procedures, and processes to improve integration and stage-matching in hopeful, strength-based, person- or family-centered service plans, and in improving the use of multi-occurring capable skill manuals, stage-matched groups, and positive rewards as part of routine person-centered planning and interventions.

12 Steps for Direct Service Staff Developing Multi-Occurring Competency

These steps are based on the principles of the Comprehensive, Continuous, Integrated System of Care (CCISC) (Minkoff and Cline, 2004), and can be practiced by any direct service staff person within the scope of his or her existing job or caseload.

1. Welcoming

   Welcome individuals who have multi-occurring conditions or disabilities, thank them for coming, and let them know you are glad to get to know them as they are.

2. Hope

   Ask everyone about their goals for a happy life, and inspire a belief that you will work with them to help them to achieve that vision.

3. Integrated

   Screen for problems in multiple life domains (MH, SA, cognitive disabilities, trauma, court, housing, health, etc.) in the course of conversation, and practice using one screening tool.

4. Empathy

   Ask clients and families to describe in detail their experience with the issues in the "other" domains, and empathize fully with what it feels like.

5. Strengths

   Ask clients to identify a period of recent success in relation to their problem, describe in detail the specific strengths they used to be successful, and what they were experiencing that they had to overcome to make progress: e.g., mental health issues during a period of sobriety, what were they and how were they managed; mental health issues for a person with DD who is trying to work, etc.

6. Quadrant

   Review each case in the caseload, and determine: Are they multi-occurring (yes, no or maybe)? What quadrant are they in? (High severity vs. low severity cognitive disability, substance dependence vs. abuse; SPMI/SED vs. less serious mental health issues.)

7. Integrated Primary Problem-specific Treatment

   For any client, list each problem or issue, and list a specific day-at-a-time set of recommendations to help that person succeed. Discuss with the client and/or

family how they use their strengths to attempt to follow each set of recommendations on any given day. Include recommendations in other areas, like medical issues, probation, etc.

8. Stage of Change

   For each identified problem that may affect the person's goals for happiness, identify stage of change. Write down a stage-matched goal for each problem in the client's or family's own words. Practice establishing empathy with clients in earlier stages of change.

9. Skills and Supports

   For any identified problem during a period of success, identify in detail with the client the specific skills that the client used to be successful, including skills asking for help or using supports.

10. Skill-based Learning

    Use one manual for teaching multi-occurring skills, and/or practice one skill exercise with a client that is connected to their life. For example, work with the client in an addiction setting on managing mental health symptoms on any day; work with a mental health client on refusing drugs from a friend; work with a DD client on how to ask for help when hearing voices, or how to say no when offered cigarettes.

11. Positive Rewards

    Identify small steps of progress for any problem in any client, and provide strong positive reward ("positive behavioral support") for those small steps, as a "round of applause for one day of sobriety."

12. "Recovery" Support

    Identify a place where the client (or family) can receive "recovery" support for each problem, whether from peers, family, or others, and discuss in detail how the client can improve asking for help from these supports.

Exercise 4: Trauma and Multi-occurring Issues

Using an clinical case example for a family with multi-occurring MH, SUD, DD and trauma issues, participants will work with tools provided in the workshop for practicing a welcoming, trauma-informed, strength-based case presentation, and then develop approaches that help individuals make progress without re-traumatizing, using evidence-based practice stage-matched interventions.

Learning Objectives

Participants will:

- Practice how to a hopeful, strength-based, trauma-informed case presentation.
- Demonstrate how to work with individuals with severe trauma to mobilize their strength as survivors to address challenging issues within a stage-matched perspective.

Family Case: Dede and Luke

This case tells the story of Luke, a four-year-old boy, and Dede, his 58-year-old grandmother who is his legal guardian. Dede and Luke are receiving services from a community-based family support team that works providing both in-home and office-based services for challenging families that have multi-occurring issues.

Dede and Luke have been receiving services for two years, since Luke's mother (Eva) died from a drug overdose. Luke's father, Dede's son, Ed Jr. is in prison with a multi-year term for repeat-offense drug charges. Although services are required by the Child Welfare system in order to provide adequate support for Luke, Dede is very motivated to get whatever help she can:

> "I love Luke very much, and I'm determined to help him grow up strong, and break the cycle of trauma and substance abuse in our family."

This story goes back many generations.

First Generation

Dede grew up in a home where both parents were alcoholic. Her father was abusive, and her mother was unsupportive emotionally. She left home as a teenager to marry Ed Sr. who very quickly turned out to be a drug addict who was physically abusive toward her. When she reached out to her mother for help, shortly after her marriage, her mother said, coldly: "You made your bed. You lie in it." Dede has never forgotten how

that statement made her feel. She has spent her life wondering what she did that made her mother unable to love her.

Dede's father died 30 years ago, but her mother is still alive at age 75, and stopped drinking in her late 50s. Her mother has a number of physical problems, and is unhappy in her current independent living situation. Dede is feeling like she should try to do something to help her mother out, and is considering taking her mother in to live with her. The family treatment team is opposed to this, telling Dede she needs to "learn to look out for herself," but Dede feels very ambivalent, and is continuing to consider whether she should do this. She feels unsupported by the team. She doesn't want to be the kind of person who turns her back on her mother, the way her mother turned her back on her.

Second Generation

Dede and Ed Sr. had two children, Tina and Ed Jr. Dede divorced Ed when Tina was 10 and Ed Jr. was 7, but both children still went on to have serious problems. Tina became a drug addict, and at one point lost her two children to Child Welfare. Dede stepped in to take care of them temporarily, but they were placed in foster care. Tina now has two years clean, and has recently gotten custody back. Dede is very nervous about Tina's ability to be a good mother, and worries about those grandchildren. Her relationship with Tina is a bit distant, because Tina feels that Dede does not appreciate all the hard work she is doing to make progress. Ed Jr. always was a nervous and anxious child, exposed to significant physical abuse. He began using marijuana at age 10 and then over the years progressed to heroin and crack cocaine. His wife, Eva, was also a drug addict, and in fact when she was pregnant with Luke in 2007 was in a drug-induced coma for a period of time. As noted above, she died in 2009 from a drug-induced coma. Luke witnessed her death (convulsions, etc.), and he has acted out what he witnessed for both Dede and the family support team.

Dede has always felt that she should try to help her children, but has also felt that no matter what she has done, it doesn't seem to work. She alternated between being indulgent and then being angry and withholding, then feeling guilty, and being indulgent again. This pattern has been more visible with Ed Jr. than with Tina. In fact, Ed Jr. has recently been in touch with Dede demanding that she bring him money so that he can make phone calls to Luke (He says: "It's not good enough for me just to write letters."), as well as insisting that she must bring Luke to visit him since "Luke is MY son, not yours." Ed Jr. is very good at causing Dede to feel guilty, and in the past has often gotten what he wants. Right now, she is going back and forth about what to do—should she keep bringing Luke to visit his father, (feeling bad for him being in prison), or should she try to protect Luke from being exposed to his unhealthy father

and the unhealthy environment. Her treatment team is advocating for the latter, but once again, she is struggling with them.

Third Generation

Not surprisingly, because of *in utero* drug exposure, Luke has shown signs of developmental delay. It is not clear how severe his developmental problems will turn out to be at this point in time. He is a very spirited and truly adorable child, but often appears to be anxious and hyperactive, and clearly was affected by the traumatic experience of witnessing his mother's death. He is verbal, but not at a four-year-old level, and is still not fully toilet-trained. He does attend a pre-school program designed for special needs children, and appears to do well there most of the time, but occasionally he engages in bursts of hyperactive and impulsive behavior that can be hard to redirect. He is very attached to Dede.

In turn, Dede loves Luke greatly, and is determined to raise him till he can be old enough to be on his own, about which she is optimistic. She has some health problems due to smoking, so she has concerns about whether she will live another 14 years. However, despite exhortations by her treatment team, she resists them when they tell her to stop smoking. (She has cut her smoking in half, and is working on slowly cutting down, but she does not want to talk to the treatment team about that, because she is afraid they will judge her harshly for not stopping entirely.) Dede does not use drugs or alcohol (not since her 30s), but she does suffer from anxiety and depression. She takes some antidepressants prescribed by her primary care doctor, which she reports are partly helpful. Dede wants to do the right thing for Luke, and values the involvement of the treatment team; at the same time, she has trouble knowing how to ask for the help she actually needs. Dede is working very hard to try to be a great "parent" for Luke. However, sometimes she finds herself run ragged, and does not know how to help Luke control his behavior more effectively. When she loses her temper on occasion, she feels terribly guilty. However, when the treatment team suggests that she should take "parenting classes" she gets pretty defensive. She feels they are being critical of her, and she cannot tolerate that very well.

Your Job as a Team

For the purpose of this exercise, you are the treatment team for Luke and Dede. Your job is to use both CCISC principles and a trauma-informed perspective to come up with some good ideas for how to engage Dede more effectively, and help her to make progress in addressing her multiple issues and in helping Luke with his multiple issues.

Step 1

As a team, identify which of the people in this family have experienced "trauma." Before you start working on the case itself, discuss the importance of establishing welcoming, hope, and safety, and avoiding doing anything that could be experienced as retraumatizing in your work with the family.

Step 2

Keeping Step 1 in mind, use the handout case presentation format to write down as a team how you would tell the story of Dede (and Luke). Write this in such a way that if Dede were reading it, she would feel welcomed and inspired by your understanding of her experience, and not at all re-traumatized or criticized. **Key question:** Is there more to Dede's "happy life goal" than just taking care of Luke? Is there some aspect of the journey that is about Dede herself?

Step 3

Dede is having difficulty in her relationship with her mother, her son, her daughter, her treatment team, and with being the most effective parent she can be for Luke. As a team, write down how you would communicate to Dede your understanding about how Dede's own history makes it hard for her to know how to be more successful right now, as well as your appreciation of how hard she is trying to learn how to do things differently. HINT: Healthy relationships permit a "middle ground" between indulgence and anger/rejection/criticism.

Step 4

Working within your strength-based, trauma-informed partnership with Dede, and applying stage-matched, cognitive behavioral strategies to help Dede find a small step of change, identify one thing (for each issue or problem relationship) you could help Dede actually do so she can make progress with her mother, her son, and her daughter, as well as with her smoking (and get a round of applause from the team.)

Step 5

How would you apply the principles of "positive behavioral supports" to help Dede become more successful in parenting Luke, and in helping him with his own memories, anxiety, hyperactivity, etc., without retraumatizing either Dede or Luke? Write down one or two ideas.

CCISC Hopeful, Strength-based (Recovery-oriented) Integrated Presenting Format

The [age]-year-old [man/woman/boy/girl] I am presenting is an amazing/cool/special person because:

I like or feel connected to the person I am presenting because:

His or her vision for a happy, meaningful, proud, successful life is:

Over the past several weeks/months, in the face of multiple challenges:

> List all the challenges (e.g., continuing mental health issues, substance issues, cognitive/learning issues, health issues, past and current trauma, relationship challenges, housing issues, criminal justice issues, etc.)
>
> 1.
>
> 2.
>
> 3.

This person has amazingly made progress toward his/her goal of happiness by doing the following things:

> List the positive things that he/she has been doing in general, and specifically to make progress for each challenge. STAY WITH A STRENGTH-BASED FOCUS (e.g., "He/she has amazingly made 75% of appointments or taken meds 60% of the time."), rather than "He/she does not keep appointments and is med non-compliant."
>
> Also note the STAGE OF CHANGE he/she is in for each issue, reflecting progress in a way that is "stage-matched." (e.g., "He/she has just started to trust us enough to talk about substance issues in spite of bad experiences with talking about these issues with caregivers in the past, and is moving into the contemplation stage.")
>
> 1.
>
> 2.
>
> 3.

Based on the above, I would like some help from the team identifying smart next-steps of progress (skills, etc.) that the person and I/the team can work on in partnership together, for each of the challenges that he/she is facing, in order to help him/her make progress toward the vision of a happy life.

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Exercise 5: Applying Best-practice CCISC Principles to Crisis Intervention

Practices

- Suicide risk assessment and intervention
- Strength-based integrated crisis planning
- Trauma-informed care in a crisis situation
- Motivational interviewing in crisis
- Working with families in a crisis situation

Learning Objectives

Participants will:

- Understand specific steps for how to engage a multi-occurring client with risky behaviors to create a successful partnership to maintain safety in the community.
- Translate the concepts of trauma-informed care and strength-based intervention to de-escalation of a crisis.
- Apply stage-matched motivational interviewing in a crisis situation to facilitate crisis resolution vs. escalation.

"How Can You Cut It If You're Not That Sharp?"

Tabatha is a talkative and engaging 17½-year-old mixed race (African American/ Caucasian) young woman who says, "It is just not fair, 'Baby Earl' is MY son." She has a 16-month-old son named Earl who is being raised by Tabatha's maternal Grandmother since his birth. Grandmother and Baby Earl live in "Dear Born" Michigan. Tabatha lives in Fresno with her maternal aunt who is a very hardworking seamstress who owns her own business and apartment, and who is very strict with Tabatha. Both of Tabatha's parents have serious problems with drugs and alcohol. Tabatha's father is an alcoholic and her mother is addicted to prescription opiates and suffers from chronic depression. Tabatha's father has not been seen for many years now. Tabatha's mother refuses to see her. Tabatha has no siblings.

When asked what she wants out of her life, Tabatha tells people, "It's not possible, but I want to bring up "Baby Earl." I have to keep myself in control. If I can do that, I can be a "really good" mother. I love MY mother and I worry if she is ok. I'm not very smart so I'm not going to be anything special. Maybe Baby Earl and I will go live in Vegas so I can find work, but wish I could have been smart enough to be a teacher. I love kids."

Background

Tabatha has a long history of childhood trauma that included emotional/verbal abuse by her father. Tabatha recalls at 14 years old being depressed and confused. She began hearing voices telling her that she was worthless and once she stabbed herself with a knitting needle in response to them. She was admitted to a children's psychiatric hospital and was prescribed Ativan and states that it helped her, but she was incoherent most of the time in the hospital "because of the medicine." While in the hospital, Tabatha was found to have an IQ of 90. Her discharge diagnosis from the psychiatric hospital was "Adjustment Disorder." Upon release after 2 weeks, Tabatha went home to live with her mother, finding that her father had left. Much to her surprise, Tabatha missed him and felt ''empty" afterwards. Her mother told Tabatha that they were better off without him. Tabatha remembers her mother saying, "Now that he is gone, you won't have to go crazy like me." She never said another word to Tabatha about him.

Tabatha became sexually active shortly thereafter. Tabatha's third sexual relationship (at age 16) consisted of physical abuse, first use of marijuana and methamphetamine and resulted in a pregnancy with her son, Earl, who was taken into custody by child protective services and placed with Tabatha's grandmother as a result of his testing positive at birth for marijuana and methamphetamine, and Tabatha's "poor parenting capacity" and "lack of supervision." Tabatha was sent by her mother to live with the

mother's sister, Tabatha's aunt. The aunt is not pleased, but was committed to making sure that Tabatha has a better life than her own sister has.

Subsequently, the aunt made Tabatha get treatment for drugs. Tabatha successfully completed an outpatient drug program for teens for one month and did not use any drugs for three months after that while living with her aunt. During this period, Tabatha focused on learning to be a parent at classes offered by the high school. She made two friends and the three girls spent most of their time together "kicking ideas around and feeling like sisters." She was hearing angry voices off and on during this time, and she kept herself distracted by listening to music. She kept hoping the voices would go away because she had stopped using drugs, but they did not. However, she felt more "normal" than she had in her whole life. "After a couple of weeks I felt like I wasn't riding such a big emotional rollercoaster anymore. Before that I never knew how I would feel when I woke up in the morning. Now I could focus on what I wanted to and the girls really, really liked me. I was not scared anymore that I was going to wind up like my cousin did." During this time Tabatha engaged well with her child welfare caseworker who has been with her through thick and thin since Earl was born. She called her frequently and began to open a little with her about her plans for the future. Tabatha's aunt told her she was proud of her.

Three months ago the aunt told Tabatha that since she was almost an adult, she would need to move out on her 18th birthday and go get a job to support herself, but she knew she could do it if she tried and kept herself pulled together. Tabatha was not so sure about that, but agreed that she would be "just fine."

Important Bits and Pieces

Her son is behind in all development markers, but most notably he is delayed physically. Tabatha feels ashamed because she feels like she has hurt him.

Tabatha has a cousin, a close family member, diagnosed with Bipolar Disorder who committed suicide two years ago.

Tabatha takes no medications and is currently not receiving mental health or substance counseling.

She attends regular school classes, although she is one grade level behind for her age because of her pregnancy. She is a junior in high school.

What is Going on Right Now

Tabatha was picked up for petty theft (shoplifting $14 worth of school supply merchandise from the Wal-Mart) two days ago. Tabatha has current legal charges for the theft and a court appearance scheduled in two days.

Yesterday Tabatha called her caseworker and told her that the voices were saying to her, "You don't deserve Baby Earl." The caseworker helped her through this in the moment and asked if she could tell Tabatha's aunt how much she was suffering, but Tabatha said no, "She doesn't really care about me. They are my voices, so it's my choice who to tell!"

Today her aunt brings her to you, her community-based behavioral health team. They are accompanied by her child welfare caseworker. When she arrives, Tabatha smells slightly of marijuana and is restless. The caseworker looks worried and the aunt is angry, but in good control of herself.

The aunt says Tabatha did not sleep at all last night. She was pacing the floor all night and covered her room with post-it notes with "her options." Aunt says Tabatha seems totally preoccupied. She got concerned enough to bring her to the community clinic because she found Tabatha sharpening all the knives in the kitchen this morning. When she asked her what she was doing, Tabatha said, "They are dull, just like me. How can you cut it if you're not that sharp? "

Our Job

Our job is to begin to figure out how to help Tabatha and her support system.

What is the current situation? What is Tabatha's experience right now? What do you think it might feel like to be her right now?

What does Tabatha say she wants out of life?

What was a recent period of relative stability? From _____ to _____

Describe what you know about Tabatha's experience during this period (Strengths!!!):

Begin to craft the longitudinal history of Tabatha's life experience. (Strengths!!!)

Exercise 6: Applying Trauma-informed, Positive Behavior Support Principles

Practices

- Strength-based interventions and positive behavior supports to address "rule violation"
- Integrated diagnostic framework for individuals with multi-occurring issues, including trauma
- Skill-based interventions to improve symptom management
- Partnership with child welfare to use best-practice approaches for child welfare applied to multi-occurring parent/child situations
- Trauma-informed women's residential treatment

Coaching Scenario

Introduction

The goal of this coaching scenario is to help participants practice how to apply the CCISC principles to developing helpful, hopeful, and inspiring approaches for people with multi-occurring issues in residential service settings who "get into trouble" for "breaking the rules." This is a common situation that challenges our abilities to remain engaged in a recovery partnership with the individual, and to figure out how to balance attention to program safety and integrity with helping the individual in service to make progress, rather than simply to experience punishment. In order to be successful in this exercise, teams will need to practice using EVERY ONE of the CCISC principles.

The "cast" of this coaching scenario involves someone playing the role of the client, someone playing the role of the coach, and a group of people playing various roles on the client's current "treatment team."

Scenes

The scenario has two scenes:

Scene 1: Setting the Stage for Intervention

In this scene the "rule-breaking problem" is presented, and the team is meeting with the client to introduce the issue for the purpose of coming up with a plan of action. The

goals of the first scene are to apply CCISC principles of welcoming engagement, empathic connection, hopeful goals, strength-based focus, and integrated attention to multiple primary issues (including health, housing, parenting, etc.) in order to engage the client in a collaborative conversation about what to do next.

Scene 2: Artful Planning

In this scene, if the client is successfully engaged as a partner, he or she will share more background about the situation that will enable the team and client to collaborate on an integrated, stage-matched plan in which the client can experience an intervention that involves "adequately supported, adequately rewarded learning" to develop new skills and approaches to managing the issues that led him or her to get into trouble in the first place.

Roles

The coach can use a special "Coaching Card" to guide the team to stay on track with the principles. It is recommended that in each group that the coach changes places with one of the team members for the second scenario, so that more people have the opportunity to be a coach. You can change the client role player as well, but that might make the scenario more challenging in terms of continuity. The team starts with some very basic information about how the client got into trouble. The client will have a "back story" that only he or she will see, that will help him or her play the role.

Scenario

The Situation

Marilyn is a 39-year-old woman who has longstanding crack cocaine and alcohol dependence, as well as a history of abuse of various tranquilizers and pain pills. She carries a diagnosis of bipolar disorder, related to a history of "mood swings," for which she takes Depakote and Seroquel. She also reports a history of physical and sexual abuse as a teenager, and a series of abusive relationships with men as an adult. She has a history of working as a real estate agent.

Marilyn was admitted to Recovery Center (RC) for addiction treatment after child welfare intervened to take temporary custody of her fourth child (Adam, age 6). Her previous three children, now in their teens, have been permanently removed, two of them with a maternal aunt, and one adopted by a former foster family. Marilyn has had many previous "treatment episodes," but reports that the longest that she ever remained "in treatment" was three weeks. "I just couldn't take being around all those people."

This time, Marilyn has told everyone at RC, as well as her child welfare worker (who is actually hoping Marilyn is able to make it), that "Things are going to be different! Adam is my last baby, and I don't want to lose him." For the past six weeks, Marilyn has been able to remain at RC. She has been actively participating in groups, and has started to acquire more privileges. She had a pass to visit Adam two weeks ago. For the first time she has been able to open up to her female counselor about her addiction, and to talk with other women in groups about getting support. She is nervous being around the men in the program, but she has managed to create a small support group of women.

She has been taking meds regularly (which, she reports, she does not do when she is working because the meds make her sleepy), but she still reports mood swings. She does not open up too much about her feelings and symptoms in the program, but she tries very hard to do what she is supposed to do.

For the last week, Marilyn has appeared to be "moody" and withdrawn. Staff and clients have confronted her about "isolating." She said there is nothing to discuss, that she is just "going through a mood swing." She insists she is taking her meds. Yesterday, she was observed furiously cleaning the kitchen in the program, working really quickly. One of the staff members came by, and said that she needed to stop this inappropriate "manic" behavior. Marilyn lost her temper, called the staff member names, and stormed into her room. She knew she was going to be in big trouble for her angry outburst.

Shortly afterwards, Marilyn's roommate found Marilyn taking some Seroquel from a small stash hidden in her drawer. Marilyn told the roommate, "Please don't tell anyone. They'll throw me out of here and then I will have lost everything." Marilyn's roommate reported this to staff anyway. Marilyn is very angry about this, as well as scared about what is going to happen to her, both for sneaking medication AND for losing her temper.

Now, the treatment team, including the Child Welfare Worker, is meeting with Marilyn to determine what should happen next.

The Job of the Team

The job of the team in Scene 1 is to come together and engage Marilyn in a helpful and hopeful conversation about how to address the problem, and to begin to share more of her "back story."

The job of the team in Scene 2 is to use your understanding of her story to help her join the team in a plan to address the immediate situation AND make progress toward her recovery goals.

Back Story (Based on a true story)

Marilyn was the oldest daughter in an abusive alcoholic household. She was physically and sexually abused by her father, and sexually abused by her uncle. Her mother was depressed and passive, and could offer her little protection. Marilyn was always a fighter and a hard worker. She fought back against her father, which often made her the target of more abuse, but she felt it was necessary to protect her younger siblings.

Marilyn always did well in school. She was smart and articulate. However, when she was about 14 years old, she began hearing voices. The voices often sounded like her father and her uncle threatening her and calling her names. The voices made her very depressed, and at times she would have suicidal thoughts. She found that focusing her brain on activities like work, chores, and school would help her get by. However, on the really bad days, she would sneak some alcohol or marijuana to calm herself down. When she was 17, she left home and moved in with her boyfriend, who was 22. She completed high school and got a job working in a real estate office as a receptionist. She continued to hear voices and drink on occasion, but her life began to make progress for a while. Then, about a year later, she got pregnant. Her boyfriend was furious with her, and made her get an abortion. This led her voices to get even worse, and her increasing depression led to more and more fights with her boyfriend, who became more abusive, and eventually started hitting her. She made a suicide attempt and was hospitalized for the first time at age 19.

She broke up with her boyfriend, and started counseling for a short while. She was put on medication for her voices and her mood swings, but she did not like to take it. She never mentioned that she was using drugs and alcohol almost every day to manage her feelings. However, she decided that she could not rely on anyone but herself, and decided that she was going to go to school at night to become a real estate agent, which she did.

In her mid-twenties, she got involved in a relationship with one of the other real estate agents, and got pregnant with her first child. They got married and had the baby, and then two more over the next three years. This relationship also became emotionally abusive, as her husband demanded more of her attention, and she felt he was competing with the babies for her love. She never told him very much about hearing voices (which never went away), and was no longer on any medication. During those years, Marilyn was drinking more and more, but still able to work and function as a mother until she went to a party where she was introduced to cocaine. Immediately, she felt strong and powerful. She thought, "This stuff helps me to function and stay on top of everything." Over the next few years, her cocaine addiction worsened, and despite numerous attempts at treatment (and during her treatment episodes for addiction, she

never disclosed the extent of her mental health issues) she continued to use. She eventually lost her marriage, her job, and all three of her children, which in turn led to another suicide attempt and hospitalization, when she was 31 years old. She was in psychiatric treatment for a while, but never disclosed the extent of her substance abuse to her psychiatrist, who was giving her medication for her voices.

Following the hospitalization, back on medication, she chose to stop using substances, and was able to get another job and put her life back together. Adam was the result of a short fling with a man she met while she was working, whom she quickly broke up with when she saw that he, too, was likely to wind up taking advantage of her. She thought, "At least, I'm getting smarter about men." She stayed away from drugs and alcohol through the pregnancy, but also stopped her medication. The voices got worse, and even though she always knew they were not real, they were very distressing. Following the birth of Adam, she did not return to the psychiatrist, but instead threw herself into work and motherhood. She also began to drink again, at first just a little, but gradually more and more. This in turn led her back to cocaine, and this in turn led to child welfare getting involved because of anonymous complaints from her neighbors about her late-night partying.

Following her last "treatment," when Adam was 4, she decided that she was just going to stay away from drugs and control her drinking. As usual, she did not talk about mental health issues in addiction treatment. She went back to work (she is actually a talented real estate agent), and did OK for a while, just by staying busy. She did not want to go to 12-step meetings or engage in counseling: "I don't like all those people being in my business, and besides, talking about all those feelings just makes me want to get high." However, about six months ago, she reports, having money in her pocket, and feeling lonely and scared, she found herself going back to cocaine to "get by." She pretty quickly began losing control. She was able for the first time to ask for help by letting her child welfare worker know that she was in trouble, so the worker agreed to put Adam in temporary foster care, and give her "another chance."

She also decided she would take a risk on sharing her mental health issues in the addiction program, and getting herself on medication as part of getting into treatment. The medication has helped her moods and helped her voices (somewhat), and contributed to her success. However, she has been unsure about how much to share in the program about her symptoms. In particular, although she is comfortable talking about "mood swings " she worries that if she talks about hearing voices everyone will think she is "crazy," so she initially kept that to herself. After being in the program for a few weeks, and beginning to trust her counselor a bit more, she mentioned to her counselor (casually) that she "sometimes heard a few voices." The counselor looked nervous, and said, "Well, you don't look psychotic, so maybe it's better that you keep

that part to yourself here." Marilyn felt like the message she was given was real clear: "Voices are not 'welcome' here. You need to manage this on your own." So she has tried to open up about her addiction, and manage her voices with meds and "hard work."

Two weeks ago, when she went to see Adam, he was very upset that she could not just take him home. She began to feel much guiltier, and the voices got really loud. She found a friend who sold her 10 Seroquel (for "backup") and she hid them in her room. All week the voices have been loud and critical. She has not felt she could tell anyone. She has been sneaking extra Seroquel without much luck, and yesterday she was so close to the edge that the only thing she could think of was to furiously clean the kitchen. When the staff member told her she was being "manic," she couldn't take it anymore and lost her temper. She ran back to her room to take some extra meds to calm down, when her roommate found her. She is really angry about what has happened, but she knows the staff care and are trying to help. She is really terrified that she will lose Adam forever, but does not know what to do.

Worksheet

Hopeful goals:

Skills used during recent period of strength and success:

Issues	Stage of Change	Stage-matched Objective/Intervention
1. Addiction		
2. Mental health (Voices/moods)		
3. Parenting		
4. Trauma history		
5. Seroquel misuse		
6. Temper outburst		
7. Anger at roommate		

For each objective and intervention, identify milestones of progress and positive contingencies (rounds of applause). List those milestones below.

Connect positive work and learning to the "reward" of gaining an opportunity to remain in the treatment program by demonstrating new skills in each issue that will advance recovery.

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Part 7: Organizational-level Continuous Quality Improvement

Introduction

CCISC is a Continuous Quality Improvement (CQI) framework that engages the entire system in a partnership so that each level of the system can be successful in making progress in the direction of a common vision in an organized way. A great deal of importance is placed on helping programs and agencies understand and implement CQI as an organizational standard of practice to manage complex change. This spirit of partnership amaong all levels of the organization in CQI processes is symbolic of an organization's ability to produce empowered partnerships in general between caregivers and consumers. In CCISC circles, we refer to CQI as "recovery planning for programs," and we call CQI plans, "Action Plans."

Criteria for Successful Program Action Plans

Commitment

- Evidence of buy-in from empowered leadership, and participation of leadership in the improvement plan. (Not just the Change Agent doing all the work….)

Comprehensiveness

- Includes some reference to all activities in the charter/consensus document. (It helps to read the charter....)
- Includes activities that relate to all programs and clinicians in the organization, not just a special unit.

Concreteness

- Measurable, achievable objectives (not vague, grandiose, perfection goals), short time frames, and responsible individuals or work groups.

Connectedness

- Policy changes are connected to practice changes are connected to competency development and training activities.

Continuous Quality Improvement Framework

- Identify an empowered quality improvement team in the agency infrastructure that oversees the activity and is formally assigned the task.
- Some kind of Plan-Do-Check-Act cycle: Identify the problem or improvement opportunity, measure baseline and multiple causes, plan an approach, do the approach, re-evaluate in a short time frame, and then plan to do the next step.

Integrated Organizational Recovery Plan Template

Program:		**Date:**	
Strength-based Discussion: Describe progress that the program has made in the 12 steps of the CCISC process in inspiring services for customers *(e.g., person-/family-centered, recovery- or resiliency-oriented, trauma-informed, complexity capability)*.		**CQI Team Members & Other Change Partners:**	
		Programs' Inspired Vision:	
Issues that were identified through COMPASS self-assessment & other processes. *(Usual starting places: Welcoming, Access, Hope, Screening & Data, All Staff Competency)*	**What Do We Do?** *(Small-step measurable interventions for each objective)*	**Responsible Persons** *(Who does what for each intervention?)*	**Timeframes, Milestones of Progress & Opportunities for Rounds of Applause** *(For each objective)*
Issue:			
Program's Goal for the Issue:			
Objectives (below):			
a. b. c.	a. b. c.	a. b. c.	a. b. c.
Issue:			
Program's Goal for the Issue:			
Objectives (below):			
a. b. c.	a. b. c.	a. b. c.	a. b. c.

Part 7: Organizational-level Continuous Quality Improvement

Issues that were identified through COMPASS self-assessment & other processes. *(Usual starting places: Welcoming, Access, Hope, Screening & Data, All Staff Competency)*	**What Do We Do?** *(Small-step measurable interventions for each objective)*	**Responsible Persons** *(Who does what for each intervention?)*	**Timeframes, Milestones of Progress & Opportunities for Rounds of Applause** *(For each objective)*
Issue:			
Program's Goal for the Issue:			
Objectives (below):			
a. b. c.	a. b. c.	a. b. c.	a. b. c.
Issue:			
Program's Goal for the Issue:			
Objectives (below):			
a. b. c.	a. b. c.	a. b. c.	a. b. c.
Signed by: ☐ CEO ☐ Program Director ☐ Supervisor ☐ Change Agents ☐ Staff ☐ MD ☐ Consumer Rep(s)			

Sample Program Action Plan for Mental Health Outpatient Agency

Program: *Mental Health Outpatient Agency*			**Fiscal Year:**
Contact Person: *Change Agent*			**Phone:**
Goals & Objectives Action Items *(Taken from the COMPASS, write broad goals & specific objectives or activities; e.g., write a policy, put up a poster, collect data, develop a new practice and competency.)*	**What Do We Do? Measurable Steps & Indicators of Progress** *(Something quantifiable; e.g., the policy is written, the poster is in place, data is collected, the practice is defined & written, the training was held.)*	**Responsible Persons** *(Individual(s) responsible for completing the action item)*	**Target Date for Completion** *(Actual date by which the action item is to be completed [not just "Spring, 2011"]).*
Program leadership announces official commitment to multi-occurring capability for the agency	*Announcement is issued on letterhead & disseminated to all staff.*	*The Boss*	*Initial draft by when? Reviewed & revised by when? Issued by when?*
Program leadership announces that all staff will be developing core competency in COD.			*Formal charter of the process by the boss, by when?*
Program leadership organizes a CQI team to cover the whole organization, including front-line staff.	*CQI team meets regularly, keeps & disseminates minutes & communicates that all agency programs will participate in their own CQI process.*	*Boss to empower team CQI leadership to provide support.*	*Set up composition & schedule of meetings by CQI team leaders, by when?*
Program leadership & CQI team create a message that welcoming is a starting place.	*Write welcoming, recovery, multi-occurring capability into the "Charter" of CQI process. Identify a committee to create a formal welcoming policy.*	*Program managers to own the CQI process inside each program in the agency.*	*Direct memos from program managers to staff, by when?*
Program leadership & CQI team indicate that screening & counting are another starting place.			
To promote welcoming engagement, increase staff knowledge about Stages of Change & Motivational Interviewing, as a first step to having staff engage with consumers in a welcoming, empathic, stage-matched motivational framework.	*Accomplish using recommended reading materials, in-service & outside training. Indicator: staff reports that they have heard of stages of change and mental illness, & wish that they knew how to do it better to produce better outcomes.*	*Change agents & all team leaders informed by feedback from staff.*	*Already done.*

Part 7: Organizational-level Continuous Quality Improvement

Program: *Mental Health Outpatient Agency*			**Fiscal Year:**
Contact Person: *Change Agent*			**Phone:**
Goals & Objectives **Action Items** *(Taken from the COMPASS, write broad goals & specific objectives or activities; e.g., write a policy, put up a poster, collect data, develop a new practice and competency.)*	**What Do We Do?** **Measurable Steps & Indicators of Progress** *(Something quantifiable; e.g., the policy is written, the poster is in place, data is collected, the practice is defined & written, the training was held.)*	**Responsible Persons** *(Individual(s) responsible for completing the action item)*	**Target Date for Completion** *(Actual date by which the action item is to be completed [not just "Spring, 2011"]).*
Improve application of stage-matched motivational strategies in actual clinical care. *a. CQI team identifies indicators & discusses with staff.* *b. CQI team works with medical records to develop a place on forms where we can put a box to check stage of change.* *c. Form a committee or work group to develop samples of stage-matched plans.*	*Indicators:* *Step 1: We discuss stages of change in the case reviews & document in the chart in a box for stage of change for each problem. We practice welcoming individuals in early stages of change.* *Step 2: We develop sample stage-matched treatment plans.* *Step 3: We practice using sample plans in real treatment.* *Step 4: We look for areas of improvement in stages as we move through treatment.*	*Who is going to oversee this?* *CQI team to identify indicators.* *Medical Records to create the box on forms.* *Program & team leaders to identify stages of change.* *Change Agents to model welcoming discussions with early-stage people & to lead the committee on sample treatment plan development, etc.*	
To begin improving screening & counting, [FILL IN]	*Form screening & counting committee. Collect baseline info from each program. Develop a plan to improve—not fix—the baseline. Plan-Do-Check-Act cycle is documented.*	*CQI team creates the group & identifies a chair. Committee chair helps committee to develop a survey for each program. Define what we count, find a place to report (yes, no, maybe), etc.*	
Comments by: ☐ Program Manager ☐ Agency Staff ☐ Other			
Program Director Signature:			Date:

Appendices

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Appendix A: CCISC Description and Principles

CCISC Description

The Comprehensive Continuous Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision-driven system "transformation" process for redesigning behavioral health and other related health and human service delivery systems to be organized at every level (policy, program, procedure, and practice)—within whatever resources are available—to be more about the needs and hopes of the individuals and families needing services, and to be developed according to values that reflect welcoming, empowered, helpful, and integrated partnerships for individuals and families with multiple challenges throughout the system.

The ultimate goal of CCISC is to help develop a system of care that is welcoming, hopeful, strength-based (sometimes termed *recovery-oriented* or *resiliency-oriented*), integrated, trauma-informed, culturally competent, and multi-occurring capable (sometimes termed *complexity capable*) in order to most effectively meet the needs of individuals and families with multi-occurring conditions of all types (mental health, substance abuse, cognitive and developmental conditions and disabilities, as well as medical, trauma-related, housing, legal, parenting, familial, and employment issues) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, every part of the system, every provider agency and program, and every person delivering support, services, and care engages in a quality improvement process—in partnership with each other, with system leadership, and with individuals and families who are receiving services—to become welcoming, recovery- or resiliency-oriented, and multi-occurring capable. Every aspect of service delivery, in every setting, is organized to make progress in this quality improvement partnership to be designed on the assumption that the next person or family entering service will have multi-occurring conditions, and will need to be welcomed for care, inspired with hope, and engaged in an integrated partnership to address each and every one of those conditions in order to achieve their most hopeful and important goals.

This model is based on eight research-based consensus best practice principles of service delivery (Minkoff and Cline, 2004, 2005) which espouse a person-centered/ family-centered, hopeful and strength-based (recovery-oriented) philosophy that

creates a common language for the mental health system, the substance disorder treatment system, the developmental disabilities system, brain injury providers, and other collaborative health and human service systems serving overlapping populations with multi-occurring needs.

CCISC Principles

Principle 1. Multi-occurring issues and conditions are an expectation, not an exception.

This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every service contact, to promote access to care and accurate screening and identification of individuals and families with multi-occurring issues.

Principle 2. The foundation of an empowered service partnership is an empathic, hopeful, integrated, strength-based relationship.

Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition. The emphasis of the partnership is to join *with* the individual and family, not do things *to* the individual and family, in order to prevent continuing trauma and promote person-centered/family-centered change.

Principle 3. All people with multi-occurring conditions are not the same, so different parts of the system have responsibility to provide multi-occurring-capable services for different populations.

Assignment of responsibility for provision of such relationships can be determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the mental health and substance use conditions, as well as high and low severity of behavioral health conditions and cognitive/developmental disabilities.

Principle 4. When multi-occurring issues and conditions are present, each issue or condition is considered to be primary.

The best-practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.

Principle 5. Progress involves moving through stages of change for each multi-occurring condition or issue.

Individuals and families address multiple conditions and issues in their step-by-step journey to achieve their most important life goals. However, it is common that individuals and families are in different stages of change for different issues at the same time, and move through those stages according to their own choices and capabilities. Therefore, for each condition or issue, interventions and outcomes must be matched to stage of change.

Principle 6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each multi-occurring condition or issue.

For each multi-occurring condition or issue, progress (treatment and support) involves getting an accurate set of recommendations for that issue and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. The progress of learning must be structured and supported to match each individual's cognitive abilities. Further, in order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward (positive behavioral support) is much more effective in promoting learning than negative consequences.

Principle 7. Service and support plans, interventions, and outcomes must be individualized. Consequently, there is no one correct multi-occurring program or intervention for everyone.

For each individual or family, integrated interventions and outcomes must be individualized according to their hopeful goals; their specific diagnoses, conditions, or issues; and the stage of change, strengths, skills, and available contingencies for each condition.

Principle 8. CCISC is designed so that all policies, procedures, practices, programs, and service providers become welcoming, hopeful, strength-based, trauma-informed, culturally competent, and multi-occurring-capable.

Each program has a different job, and programs partner to help each other succeed with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships in which each multi-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based, community-based learning for each condition, in order to help the individual or family make progress toward achieving their hopeful goals for a happy, productive, and meaningful life.

Appendix B:
CCISC Tool Cover Sheets

- COMPASS-EZ™
- CODECAT-EZ™
- COFIT-100™
- COMPASS-PH™
- COMPASS-PH/BH™
- COMPASS-ID™
- COMPASS-Prevention™
- COCAP™
- SOCAT™

COMPASS-EZ™

A Self-assessment Tool for Behavioral Health Programs

Creating Welcoming, Recovery-oriented, Co-occurring-capable Services for Adults, Children, Youth, and Families with Complex Needs

Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Authors: Christie A. Cline, MD and Kenneth Minkoff, MD

Agency Name: _____

Program Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-EZ™ Participants: _____

_____

_____

Date Completed: _____

CODECAT-EZ™

A Tool for Behavioral Health Treatment and Service Providers Working with Adults, Children, Youth and Families

Recovery-oriented Co-occurring Competency:
A Clinician Self-assessment Tool

Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Authors: Christie A. Cline, MD and Kenneth Minkoff, MD

Name: _____

Role or Job Title: _____

Program Name: _____

Agency Name: _____

Date Completed: _____

CO-FIT100™

CCISC Outcome Fidelity and Implementation Tool

Systems Measurement Tool for the Comprehensive Continuous Integrated System of Care Model for Integration of Psychiatric and Substance Disorder Services

Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Authors: Kenneth Minkoff, MD and Christie A. Cline, MD

COMPASS-PH™

A Self-Survey Tool for Primary Health Clinics, Programs and Teams

Developing Behavioral Health Capability in Primary Health Settings

Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Authors: Christie A. Cline, MD and Kenneth Minkoff, MD

Clinic Name: _____

Program/Team Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-PH™ Participants: _____

_____

_____

Date Completed: _____

COMPASS-PH/BH™

Developing Integrated Physical Health/Behavioral Health Capability in Treatment Settings

Version 1.1

A Self-assessment Tool for Behavioral Health and Primary Health Clinics and Programs

Authors:
Christie A. Cline, MD, MBA
Kenneth Minkoff, MD

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Clinic Name: _____

Program/Team Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-PH/BH™ Participants: _____

_____

_____

Date Completed: _____

COMPASS-ID™

A Self-assessment Tool
for Service and Support Programs

Creating Co-occurring-Capable Intellectual Disabilities Services and Supports for Individuals and their Families

Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Authors: Christie A. Cline, MD and Kenneth Minkoff, MD

Agency Name: _____

Program Name: _____

Contact Person: _____

Change Agents: _____

COMPASS-ID™ Participants: _____

_____

_____

Date Completed: _____

COMPASS-PREVENTION™

Prevention Provider Tool
Co-occurring Disorders Services Enhancement Toolkit Item Version 1.0

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Organization: _____

Program/Team Name: _____

Contact Person: _____

COMPASS-Prevention™ Participants: _____

_____

_____

Date Completed: _____

COCAP™

A Tool for Recognizing Progress in Programs, Agencies and Systems

Co-occurring Capability for

- Substance Abuse Treatment Provider Agencies
- Mental Health Treatment Provider Agencies
- Agencies that Provide Services to Individuals and Families with Mental Health and Substance Abuse Needs

Version 2.0

Authors: Christie A. Cline, MD and Kenneth Minkoff, MD

ZIA PARTNERS

369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Agency Name: _____

Program Name: _____

COCAP Participants: _____

_____

_____

Date Completed: _____

Part I Score: _____ Part II Score: _____ Total Score: _____

SOCAT™

System of Care Assessment Tool

A Self-Survey Tool for Participating Organizations and Agencies in Community-based System of Care Partnerships

Version 1.0

ZIA PARTNERS
369-B 3rd Street., #223
San Rafael, CA 94901
e: *info@ziapartners.com*
w: *www.ziapartners.com*

Community SOC: _____

Partner Organization: _____

Change Agent: _____

Date: _____

Appendix C: 12 Steps for CCISC Implementation

(See Minkoff & Cline, 2005, Welcoming Systems of Care, Journal of Dual Diagnosis).

CCISC implementation involves a system-wide quality improvement partnership in which all components of the system are organized to make step-by-step progress toward a common vision. The partnership is both horizontal and vertical.

The horizontal partnership means that all "subsystems" (e.g., mental health, substance abuse, developmental disabilities, adult and children's systems, county or regional systems), all provider agencies and programs and consumer/family advocacy organizations are welcomed as partners into the process, exactly as they are. Whether the subsystem, provider agency, or program is an "excited front-runner," a good partner right in the middle, or nervous about the changes, everyone is welcome.

The motto is: **All you have to have is an interest in making things better for the people receiving service, and you have a place at the table.**

In the horizontal partnership, Change Agents represent each participating partner program, agency, or constituency to become a boundary-spanning team across the whole system.

The vertical partnership means that the change process is neither top-down nor bottom-up. The quality improvement process is a partnership among system leadership, system middle managers, agency leadership, agency and program managers and supervisors, front-line staff and, of course, individuals and families receiving service, who are the drivers of the process and the people to whom we are all ultimately accountable.

In the top-down, bottom-up vertical partnership, Change Agents represent the front-line voice of people delivering care, people providing services and supports, and people receiving services.

Individually, within their own programs or settings, Change Agents partner with their own leadership to help them make progress toward multi-occurring capability.

As a team, Change Agents work as empowered partners as a formal constituency within the system, to partner with leadership to transform the system at every level.

The following section describes what are called the *12 Steps of Implementation of CCISC*. These steps organize the implementation process at multiple levels simultaneously. Although they are listed in order, they do not occur sequentially. The earlier steps occur

more at the "top of the system," and the later steps more at the front lines of the system; all the activities are coordinated to create change in many places at many levels across the system as a whole.

This model of system transformation by having multiple distinct activities all moving toward a common vision at the same time is called "collective impact".

CCISC implementation is an example of collective impact applied to behavioral health, health, and human service delivery systems.

The 12 Steps of Implementation listed and discussed below.

1. Integrated System Planning and Implementation Process

Implementation of the CCISC requires a system-wide integrated strategic planning process and quality improvement partnership that creates an empowered partnership among all levels of the system, including consumers, families, and front-line clinicians. This partnership can address the need to create change at every level of the system:

- System philosophy, regulations, and funding
- Program standards and design
- Clinical/service practice and treatment/support interventions
- Staff competencies and training

The integrated system planning process must:

- Be empowered within the structure of the system.
- Include all key funders, providers, and consumer/family stakeholders.
- Have the authority to oversee continuing implementation of the elements of CCISC.
- Use a structured process of system change (e.g., continuous quality improvement).
- Define measurable system outcomes for the CCISC in accordance with the elements listed herein.

Consumer- and family-driven outcomes measure the ability of the system to be designed, with all programs, policies, practices, and persons providing care, to be welcoming, hopeful, strength-based, trauma-informed, culturally competent, and multi-occurring capable, as well as accessible, integrated, continuous, and comprehensive, from the perspective of individuals in service and their families.

The COFIT-100™ was developed to facilitate this CCISC outcome measurement process at the system or sub-system level.

The COMPASS-EXEC™ is a self-assessment tool for system leadership to determine how well they are organized to oversee implementation of CCISC.

The SOCAT™ is a self-assessment tool for system partnerships (for children or adults, county, regional, or statewide) among multiple agencies (e.g., behavioral health, developmental disabilities, criminal justice, housing, education, health, vocational rehabilitation, and so on) to determine how well organized the system partnership is to implement CCISC principles and SOC (system of care) principles at every level.

See 15 Steps for Implementation Teams in Appendix D.

Steering Committees and Leadership Teams

Many systems will organize the integrated system partnership by creating a formal transformation leadership team or steering committee, on which all the partners are represented.

Change agent teams will identify specific representatives to the Steering Committee. These representatives represent the collective voice of all the Change Agents across the system, and join representatives of other constituencies (consumers, families, provider leadership, system managers) at the partnership table.

2. Formal Consensus on CCISC Implementation

The system must develop a clear mechanism for:

- Articulating the CCISC process, including principles of treatment and goals of implementation.
- Developing a formal process for obtaining consensus from all stakeholders.
- Creating a formal Charter Document that "charters" the action steps and objectives in the quality improvement partnership and process.
- Describing the implementation steps and responsibilities for system leadership, as well as implementation steps and responsibilities for each participating program partner (The 12 Steps for Agencies/Programs).
- Disseminating this consensus for action to all providers and consumers within the system.

Change agents participate as partners in the development of the charter, in the dissemination of the charter across the system, and the implementation of the agreed upon "steps" for change within their own agencies.

3. Funding Plan within Existing Resources

CCISC implementation involves the recognition that *each* funder or funding stream within the system—with every dollar spent—can promote welcoming, hopeful, strength-based, trauma-informed (recovery-oriented) multi-occurring-capable services within the full range of services provided through its own funding stream—whether by contract or by billable service code—in accordance with CCISC principles and in accordance with the specific tools and standards described below. That is, integrated service delivery is supported within each single-funded event, rather than every person with multiple issues requiring multiple providers and multiple funding streams. Further, every dollar in the system is used to support the vision of transformation.

Using funding instructions and incentives to support inter-program partnerships and blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone is only a small component of the collective impact of CCISC.

CCISC supports:

- Developing the flexibility to more creatively use limited resources to design services across a whole system that are more accurately matched to the needs of complex populations.
- Using available incentives to support providers engaged in the transformative quality improvement process.

Change Agents are advocates in their own programs and as a team across the system for creative "out-of-the-box" approaches to care that use resources more effectively because they are better matched to what people receiving services really need.

4. Strategic Prioritization and Population-Based Planning

Strategic Alignment of Initiatives

CCISC encourages alignment of all "initiatives" in a common transformation vision, and building energy for change from existing strategic opportunities or priorities, including funding increases or reductions. Examples of "initiatives" that can be aligned or folded into a CCISC implementation process include:

- Primary Health/Behavioral Health Integration
- Recovery-oriented Systems of Care
- Trauma-informed Systems of Care
- Children's Systems of Care
- Positive Behavioral Supports
- Criminal Justice Diversion and Re-entry (Sequential Intercept)
- Housing and Homelessness Planning
- Child Welfare System Redesign
- Cultural Competency Development
- Development of a Managed Care Continuum (ASAM, LOCUS)
- Crisis System Redesign

The Four-quadrant Model

In addition, the system should organize a **population-mapping plan** for individuals and families with multi-occurring needs that present in various types of systems and settings. Using the national consensus Four-quadrant Model, the system develops a plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care.

The two Four-quadrant Model examples below are applied to mental health and substance use disorder services, and to behavioral health and developmental disability services. The Four-quadrant Model has also been adapted to provide a framework for population mapping for behavioral health and primary care integration.

Four-Quadrant Model for Mental Health and Substance Use Conditions	
Quadrant IV Psych High - Substance High Serious & persistent mental illness* with substance dependence	**Quadrant III** Psych Low - Substance High Psychiatrically complicated substance dependence
Quadrant II Psych High - Substance Low Serious & persistent mental illness* with substance abuse	**Quadrant I** Psych Low - Substance Low Mild psychopathology with substance abuse
Four-Quadrant Model for Intellectual/Developmental/Cognitive Disabilities and Behavioral Health Conditions	
Quadrant IV Behavioral Health High (SPMI/SED) Developmental Disability High	**Quadrant III** BH Low - DD High
Quadrant II BH High (SPMI or SED) Cognitive Impairment Low-Moderate	**Quadrant I** BH Low, DD/Cognitive Impairment low
**Serious & Persistent Mental Illness (SPMI) is a term for adults; can be replaced by Serious Emotional Disturbance (SED) for children & adolescents.*	

In the MH/SA four-quadrant model, programs in the mental health system provide acute and continuing care to adults, children, and families with high priority mental health conditions (SPMI/SED), who may also have co-occurring substance abuse or dependence, as well as a variety of cognitive impairments that do not meet developmental disability criteria. Programs in the substance abuse system are mostly serving individuals with more serious substance use disorders (e.g., substance dependence) with lower severity mental health conditions, including trauma, as well as a range of cognitive impairments, usually below the threshold of formal developmental disability or serious brain injury.

In the BH/DD four-quadrant model, programs in the developmental disability system are supporting individuals and families with more severe well-defined developmental and intellectual disabilities, some of whom may have more severe mental health conditions and many of whom have less severe conditions, including trauma. As noted above, the behavioral health (MH and/or SA) programs are commonly serving individuals with more significant behavioral health conditions who occasionally have a

developmental disability, but more commonly have co-occurring cognitive impairments that are lower in severity.

In both cases, each system helps the other develop its internal capability, not primarily through referrals, but through consultation, education, in-reach and support, so more people can get what they need in a single door.

Motto: **It is easier for service providers to move around so that clients don't have to.**

Change agents are key partners in developing relationships with one another's programs, to provide that consultation, education, in-reach and support that spans the boundaries of the whole system and makes it more likely that individuals with complex needs will NOT fall through the cracks.

5. Development and Implementation of Multi-occurring-capable Programs

A crucial element of the CCISC model is the expectation that all child and adult programs in the service system meet basic standards for person-/family-centered, hopeful, strength-based (recovery- or resiliency-oriented) multi-occurring capability, whether in the mental health system, the developmental disability system, the brain injury system, or the addiction system. There needs to be consensus that each program can begin its own quality-improvement process to achieve multi-occurring capability. Note that even though each program is working on multi-occurring capability, each program in the system will have a different "job," based on its primary mission and resources, to provide multi-occurring capable services to the population that it already is likely to be serving.

COMPASS-EZ™ (ZiaPartners, 2009) is a program self-assessment tool for mental health and substance abuse providers working on multi-occurring capability that can be helpful in initiating the program quality-improvement process.

COMPASS-ID™ is a similar tool for intellectual disability, developmental disability, and brain injury providers.

COMPASS-Prevention™ is a similar tool for prevention and early intervention providers.

COMPASS PH-BH™ is a similar tool for primary health programs, developmental disability programs, or behavioral health programs working on improvement of primary health/behavioral health integration capability.

Using these tools in their own quality improvement activities, programs throughout the system make progress at their own pace in relation to their own goals toward multi-occurring capability, and anchor change into their own policies, practices, and paperwork. As programs make progress, the system can develop multi-occurring capability standards; over time, those standards can be built into regulatory, funding, and licensing requirements.

Change Agents play a critical role in helping their own programs make progress toward multi-occurring capability.

6. Inter-system and Inter-program Partnership and Collaboration

CCISC implementation involves creating routine structures and mechanisms for collaborative partnerships among developmental disability programs/providers, brain injury programs/providers, addiction programs/providers, mental health programs/providers, and representatives from other participating systems (e.g., corrections) to develop local (county or regional) system processes whereby all the providers work together to share responsibility for their common population, as well as to share clinical planning for complex cases whose needs cross traditional system boundaries.

Over time the system will develop formal policies and procedures that define how all the various types of providers develop and demonstrate that they are participating actively in those partnerships, both by joining local system collaborations, and by creating partnership relationships with collaborative programs in their communities.

Change Agent teams work collaboratively as the "front-runners" in inter-program and local system partnerships. Change agents build relationships across different programs in the same community to become the starting place for local system development and inter-agency collaborations.

7. Development and Implementation of Multi-occurring-capable Practices and Practice Guidelines

CCISC implementation requires system-wide transformation of clinical/service/support practice in accordance with the CCISC principles. This can be realized via continuous quality improvement (CQI) processes through dissemination and incremental developmental implementation of consensus best-practice service planning guidelines that address welcoming, engagement, integrated screening, integrated longitudinal strength-based assessment, integrated stage-matched and skill-based intervention and service planning, positive behavioral support, rehabilitation programming, program matching for multiple types of services and levels of care, psychopharmacology, transition planning, and peer support.

This manual provides a wide range of screening, assessment, and service planning tools and materials to guide this process, all based on CCISC principles. Existing practice guideline documents are adapted for this manual from national sources (visit *www.bhrm.org*).

Clinical practice implementation does not occur simply by training staff. Clinical practices must be supported by changes in policy, procedure, and paperwork, by regulatory changes (both to promote adherence to guidelines and eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor adherence. Quality improvement processes at the system and agency level to facilitate welcoming, access and identification, and to promote empathic, hopeful, integrated continuous relationships, are a particular priority.

Change Agents are front-runners in the implementation of clinical practice across the system. Change Agent teams receive training in the application of the CCISC principles and in using the materials in this manual to support the implementation of those practices in their own settings. This information provides a front-line and service-recipient perspective that allows systems and programs to implement new approaches in a way that is matched to the experience of people receiving and providing care and support.

8. Facilitation of Welcoming, Access, Integrated Screening and Identification of Multi-occurring Conditions

This step reflects the first priority for system and program improvement, based on the first CCISC principle that describes welcoming expectation for people with complex and multi-occurring needs.

Implementation of this step requires a quality improvement partnership that:

- Addresses welcoming and "no wrong door" access in all programs.
- Eliminates arbitrary barriers to initial access and evaluation.
- Improves clinical and administrative practices of screening, clinical documentation, Management Information System reporting, and appropriate next-step intervention for people with multi-occurring conditions, disorders, and disabilities.

Each program will usually prioritize welcoming, access, and integrated screening as the first steps in its quality improvement process toward multi-occurring capability. The system as a whole will support similar priorities, through such activities as developing a system-wide welcoming policy, creating mechanisms for improving routine integrated screening, increasing data reporting of individuals with various combinations of MH, SUD, DD, BI, and trauma, and developing policies that remove arbitrary access barriers based on things like presence of multi-occurring conditions, length of sobriety, level of IQ, and type of medication.

Change Agents are often the champions of welcoming, engagement, and access for individuals and families with complex needs who might otherwise be experienced as "misfits." Change Agents model welcoming with all partners in the system, and champion welcoming with their peers, within their programs, and across the system as a whole.

9. Implementation and Documentation of Integrated Services

Empathic, hopeful, strength-based integrated treatment/support relationships are the core of the second principle of CCISC, and are a critical component of both short-term and ongoing success for individuals and families with complex needs.

Implementation requires creating a quality improvement process in which service staff, supervisors, and managers partner in developing and documenting an integrated support, service, treatment or recovery plan in which the person or family is assisted to make progress toward hopeful goals by simultaneously following issue- and stage-specific recommendations for each primary multi-occurring condition or issue.

This expectation must be supported in a variety of ways within each program, and within the system as a whole. Examples of organizational supports include policies and protocols describing appropriate integrated person-centered documentation and service plans, clear definition of the expected "scope of practice" for how each type of service provider can provide and document integrated interventions, and standards of practice for documentation of reimbursable interventions that are acceptable to funders—in developmental disability, mental health and substance settings—for individuals who have multi-occurring conditions.

Change Agents frequently work in partnership with each other and with system and program leadership to develop the protocols and policies described above. Some Change Agents may work in the part of the system that performs quality oversight for charting and billing; they work with their service provider Change Agents and consumer/family Change Agents to develop improved instructions for how integrated services can and should be provided and documented to support hope and progress for individuals and families with complex and multi-occurring needs.

10. Development of Multi-occurring Competencies for All Persons Providing Service and Support

A significant characteristic of the CCISC process is creating the expectation that all staff, regardless of level or type of training and licensure, including those with no certification or license at all, can make progress toward developing universal multi-occurring competency, including attitudes and values as well as knowledge and skills. Available competency lists for multi-occurring conditions, such as the 12 Steps for Direct Service Staff (see discussion later in this chapter) (see page 45), can be used as a reference for beginning a process of consensus building regarding the competencies.

Mechanisms can be developed to:

- Establish competencies in existing human resource policies and job descriptions.
- Incorporate them into personnel evaluation, credentialing, and licensure.

- Measure and support clinician attainment of competency.

Competency self-assessment tools for front-line staff and supervisors (e.g., CODECAT-EZ™ ZiaPartners, 2009) can be utilized to facilitate this process.

Change Agents often function as peer supports for each other in learning new competencies and then bringing those competencies back to their colleagues in their own programs, as well as working with their program leaders on how to anchor those new competencies into place. Further, Change Agent teams commonly work with system leadership to develop system-wide competency instructions and scopes of practice. Some Change Agent teams have worked with state licensure boards to include a definition of multi-occurring competency within the scope of practice supported by licensure or certification.

11. Implementation of a Change Agent Team

In the CCISC quality improvement process, development of program multi-occurring capability and staff multi-occurring competency occur through a top-down/bottom-up partnership in which front-line clinicians and consumer/family Change Agents work with leadership to effect change. Change Agents in a system ideally become an empowered team that represents the principles and values of front-line service delivery and service recipients in the system planning and implementation process. ZiaPartners has developed this Change Agent Manual for systems to provide orientation and structure to help Change Agents with their growth and development.

Even though Change Agent Team development is "Step 11," because a lot of the other structures have to begin before the Change Agents have a "place" within the system process, Change Agents are usually recruited early in the process since they perform a vital role in the evolution of *all* the steps.

12. Development of a Plan for a Comprehensive Program Array

The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency in providing person-/family-centered, multi-occurring capable services for people with multi-occurring conditions, within the context of available resources. This plan should also identify system gaps or key areas of system mis-design that require longer-range planning and/or additional resources to address, and strategies for promoting

appropriate redesign and more effective resource utilization in the long term. Four important areas that must be addressed in each CCISC process are:

Welcoming Integrated Continuum of Crisis Access and Engagement with an Integrated Continuum of Levels of Care

Crisis Redesign

Most systems have a continuing mismatch in the design of crisis evaluation, intervention, and stabilization services for individuals or families with mental health and/or substance use and/or developmental conditions. The common areas of mis-design include the following:

- The crisis response continuum is designed as if individuals presented with single problems, rather than on the expectation of multi-occurring conditions.
- There are parallel crisis continua for each type of problem (e.g., MH crisis teams, crisis beds, and psychiatric units; SUD referral centers and residential/outpatient detoxification programs; DD respite centers), which are both inefficient and lead to battles about which setting is the best match for individuals with multiple issues.
- The crisis evaluation system is often designed mostly to determine appropriate disposition after a single assessment, when individuals with complex conditions may need continuing crisis assessment and intervention.
- The crisis system is often expected to transition individuals to continuing routine care after a relatively brief period of stabilization, when these individuals might not fit well into "routine intake" processes, and need extended (up to 3 months) flexible integrated community-based engagement and intervention.
- Most systems are designed so that the majority of "entry points" for ongoing care are for "routine intake," although the majority of individuals and families entering the system are entering in "crisis."
- Further, most systems have funded expensive "workarounds" to their existing crisis system to engage a limited number of people with complexity, but it is ultimately not cost-effective to continually spend scarce resources to work around the existing system, rather than re-organizing the core capability of the crisis system.

CCISC helps systems redesign the crisis system with better use of limited resources, by helping all parts of the existing system become multi-occurring capable and join in an integrated partnership to create welcoming and integrated engagement for individuals and families with complex needs based on existing principles.

Integrated Continuum of Levels of Care

CCISC also facilitates the system regarding all intermediate-length-of-stay or continuing-care programs as part of a single continuum of multi-occurring capable services with different levels of care, rather than a parallel array of distinct and competitive services. The basic components include:

- Outpatient services at various levels of intensity
- Intensive outpatient/day treatment/psychosocial (re)habilitation
- Residential treatment and supports
- Hospital diversion programming (including detox capacity)
- Hospitalization

Further, in CCISC, this continuum of levels of care can often be operationalized in managed care payment arrangements and may involve more sophisticated level-of-care assessment capacity that is built into the utilization management guidelines provided by all types of payers. (See Minkoff and Pollack, *Managed Mental Health Care in the Public Sector: A Survival Manual*).

Peer Multi-occurring Supports

The implementation of formal and informal peer supports has been an emerging best practice in person-centered/family-centered/recovery-oriented systems of care serving individuals and families with all types of multi-occurring conditions. This includes the following types of interventions, all of which can be designed to be multi-occurring capable.

- Certified Peer Specialists
- Recovery coaching
- Family or parent partners
- Youth peer mentors
- Culturally specific peer support
- Health and wellness coaches
- Dual Recovery Anonymous sponsors

In addition, the system can identify one or more dual-recovery self-help 12-Step recovery programs (e.g., Double Trouble in Recovery, Dual Recovery Anonymous,

Dual-Anon) and establish a plan to facilitate creation of these groups throughout the system.

Change Agent teams very often include peer specialists and parent partners as key members.

Integrated Continuum of Person-centered Multi-occurring-capable Residential Supports and Services

Building initially upon existing resources, the system should begin to plan for a comprehensive range of programs that address a variety of housing or residential needs, by redesigning services with the recognition that multi-occurring conditions are an expectation. This range of programs should include:

- Universal multi-occurring-capable and targeted multi-occurring-enhanced addiction **residential treatment** (e.g., modified therapeutic community programs) or other types of residential rehabilitation for individuals with more severe psychiatric or cognitive impairments.
- **Abstinence-mandated (dry or sober) supported housing** for individuals with psychiatric or cognitive disabilities who wish to live in sober settings.
- **Abstinence-encouraged (damp) supported housing** for individuals with psychiatric and cognitive disabilities who may not wish to stop using substances, but do wish to live in housing with social support and are open to working on more successful choices regarding substance use in order to be successful in the setting.
- **Consumer-choice (wet) supported housing ("Housing First")** for individuals with cognitive and psychiatric disabilities at risk of homelessness who need to be supported in individual sites of their own choosing.

Strategic Implementation of Evidence-based Programs or Practices and Culturally Specific Programs

CCISC incorporates all available evidence-based and consensus practices in the design of the whole system, provided that all services and practices are provided in a person-centered, hopeful, strength-based (recovery-oriented), trauma-informed, culturally competent, and multi-occurring-capable framework.

CCISC principles define the translation of evidence-based approaches into interventions that can be used in any setting, by any service provider, with any population with complex needs.

In addition, each system should develop a strategic plan for how to implement and organize evidence-based practices or programs that are targeted to specialized populations or specialized needs. Such programs must be designed and matched according to the size of the population that needs such services. All specialized programs must also be multi-occurring capable.

Culturally or linguistically specific integrated teams and multi-occurring capable programs must be included at all levels that match threshold populations in the system.

Examples of evidence-based/specialized programs and practices include, but are not limited to:

- Integrated Dual Disorder Treatment Teams (IDDT)
- Assertive Community Treatment (ACT)
- Intensive Family Wraparound Services (e.g., MST, FFT)
- Opiate Maintenance Treatment (methadone, buprenorphine)
- Specialized programming for Autism Spectrum Disorders
- Illness Self-management and Recovery/WRAP
- Supported Employment (IPS)
- Trauma-specific Treatment (Exposure Therapies)
- Dialectical Behavior Therapy (DBT)

Appendix D: Steps for Agencies/Programs, Direct Service Staff, and Implementation Teams

12 Steps for Agencies/Programs Developing Multi-occurring Capability

These steps are based on the principles for CCISC implementation (Minkoff and Cline, 2004), and can be initiated by any agency (for all of its programs, or by an individual program), within the scope of the agency/program mission and resources.

1. *Formal Announcement and Commitment*

   Leadership officially announces its formal commitment to achieve multi-occurring capability for all programs, and communicates to all staff about the CCISC implementation process.

2. *Continuous Quality Improvement (CQI) Team*

   Leadership organizes a CQI team intended to represent all levels of the agency or program in partnership, and to meet regularly to oversee the change process.

3. *Change Agents*

   The organization identifies a team of Change Agents that represents the voice of front-line staff (and, where appropriate, persons and families) in each program. Change Agents are represented on the CQI team and help programs and staff achieve multi-occurring competency in the practice priorities listed below.

4. *Goal of Multi-occurring Competency for All Staff*

   The agency or program commits to the goal to work in partnership with all staff to support their development of multi-occurring competency at their level of training and/or licensure.

5. *Program Self-assessment*

Each program uses a structured tool (e.g., COMPASS-EZ™ or COMPASS-ID™) to involve as many staff as possible in a program baseline conversation and self-assessment of multi-occurring capability.

6. *Program CQI Action Plan*

Based on the results of the COMPASS™ survey, each program creates an achievable three- to six-month action plan, with measurable objectives, to make progress toward multi-occurring capability. Initial action plan objectives are developed in the following areas.

7. *Welcoming and Access*

The program action plan addresses multi-occurring welcoming policies, procedures, practice, and staff competencies, and identifies access barriers that need to be removed.

8. *Integrated Screening*

The program creates a definition and process to implement universal integrated screening.

9. *Identification and Counting*

The program measures baseline data on the number of multi-occurring persons and families it serves, and develops a CQI plan to improve recognition of the population.

10. *Empathic, Hopeful, Integrated, Strength-based Assessment*

The program CQI plan helps clinicians to demonstrate integrated empathy and hope, and provides support for documentation of hopeful goals and periods of strength and relative success.

11. *Stage-matched Interventions*

The program plan focuses on identification and documentation of stages of change and stage-matched goals for each issue.

12. Integrated Stage-matched Treatment/Support/Recovery Planning and Programming

The program plans and develops policies, procedures, and processes for improving integration and stage matching in service plans, and works to improve the use of multi-occurring skill manuals, stage-matched groups, and positive behavior supports for multiple issues, as part of routine service planning and interventions.

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12 Steps for Direct Service Staff Developing Multi-Occurring Competency

These steps are based on the principles of CCISC (Minkoff and Cline, 2004), and can be taken by any clinician within the scope of his or her existing job category.

1. *Welcoming*

   Welcome individuals who have multi-occurring conditions or disabilities, thank them for coming, and let them know you are glad to get to know them as they are.

2. *Hope*

   Ask every one about their goals for a happy life, and inspire a belief that you will work with them to help them to achieve that vision.

3. *Integrated*

   Screen for problems in multiple life domains (MH, SA, cognitive disabilities, trauma, court, housing, health, etc.) in the course of conversation, and practice using one screening tool.

4. *Empathy*

   Ask clients and families to describe in detail their experience with the issues in the "other" domains, and empathize fully with what it feels like.

5. *Strengths*

   Ask clients to identify a period of recent success in relation to their problem, describe in detail the specific strengths they used to be successful, and what they were experiencing that they had to overcome to make progress (e.g., mental health issues during a period of sobriety, what were they and how were they managed; mental health issues for a person with DD who is trying to work, etc.).

6. *Quadrant*

   Review each case in the caseload, and determine: Are they multi-occurring (yes, no, maybe)? What quadrant are they in? (High severity vs. low severity cognitive disability, substance dependence vs. abuse; SPMI/SED vs. less serious mental health issues).

7. Integrated Primary Problem-specific Treatment

For any client, list each problem or issue, and list a specific day-at-a-time set of recommendations to help that person succeed. Discuss with the client and/or family how they use their strengths to attempt to follow each set of recommendations on any given day. Include recommendations in other areas, like medical issues, probation, etc.

8. Stage of Change

For each identified problem that may affect the person's goals for happiness, identify stage of change. Write down a stage-matched goal for each problem in the client's or family's own words. Practice establishing empathy with clients in earlier stages of change.

9. Skills and Supports

For any identified problem during a period of success, identify in detail with the client the specific skills that the client used to be successful, including skills asking for help or using supports.

10. Skill-based Learning

Use one manual for teaching multi-occurring skills, and/or practice one skill exercise with a client that is connected to their life. For example, work with the client in an addiction setting on managing mental health symptoms on any day; work with a mental health client on refusing drugs from a friend; work with a DD client on how to ask for help when hearing voices, or how to say no when offered cigarettes.

11. Positive Rewards

Identify small steps of progress for any problem in any client, and provide strong positive reward ("positive behavioral support") for those small steps, as a "round of applause for one day of sobriety."

12. "Recovery" Support

Identify a place where the client (or family) can receive "recovery" support for each problem, whether from peers, family, or others, and discuss in detail how the client can improve asking for help from these supports.

15 Steps for System Implementation Teams Developing Multi-occurring Competency

These steps are based on the principles for CCISC implementation (Minkoff and Cline, 2004), and can help an implementation team organize progress in a system, within existing resources.

1. *Regular Meetings*

Commit to regular meetings; take minutes; and use the minutes to organize specific objectives for each meeting. Involve key stakeholders, such as consumer and family advocates, physician leaders, etc.

2. *Consensus Plan of Action*

Develop a written document that outlines the commitment to CCISC, specific action steps to be taken by the team (as listed below), each program's goals to engage in a quality improvement process to achieve multi-occurring capability, specific actions to be taken by each program, and priority activities like welcoming, access, and screening.

3. *Communication*

Say out loud what team is doing, circulate the consensus plan to all staff, and maintain regular communication in both directions. Keep physicians constantly informed and involved.

4. *Commitment*

Each program should officially announce to all staff and constituencies that multi-occurring capability is a program goal, and that multi-occurring competency is a goal for all staff.

5. *Continuous Quality Improvement (CQI) Teams*

Each program should organize a CQI team to plan its improvement activity. The team should include both managers and front-line clinicians, and involve physicians.

6. COMPASS-EZ™

Help each program do the COMPASS-EZ™, and engage as many staff as possible in the conversation. Bring programs together, not so much to discuss their scores as to discuss their stories, experiences, and what they learned. Keep track of which programs used the tool, and what they learned.

7. CQI Plans

Each program should be asked to generate a measurable, achievable, CQI plan based on the COMPASS-EZ™, with four or five action items related to welcoming, access, screening and counting, integrated documentation, and improving competency for all staff.

8. Change Agents

Each program should identify one or more front-line staff to be "Change Agents" that partner with management in the process. Change Agents should meet with each other as a group to share resources and training. The Change Agent and implementation teams should meet regularly to create a partnership to develop new practices.

9. Welcoming

Develop, in partnership with the Change Agents, a system *Welcoming Policy* that states that individuals with multi-occurring issues will be proactively welcomed for care in every setting.

10. Screening and Counting

Ask each program to identify its current baseline for recognizing in its data the number of clients that are multi-occurring, and organize a *Plan-Do-Check-Act* improvement process for everyone. Work with Change Agents to develop a definition for "multi-occurring" that is not based on already being diagnosed.

11. Integrated Practice

Work with Change Agents to draft sample progress notes, billing instructions, and/or treatment plans that show how to document integrated services within a single funding stream or program. Circulate the Minkoff/Cline *Integrated Scope of Practice for Singly trained Clinicians* (see page 165) as a guideline for clinicians. In the

integrated assessment process, begin to identify hopeful goals, multiple primary problems, and periods of strength and success.

12. Stage of Change

Encourage programs to identify—both in the assessment and in the treatment plan—the stage of change for each issue, to help them to begin to think about using integrated stage-matched interventions.

13. Curricula and Manuals

Gather resources for Change Agents, program managers, and staff. Identify skill-training manuals that programs can incorporate into their services for persons and families.

14. Positive Rewards

Identify small steps of progress for each program, and provide regular "rounds of applause" for small significant successes in changing practice.

15. Recovery Support for Programs

Identify opportunities for the implementation team, physicians, program supervisors, and Change Agents to come together for peer support and open dialogue.

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Appendix E: Examples of Children's System of Care Principles and Guidelines

Excerpts from SAMHSA System of Care Materials

The SOC philosophy is built around three core values and ten guiding principles. The three core values require that a system of care be:

1. Child-centered and Family-focused - In a child-centered, family-focused system, services are individualized and are based on the needs of the child and family. The child (to the extent possible) and family have been included as full participants in the development of the service plan. Effective case management is provided to the child and family, thereby assisting in the coordinating and obtaining of needed services.
2. Community-based - Services are provided within or close to the child's home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers. In addition, early identification and intervention for children with emotional disturbances are promoted to enhance the likelihood of positive outcomes.
3. Culturally Competent - A system that demonstrates cultural competence is responsive to the cultural, racial, and ethnic differences of the population it serves. More specifically, diversity is valued and acknowledged by service providers' efforts to meet the needs of culturally and ethnically diverse groups within the community. Service systems that are culturally competent are aware of their own culture as well as the culture of each family they serve. Additionally, these systems are sensitive and responsive to the cultural, racial, and ethnic identity of each child and family. For a comprehensive discussion on systems of care, see Stroul & Friedman (1994) or Pires (2002).

System of Care Guiding Principles

- Children have access to a comprehensive array of services.
- Services are individualized.

- Services are received within the least restrictive environment.
- Families are included as full participants in service planning and delivery.
- Services are integrated and coordinated.
- Case management is provided to ensure service coordination and system navigation.
- The system promotes early identification and intervention.
- Children with SED are ensured a smooth transition to adult services when they reach maturity.
- The rights of children with SED are protected.
- Children with SED receive services regardless of race, religion, national origin, sex, physical disability, or other characteristics.

The following excerpts were taken from the SOC-R and are illustrative of the focus of SOC implementation oversight at the national level. This information is taken verbatim from the SOC-R oversight manual.

Within a system of care, it is possible for the core values and guiding principles to be evident at the management level yet inadequately infused at the practice level, and vice versa. To effectively determine the benefits of a system of care, it is necessary to assess the extent to which the service system adheres to the system of care philosophy at the practice level. The four domains and their subdomains are:

1. Child-centered and Family-focused: The needs of the child and family determine the types and mix of services provided. This domain reflects a commitment to adapt services to the child and family, rather than expecting the child and family to conform to preexisting service configurations. It includes three subdomains: Individualization, Full Participation, and Case Management. Through these subdomains, the review reflects the effectiveness of the site in providing services that are individualized, independently of how successful they have been in including families as full participants, or in providing effective case management.
   Individualization: Individualization calls for the development of a unique service plan for children and families in which their needs are assessed and prioritized by life domains. Strengths must also be identified and included as part of the plan.
   Full Participation: Developing an individualized service plan requires full participation of the child, family, providers, and significant others. Additionally, children and families should participate in setting their own treatment goals, and plan for the evaluation of interventions to reach those goals.
   Case Management: Case management is intended to ensure that children and

families receive coordinated services of an appropriate type and intensity, and that services are driven by the families' changing needs over time.

2. Community-based: Services are provided within or close to the child's home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers. This domain includes four subdomains: Early Intervention, Access to Services, Minimal Restrictiveness, and Integration and Coordination. These subdomains are measured to evaluate the effectiveness of the site in identifying needs and providing supports early, facilitating access to services, providing less restrictive services, and integrating and coordinating services for families.
   Early Intervention: Early identification and intervention for children with emotional disturbances enhance the likelihood of positive outcomes by addressing maladaptive behaviors and preventing problems from reaching serious proportions. This refers both to providing services before problems escalate, in the case of older children, or providing services for younger children.
   Access to Services: Children and their families should have access to comprehensive services across physical, emotional, social, and educational domains. These services should be flexible enough to allow children and families to integrate them into their daily routines.
   Minimal Restrictiveness: Systems should serve children in as normal an environment as possible. Interventions should provide the needed services in the least intrusive manner to allow families to continue their day-to-day routine as much as possible.
   Integration and Coordination: Coordination among providers, continuity of services, and movement within the components of the system are of central importance for children and families with multiple needs.

3. Culturally Competent: Services are attuned to the cultural, racial, and ethnic background and identity of the child and family. This domain includes four subdomains: Awareness, Agency Culture, Sensitivity and Responsiveness, and Informal Supports. The measurement of these subdomains allows for the evaluation of the level of cultural awareness of the service provider, demonstrated efforts to orient the family to the agency culture, sensitivity and responsiveness to the cultural background of families, and inclusion of informal supports in service planning and delivery.
   Awareness: Awareness refers to the level of service providers' cultural awareness regarding the family's cultural background as well as their own. Self-awareness relates to their ability to place themselves within a cultural context and understand how that context impacts their lives. Awareness of the cultural background of the families served refers to service providers' ability to place

families within relevant cultural and environmental contexts.
Agency Culture: The families' understanding of the agency's culture (how the system operates, its rules and regulations, and what is expected of them) is also relevant to the treatment process.
Sensitivity and Responsiveness: Culturally competent service systems are aware of their own organization's culture and the culture of the families they serve. This implies that they accept cultural differences, understand the dynamics at play when persons from different cultural backgrounds come into contact with each other, and are able to adapt their services to the cultural context of their clients.
Informal Supports: Refers to the inclusion of the families' informal or natural sources of support in formal service planning and delivery. Implementation of a culturally competent system of care requires that service providers become knowledgeable about the natural resources that may be used on behalf of their clients and are able to access them.

4. Impact: Services hopefully produce positive outcomes for the child and family. A system that has implemented a system of care philosophy assumes that the implementation of SOC principles at the practice level produces positive impacts for the child and family receiving services. This domain includes two subdomains: Improvement and Appropriateness of Services. Improvement is evaluated independently of the appropriateness of the services provided.
Improvement: Service systems that have had a positive impact on the children and families they serve have enabled the child and family to improve their situation.
Appropriateness of Services: Service systems that have had a positive impact on the children and families they serve have provided appropriate services—they have met the needs of the child and family.

Example Practice Guidelines for Children, Youth and Families (Vermont)

This document is adapted from the *Vermont Practice Guidelines on Co-occurring Mental Health and Substance Abuse Issues in Children, Youth and Families* created during the spring and summer of 2004 in consultations with over 90 stakeholders including youth and their families, community providers, state policy makers and staff from the Vermont Agency of Human Services member departments. Drs. Ken Minkoff, Christie Cline, Win Turner and Kim Mueser provided technical feedback and clinical consultation during several daylong stakeholder sessions and small group working sessions.

The Practice Guidelines on Co-occurring Mental Health and Substance Abuse Issues in Children, Youth and Families are based on the Comprehensive Continuous Integrated Systems of Care (CCISC) model, which defines the characteristics of a system of care for individuals with co-occurring issues. This model has been adopted as a framework for service system design and implementation.

The principles defined in this document—*welcoming, relationship-building, matching, and integrating*—will be the basis for the delivery of treatment services to children, youth and families with co-occurring mental health and substance abuse issues. These principles organize key clinical expectations in the development of integrated, continuous, and comprehensive services for children, youth and families. Each system and program is responsible for generating positive outcomes for children, youth and families with co-occurring mental health and substance abuse issues, in keeping with the core principles outlined here.

Welcoming

Children, youth and families with co-occurring mental health and substance abuse issues are welcomed in every contact, and in every setting.

Standards

- When taking steps to contact services and supports, children, youth and families are met by caring and competent people:
    - Children, youth and families have access to interested and engaged staff and volunteers from their first point of contact forward.
    - Whether the contact is made by phone or in person, staff and community volunteers assure that a direct connection (not just referral) is made for the individual seeking services.
    - Whenever possible, staff, community volunteers, peer support networks and peer counselors are educated about co-occurring mental health and substance abuse issues, and will reach out and provide education in the community.
- Programs provide access to integrated services at times and places that are convenient to children, youth and families.
    - Whenever possible, staff and volunteers are available in places where children, youth and families are found, such as schools, courts, and other community-based settings.

    - Whenever possible, programs are open and staffed during some evening and weekend hours.
    - Each program has a policy of non-discrimination so that children, youth and families receive services and supports without regard to their race, religion, national origin, gender, sexual orientation, disability, or socio-economic status.
- Welcoming involves cultural sensitivity. Each program will:
    - Address the needs of children, youth and families of various cultures in ways that elevate their culture.
    - Make every effort to provide access to staff, community volunteers, peers, and/or positive role models that represent the cultural background of children, youth and families.
    - Recognize varying degrees of acculturation and cultural conflict within the family, understanding that perceptions of the majority cultures and minority cultures may differ considerably about "treatment."
    - Incorporate a variety of strategies that build on cultural strengths to engage and retain children, youth and families in treatment.
    - Make accommodations for individuals seeking help (such as ESL, translators, vision and/or hearing impairment, developmental & learning disabilities).
- Welcoming involves gender sensitivity. Each program will:
    - Specifically train staff, including community volunteers, in gender-appropriate interventions and have the ability to screen for risk factors that may be present due to gender.
    - Give children, youth and families access to gender-appropriate services and supports.

Relationship-building

Successful treatment is based on empathic, hopeful, integrated, continuing and collaborative family, peer, treatment and community relationships.

Standards

- The integrated service system will support the development and maintenance of a long-term continuous clinical *relationship*.
    - Policy and practices will be implemented that support children, youth and families remaining in programs based on their individual needs (i.e., neither

relapse nor improvement will result in sanctions or removal from an integrated treatment program).

- Providers will add capacity for additional services when necessary within their agency or through the development of partnerships with other providers.

- Children, youth and families are connected to a caring individual or team that will provide an ongoing integrated assessment as quickly as possible after initial integrated screening indicates that co-occurring issues may be present.
- Youth and families are assured a smooth transition into and through the system of care, including transition into adult life.
  - Children, youth and families have their housing, safety, and sustainability issues adequately addressed.
  - Children and youth in out-of-home placements are provided the supports needed to ensure placement stability with no more than two placements.
- Collaborative treatment team *relationships* and roles are clearly defined through a treatment plan that addresses multiple problems experienced by children, youth and families, including co-occurring issues, medical and legal issues, and the complementary services needed to deal with these issues.
- Youth-centered and family-focused treatment and support can best be delivered through an individual treatment plan developed with youth and family input.
  - The treatment plan must be developed in conjunction with the youth and involve the youth in recognizing and appreciating his/her unique strengths and assets as well as clarifying needs.
  - The treatment plan must include goals with realistic objectives and timeframes for completing them that are mutually agreed upon by the program and the youth.
  - Programs will ensure that the basic relationship is maintained until the child, youth or family is ready to respond to the treatment plan.
- People and families with more complex needs should have access to enhanced case management support, regardless of setting.
  - The case manager will collaborate with and manage all services as appropriate including healthcare, housing, skills development, education, etc.
  - The case manager must have training and skills in the following areas:

  - An understanding of addiction, and the intergenerational nature of alcohol, tobacco and other drugs abuse.
  - An understanding of mental health issues and associated risk factors.
  - Familiarity with community resources and other youth service systems (education, child welfare, youth justice, mental health, substance abuse, employment services, etc.).
  - Trauma.
  - Family dynamics.
  - Legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty-to-warn issues, informing parents).
  - Competency in race, ethnicity, gender, poverty, sexual preference, and other cultural issues.

- Individualized treatment planning and risk management will create an environment in which children, youth and families can achieve the next level of competency in order to attain the next incremental step in autonomy and self-management.
  * Programs commit to implementing evidence-based and/or promising outcome-based treatment strategies that are age-appropriate.
  * Programs help children, youth and families to develop support systems that reinforce behavioral gains made during treatment and provide ongoing support to prevent relapse. Peer support programs such as mentoring, anonymous programs, clean and sober community events, and extended family supports are utilized where appropriate.
- Incentives, support, and progressive responses built into empathic, hopeful, and continuous learning *relationships* are an essential component of successful treatment.
- Services and supports are best provided by people who are competent, well-trained, and well-supported.
  * All clinicians will have licensure or accreditations that indicate their competence with an integrated scope of practice that defines appropriate person- and family-centered attention to both mental health and substance issues within the context of their licensure, job responsibilities, and programs.
  * Programs will enhance recruitment and retention of professionals specifically qualified to treat youth and families with co-occurring mental health and substance abuse problems.

- The state and the community provider system will work together to provide initial and ongoing training opportunities for staff, community volunteers, and peer supports in the screening, assessment, and treatment of co-occurring mental health and substance abuse issues.
- Staff, community volunteers, and peer supports are provided adequate opportunities to receive supervision.

Matching

All individuals with co-occurring issues are not the same; treatment needs to be matched to individual needs throughout the service system, and interventions must be matched to phases of recovery and stages of change.

Standards

- Children, youth and families present with many different needs, goals, and learning styles. Interventions and outcomes must be flexible, adaptive, and responsive to *match* with individual needs.
  - For each child, youth and family, the correct intervention and outcome has to be matched to need for integrated relationship, quadrant, diagnoses, level of impairment, stage of change/phase of recovery, skills for managing issues, availability of contingencies, rehabilitative goals, and level of care.
  - Within the context of continuous, integrated, unconditional treatment relationships, children, youth and families can receive a variety of episodic interventions that build on prior treatment progress and are matched to particular needs and stages of change.
  - Substance abuse and mental health issues may be chronic relapsing conditions. Therefore, youth and families may be appropriately served by a variety of interventions and supports.
- All children, youth and families presenting for services receive appropriately matched integrated screening to facilitate the detection of mental health and substance abuse issues, as well as to facilitate recognition of trauma-related issues that may interfere with access to treatment, and may need to be addressed during the course of intervention.
- Assessment is not a single event, but an ongoing process to develop a relationship and to gain insight into the unique abilities, strengths, and needs of children, youth and families in order to match services and available resources appropriately.

- The assessment must identify whether a child, youth or family is in need of treatment, and if so, determine and document the level of severity and recommended placement option for treatment of both the mental health and substance abuse problems.
- The assessment process must be a collaborative process between the provider and the child, youth and family, and their primary support network.
- Essential assessment components are:
  - Family history.
  - Medical and health history.
  - Education history and skill abilities.
  - Identification of developmental or learning abilities and disabilities.
  - Identification of necessary communication, learning, language, physical or other accommodations.
  - Previous treatment history.
  - Inventory of assets and strengths.
  - Sensitive approach to potential trauma history.
  - Collateral information.
  - Diagnostic criteria (for substance use and mental health issues).
- Programs may use one of the identified components of assessment, including:
  - ASAM Criteria – 6 dimensions.
  - DSM IV criteria-based interview.
  - Urine test.
  - Validated assessment tools for mental health and substance abuse.
  - Personalized Feedback Report Form.
  - Substance Problem Index/Reasons for Quitting.
  - Tools for the identification of developmental, cognitive and/or learning disabilities.

- Assignment of responsibility for the provision of integrated assessment and ongoing integrated treatment should be defined so that each component of the service system knows which children, youth and families need to be assessed and treated.

  - The continuum of services and systems from prevention through intervention—including primary healthcare, child protection, youth justice, mental health, substance abuse, education, runaway and homeless youth service organizations and community-based services—must work collaboratively to ensure that children and youth are identified quickly, regardless of the "door" they enter.
  - Children and youth must not be placed in the custody of the state in order to receive services.
- There must be recognition that, for children, youth and families, the threshold for problematic substance use may be well below the threshold for addiction, so that services for non-addicted substance-using children, youth and families need to be made available.
  - Children and youth whose alcohol, tobacco and other drug use symptoms are severe, but who do not meet the diagnostic criteria, may be appropriate for outpatient treatment for further evaluation.
  - If the presenting alcohol, tobacco and other drug history is not adequate to substantiate a diagnosis, the program may use information submitted by collateral parties (family members, legal, guardians, etc.) that indicates a high probability of such a diagnosis.
  - All youth and families should have access to all core services and supports within their local community.
- Treatment planning will ensure that there are no children, youth and families that "fall through the cracks." There will be clear instructions for defining responsibility for children, youth and families at every point in the system.
  - At intake, children, youth and families collaborate on the development of a treatment plan that will define responsibility and coordinate services.
  - Each child, youth, and family will be assigned a primary counselor who will be responsible for the treatment plan and, when needed, a case manager and/or service coordinator.
  - At critical junctures/transition or life events, the responsibility and need for coordination will be reassessed.
- Services and supports for youth need to be integrated into the settings where youth are, including mental health settings, substance treatment settings, youth justice, educational and other settings.
- Relapse will be clinically assessed and re-assessed.

    - Children, youth and families must have access to psychiatric evaluation and re-evaluation as needed. More risky behavior requires closer monitoring, not treatment exclusion.
    - Programs must have an established protocol for management of medications that includes the program's policy regarding documentation, storage, supervision, distribution, and administration.
    - Medications will not be routinely withdrawn or reduced because of relapse.
- Programs will adapt services to provide treatment with more support, or a slower pace, in smaller increments, with more practice, rehearsal, or repetition as needed to achieve skill acquisition.
    - Programs must address potential long-term deficits in developmental, psychological, and social growth to help youth make up for the developmental stages that have been compromised due to substance use.
- Each program and system must properly match and re-match its services to the needs of children, youth and families, according to these principles.
- A lead service coordinator who will monitor and assure appropriate placement is assigned when needed to help promote success for children, youth and families.

Integrating

Mental health and substance problems are both primary when they co-exist for children, youth and families and integrated primary treatment for each problem is required.

Standards

- No problem should be underserved because the others are present.
    - Whenever substance use and mental health problems co-occur, a youth should receive appropriately intensive, specific treatment simultaneously.
    - Programs must address contributing factors to substance use and mental health issues, including sexual abuse, domestic violence, and relationship issues.
        - Children, youth and families need sensitive supports in order to facilitate the identification, evaluation and treatment of violence and trauma.
        - Gender-appropriate services and supports must be provided, particularly for those who have been victims of trauma.

- The system of care functions best when there is coordinated and collaborative service delivery among all involved parties.
    - Each child, youth and family will have an integrated treatment plan that combines best-practice attention for each mental health problem, each substance problem, each trauma problem, and any criminal justice problem.
- Treatment for each issue—mental health, substance abuse, or trauma—must be provided immediately. No issue will be allowed to "wait" while other issues are being attended.
- *Integrated* assessment should identify stage of change for each problem, and integrated treatment plans should identify stage-specific treatment interventions, as well as stage-specific outcomes.
    - Effective interventions must be stage-specific. Therefore, stage-specific assessment is required. The five stages of change (Prochaska & DiClemente, 1992) are pre-contemplation, contemplation, preparation, action, and maintenance. The four stages of treatment (Osher & Kofoed, 1989) are engagement, persuasion, active treatment, and relapse prevention.
- For individuals and families in earlier stages of change, motivational enhancement is the appropriate intervention, whether involving individual, family, or group modalities. Individuals, once motivated, receive active treatment, and once stabilized, enter the phase of relapse prevention.
- Rehabilitative goals (relationship, school, and work goals) must be identified early, and may be used to promote the recognition of a need for treatment for mental health and/or substance problems.

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Appendix F: Substance Use and Psychiatric Symptomatology (SUPS) Table

Category of Substance	Type of Symptoms Seen with Use Pattern			Resolution Period
	Mild Use *Uses no more than 1-2 times/week; does not use to severe intoxication; no observable impairment.*	**Moderate Use** *Uses regularly, but not usually to severe intoxication; and/or episodes of severe intoxication occur, but once/week or less; and/or presence of negative outcomes (hangover, money loss, but not severe*	**Heavy Use** *Uses regularly (more than 2 times/week) to point of severe intoxication; significant impairment, negative outcomes noted, such as ER visits, fights, can't pay rent, medical complications of substance dependence (liver disease, hemorrhage, etc.)*	*Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis*
Alcohol Benzodiazepine Sedatives	None	Anxiety, depression, not dysfunctional	Hallucinosis, not psychosis *Person usually reports hearing "voices," content non-bizarre, good reality testing, no thought disorder/bizarre behavior.*	30 days
			Anxiety, mood instability *People occasionally can develop a first-time true manic episode during withdrawal.* Personality disorder	30-90 days *Most severe symptoms will resolve (if they do) within 30 days; disability/ fragility may persist longer.*
Stimulants (Cocaine, meth)	Mild anxiety, depression	Anxiety/panic, depression, mood instability	More severe anxiety and depression; personality disorder symptoms.	30 days (mild/ moderate) 30-90 days (heavy)
Hallucinogen (Mescaline, LSD, peyote)	Anxiety and depression	Anxiety and depression	Psychosis	Usually 30 days *For heavy marijuana users, persistent anxiety, panic attacks, and mood/ thought alteration may last up to 90 days.*
	Occasional psychosis or near panic *A single episode of hallucinogen use can occasionally precipitate psychosis or severe panic. This may also happen with methamphetamine.*	Flashbacks/ hallucinotic experiences. Sometimes, psychosis, panic, mood instability.	Severe panic, mood instability	Up to 90 days

Appendix F: SUPS Table

Category of Substance	Type of Symptoms Seen with Use Pattern			Resolution Period
	Mild Use *Uses no more than 1-2 times/week; does not use to severe intoxication; no observable impairment.*	**Moderate Use** *Uses regularly, but not usually to severe intoxication; and/or episodes of severe intoxication occur, but once/week or less; and/or presence of negative outcomes (hangover, money loss, but not severe*	**Heavy Use** *Uses regularly (more than 2 times/week) to point of severe intoxication; significant impairment, negative outcomes noted, such as ER visits, fights, can't pay rent, medical complications of substance dependence (liver disease, hemorrhage, etc.)*	*Persistence of symptoms/impairment past this period is sufficient for psychiatric diagnosis*
Opiates	None	Mild-moderate anxiety and depression	More severe anxiety and depression, personality disorder symptoms	60-90 days
			Occasional psychotic symptoms during withdrawal only.	7-10 days
Marijuana (cannabis sativa)	None	Mental confusion, agitation, feelings of panic	Acute toxic psychosis, paranoia, disorientation, severe agitation, depersonalization	24-72 hours (moderate) 30-60 days (heavy)

Appendix G: Sample Screening Tools and Screening Resources

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Screening Resources 303

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CRAFFT Alcohol & Other Drug Screening

Name: _____ Date: _____

The following questions concern information about your potential involvement with alcohol and other drugs during the past 12 months. Carefully read each statement and decide if your answer is YES or NO. Fill in the appropriate box beside the question.

When the word "drug" is used, it refers to use of prescribed or over-the-counter drugs that are used in excess of the directions, as well as any non-medical use of drugs. The various classes of drugs may include but are not limited to cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc.), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months only.	Circle Answer	
1. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	Yes	No
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	Yes	No
3. Do you ever use alcohol or drugs while you are b yourself or alone?	Yes	No
4. Do you ever forget things you did while using alcohol or drugs?	Yes	No
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	Yes	No
6. Have you ever gotten into trouble while you were using alcohol or drugs?	Yes	No
CRAFFT Score (see instructions for correct scoring procedure)		

CRAFFT Administration & Interpretation Instructions

The CRAFFT is a 6-item screening instrument that is used to screen for alcohol and other drug use in the adolescent population ages 14 to 18 years old. The CRAFFT takes approximately 5 minutes to administer and score.

Administration: The CRAFFT is a self-administered screening but it can be read to the adolescent if necessary.

Scoring and Interpretation: Score 1 point for each "YES" answer. A score of 2 or more indicates the need for further assessment.

CRAFFT Score	Degree of Problem Related to Alcohol/Other Drug Use	Suggested Action
0-1	No problems reported	None at this time
2 or more	Potential significant problem	Assessment required

CIWA – Alcohol Scale

Symptom	Rating							
	0	1	2	3	4	5	6	7
	None		Moderate				Severe	
Agitation								
Anxiety								
Auditory disturbance								
Clouding of sensorium								
Headache								
Nausea/vomiting								
Paroxysmal sweats								
Tactile disturbances								
Tremor								
Visual disturbances								
TOTAL:								

CIWA – Opiate Scale

Symptom	Rating			
	None			Severe
Nausea and vomiting	0	2	4	6
Goose flesh	0	1	2	3
Sweating	0	1	2	3
Restlessness	0	1	2	3
Tremor	0	1	2	3
Lacrimation	0	0	1	2
Nasal congestion	0	0	1	2
Yawning	0	0	1	2
Abdominal cramps/diarrhea	0	0	1	2
Feeling hot and cold	0	0	1	2
Muscle aches/cramps	0	0	1	2
Total				

Alcohol and Drug Use Intake Assessment (Modified Michigan Alcohol Screening Test)

1. Tell me about your drinking pattern. What do you drink? Do you drink/drug every day? How many drinks? How much alcohol do you put in each drink? Do you measure the alcohol?
2. How much alcohol do you consume in a week?
3. Was there ever a time in your life when you worried about your alcohol or drug intake? Have you ever tried to control amount/frequency?
4. Have you ever taken any drugs? (Mention pot, cocaine, speed, acid, PCP, tranquilizers.) Has a doctor ever prescribed tranquilizers for you? (Get name and dosage.)
5. Does anyone in your family have a problem with drinking or taking drugs?
6. Is anyone in your family concerned about your drinking/drugging?
7. What do you do to relax or unwind or calm down? What do you do if you can't get to sleep at night?
8. Have you ever taken a drink/drug in the morning?
9. Do you have any health problems that may relate to alcohol/drugs? (Suggest specific problems.)
10. Are your caregivers concerned about your drinking/drugging?
11. Have you gotten in trouble at your treatment program due to alcohol/drugs? Have you been suspended or terminated?
12. Have alcohol and drugs led to ER visits? To hospitalization?
13. Have you ever lost time from work because of drinking or because you were sick from drinking?
14. Have you ever been in a motor vehicle accident or dangerous situation where alcohol/drugs were involved? Who was driving? Were alcohol or drugs involved?
15. Have you ever been arrested for DUI (driving under the influence)?
16. Do you know what a blackout is? Have you ever had a blackout when you drink?
17. Does it annoy you if someone tells you that you drink too much?
18. Has there been an increase in the amount of alcohol/drugs you use in the last 6-12 months?

19. Do you seem to be able to "hold your liquor" better than others you know? Does it take more alcohol or drugs to get you "feeling good" than it does others?
20. Have you ever tried to cut down on the amounts or kinds of alcohol and/or drugs? (See #3)
21. Have you ever tried to quit?
22. Have you ever felt guilty after drinking or drugging?
23. Have you ever lied about drinking the amounts you drank?
24. Have you ever "gotten drunk" even when you planned not to?
25. If you drink or use drugs, what do you like about it? What, if anything, don't you like?
26. Do you find that drugs and alcohol are helpful or unhelpful in dealing with your mental illness? In what ways?
27. What effect does getting drunk or high have on your symptoms? How about when you are coming down, hung over, or crashing?

After asking these questions, ask yourself (interviewer) how you feel. Do you feel that the person has been defensive or uncomfortable when answering the questions? Does your "gut" feeling tell you there is probably more to the story than he/she is letting on? If so, there probably is.

If a provider agency elects to use the following screening tools—the SMAST and DAST—in order to do a comprehensive screen for substance abuse, they must be used together, as one screens only for alcohol and the other only for drug abuse.

Short Michigan Alcohol Screening Test (SMAST)

Name: _____ Date:_____

The following questions concern information about your involvement with alcohol during the past 12 months. Carefully read each statement and decide if your answer is YES or NO. Then, check the appropriate box beside the question.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months only.	Yes	No
1. Do you feel that you are a normal drinker? (By "normal" we mean do you drink less than or as much as most other people?)		
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?		
3. Do you ever feel guilty about your drinking?		
4. Do friends or relatives think you are a normal drinker?		
5. Are you able to stop drinking when you want to?		
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
7. Has your drinking ever created problems between you and your wife, husband, a parent or other near relative?		
8. Have you ever gotten into trouble at work because of your drinking?		
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
10. Have you ever gone to anyone for help about your drinking?		
11. Have you ever been in a hospital because of drinking?		
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?		
13. Have you ever been arrested, even for a few hours, because of other drunken behaviors?		
SMAST Score (see scoring instructions for correct scoring procedure)		

SMAST Administration and Interpretation Instructions

The Short California Alcohol Screening Test (SMAST) is a 13-item questionnaire that requires a seventh-grade reading level, and only a few minutes to complete. It was developed from the California Alcoholism Screening Test. Evaluation data indicate that it is an effective diagnostic instrument, and does not have a tendency for false positives, as does the California Alcoholism Screening Test. It is **strongly recommended** that the DAST-10 be used along with the SMAST unless there is a clear indication that the person uses alcohol but does not use any other drug at all.

The SMAST is self-administered. All questions are to be answered with YES or NO answers only.

Scoring: Each YES answer equals one (1) point.

Interpretations: A score of 1 or 2 indicates that there is no alcohol problem and no further action is needed at this time. A score of 3 indicates a borderline alcohol problem and further investigation is necessary. A score of 4 or more indicates that there may be an alcohol problem and that a full assessment is needed.

SMAST Score	Degree of Problem Alcohol Involvement	Suggested Action
0-2	No problems reported	None at this time
3	Borderline alcohol problem reported	Further investigation is required
4 or more	Potential alcohol abuse reported	Full assessment is required

Drug Use Questionnaire (DAST-10)

Name: _____ Date:_____

The following questions concern information about your potential involvement with drugs—excluding alcohol and tobacco—during the past 12 months. Carefully read each statement and decide if your answer is YES or NO. Then, check the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc.), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months only.	Yes	No
1. Have you used drugs other than those required for medical reasons?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had "blackouts" or "flashbacks" as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?		
DAST Score (see scoring instructions for correct scoring procedure)		

DAST-10 Administration & Interpretation Instructions

The DAST-10 is a 10-item, yes/no, self-report instrument that has been shortened from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. It is **strongly recommended** that the SMAST be used along with the DAST-10 unless there is a clear indication that the person uses NO ALCOHOL at all. The answer options for each item are YES or NO. The DAST-10 is a self-administered screening instrument.

Scoring and Interpretation: For the DAST-10, score 1 point for each question answered YES, except for question 3 for which a NO answer receives 1 point and (0) for a YES. Add up the points; interpretations are as follows:

DAST-10 Score	Degree of Problem Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor; reassess at later date
3-5	Moderate level	Further investigation is required
6-8	Substantial level	Assessment required
9-10	Severe level	Assessment required

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	Yes	No
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?	Yes	No
6. a. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	Yes	No
b. Did you ever attempt to kill yourself?	Yes	No
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?	Yes	No
8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	Yes	No
9. Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to the destruction of property?	Yes	No
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	Yes	No
11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?	Yes	No
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	Yes	No
14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	Yes	No
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.	Yes	No
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	Yes	No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	Yes	No
Total Score (each yes = 1 point)		

Print Person's Name: _____

Program to which person will be assigned: _____

Name of Admissions Counselor: _____

Date: _____

Reviewer's Comments:

Guidelines for Using the Mental Health Screening Form III

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for people seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's entire life history; therefore all questions begin with the phrase "Have you ever..."

The preferred mode of administration is for staff members to read each item to the respondent and get their "yes" and "no" responses. Then, after completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "When did this problem first develop?" "How long did it last?" "Did the problem develop before, during, or after you started using substances?" and "What was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to people for them to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the person read the MHSF-II instructions and question number one to the staff member monitoring this process. If the person cannot read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a person or s/he reads the questions and responds on his/her own, the completed MHSF-III should be carefully reviewed by a staff member to determine how best to use the information. It is strongly recommended that a qualified mental health specialist be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their people.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories:

5. Schizophrenia
6. Depressive Issues
7. Post-Traumatic Stress Disorder

8. Phobias
9. Intermittent Explosive Disorder
10. Delusional Disorder
11. Sexual and Gender Identity Issues
12. Eating Issues (Anorexia, Bulimia)
13. Manic Episode
14. Panic Disorder
15. Obsessive-Compulsive Disorder
16. Pathological Gambling
17. Learning Disorder and Mental Retardation

The relationship between the diagnoses/diagnostic categories and the above-cited questions was investigated by having four mental health specialists independently "select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories." All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does **not**, by itself, insure that a mental health problem exists at this time. A "yes" response raises only the **possibility** of a **current** problem, which is why a consult with a mental health specialist is strongly recommended.

Alaska Screening Tool for Mental Health and Traumatic Brain Injury

Please circle your answer to these questions based on the past 12 months.		
1. Do you ever hear or see things that other people tell you they don't see or hear?	Yes	No
2. Do you often have difficulty sitting still and paying attention at school, work or social settings?	Yes	No
3. Do you spend time thinking about hurting or killing yourself or anyone else?	Yes	No
4. Do you think people are out to get you and you have to watch your step?	Yes	No
5. Do disturbing thoughts that you can't get rid of come into your mind?	Yes	No
6. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away?	Yes	No
7. Do you sometimes have so much energy that your thoughts come quickly, you jump from one activity to another, you feel like you don't need sleep and like you can do anything?	Yes	No
8. Have you destroyed property or set a fire that caused damage?	Yes	No
9. Do you feel trapped, lonely, confused, lost or hopeless about your future?	Yes	No
10. Do you have nightmares, flashbacks or unpleasant thoughts because of a terrible event like rape, domestic violence, incest/unwanted touching, warfare, a bad accident, fights, being or seeing someone shot or stabbed, knowing or seeing someone who has committed suicide, fire, or natural disasters like earthquake or flood?	Yes	No
11. Do you have difficulty sleeping or eating?	Yes	No
12. Have you physically harmed or threatened to harm an animal or person on purpose?	Yes	No
13. Have you lost interest or pleasure in school, work, friends, activities or other things that you once cared about?	Yes	No
14. Do you feel angry and think about doing things that you know are wrong?	Yes	No
15. Do you often get into trouble because of breaking the rules?	Yes	No
16. Do you sometimes feel afraid, panicky, nervous or scared?	Yes	No
17. Do you feel dissatisfied with your life and relationships?	Yes	No
18. Are you sometimes uncomfortable with the way your mind is working?	Yes	No
19. Do you spend a lot of time thinking about your weight or how much you eat?	Yes	No

Please circle and fill-in your answer to these questions based on events in your lifetime.			
1. Have you ever had a blow to the head that was severe enough to make you lose consciousness?		Yes	No
When did it occur? _____			
2. How long were you unconscious? Circle One: N/A Seconds Minutes Hours Days Weeks Months			
3. Have you ever had a blow to the head that was severe enough to cause a concussion?		Yes	No
When did it occur? _____			
4. How long did the concussion last? Circle One: N/A Seconds Minutes Hours Days Weeks Months			
5. Did you receive treatment for the head injury?		Yes	No
6. If you had a blow to the head that caused unconsciousness or a concussion, was there a change in any of the following that seemed to last a long time? (Circle all that apply):			
N/A (Did not have head injury)			
Physical Abilities	Still there?	Yes	No
Ability to care for yourself	Still there?	Yes	No
Speech	Still there?	Yes	No
Hearing, vision, or other senses	Still there?	Yes	No
Memory	Still there?	Yes	No
Ability to concentrate	Still there?	Yes	No
Mood	Still there?	Yes	No
Temper	Still there?	Yes	No
Relationships with others	Still there?	Yes	No
Ability to work, or do school work	Still there?	Yes	No
Use of alcohol or other drugs	Still there?	Yes	No
7. Did you receive treatment for any of the things that changed after the head injury? N/A		Yes	No

Scoring Information for the Alaska Screening Tools

- Mental Health Screen Scoring Instructions

  If a consumer responds negatively to all questions, and the interviewer has not learned anything during the interview that is contradictory, the person is not considered as a potential dual-diagnosis consumer.

  If a consumer responds positively (Yes) to any of the top ten questions (1-10), the person should be asked for clarifying information about the question and if the positive response is validated, this will trigger a referral for a full mental health assessment.

  If a consumer responds positively to any two of the remaining questions (11-19), the person should be asked for clarifying information and if the responses are validated, this will trigger a referral for a full mental health assessment.

  Screeners are urged to err on the side of referring for an assessment when they are not sure of the likelihood of a positive screen, rather than to miss someone who needs treatment.

- Traumatic Brain Injury Screen Scoring Instructions

  If a consumer answers "Yes" to question 1 and/or 3 and has responded that they still have symptoms, the consumer needs to be:

  * Referred by a substance abuse treatment facility to a mental health facility, for assessment
  * Assessed for traumatic brain injury and properly diagnosed, or
  * Referred to a neurologist for assessment for traumatic brain injury.

CAGE Screening

C Have you ever felt the need to CUT DOWN on your drinking?

A Have you ever been ANNOYED by criticism of your drinking?

G Have you ever felt GUILTY about your drinking?

E Have you ever felt the need for an EYE-OPENER in the morning?

Scoring

* 2 or more "yes" answers are indicative of probable alcohol dependency.
* 1 "yes" answer is indicative of a probable alcohol problem.

Mental Illness Drug & Alcohol Screening (MIDAS)

Person Name and/or ID number: _____

Worker Name: _____ Date: _____

Each question refers to the past six months. ***Please circle the specific substance/gambling issue(s) as well as YES or NO.**		
1. In the past 6 months have you felt that you have a problem, or used to have a problem, with your use of drugs and/or alcohol and/or gambling?	Yes	No
2. In the past 6 months have you used drugs or alcohol, or gambled even though your doctor or other treaters recommended that you do not?	Yes	No
3. In the past 6 months has your family been concerned about your drugs and/or alcohol or gambling?	Yes	No
4. In the past 6 months have your treaters expressed concerns about your drugs and/or alcohol or gambling?	Yes	No
5. In the past 6 months have you had legal problems or engaged in illegal activity (other than using drugs) due to drugs and/or alcohol or gambling?	Yes	No
6. In the past 6 months have you had medical problems related to, or worsened by, drugs and/or alcohol or gambling?	Yes	No
7. In the past 6 months have you used drugs and/or alcohol or gambling to relieve mental health symptoms?	Yes	No
8. In the past 6 months have you found that using drugs and/or alcohol or gambling worsens your mental health symptoms?	Yes	No
9. In the past 6 months have you had problems taking your psychiatric medication as prescribed because of drug and/or alcohol use or gambling?	Yes	No
10. Have you gotten in trouble, including getting in trouble at a mental health treatment program, because of drug and/or alcohol use or gambling?	Yes	No
11. In the past 6 months have you had ER visits or psychiatric hospitalizations that were connected to drug and/or alcohol use or gambling?	Yes	No
12. In the past 6 months have you ever felt guilty about your drug and/or alcohol use or gambling?	Yes	No
13. In the past 6 months have you experienced withdrawal symptoms or intensive cravings to use drugs or alcohol or to gamble?	Yes	No
14. In the past 6 months have you attended self-help (e.g., 12-step) meetings relating to drug and/or alcohol addiction or gambling?	Yes	No
15. In the past 6 months have you received any addiction treatment, including detoxification?	Yes	No
16. In the past 6 months have you felt unable to control your use of any drug or alcohol or gambling?	Yes	No
17. Do you consider yourself to be an alcoholic or drug addict or gambling addict?	Yes	No
Total Score		

Scoring Category

Please circle the applicable diagnostic category:

* **Any YES answer** on questions 1-12 indicates **probable abuse.**
* **Any YES answer** on questions 13-17 indicates **probable dependence.**
* **Absence of YES answers** indicates **no abuse or dependence.**

Notes

Total score may be an indicator of severity, but even a low score can indicate probable substance abuse or dependence.

If the person answers YES to even one question, then s/he is considered to have probable abuse or dependence.

If a person scores in both probable abuse and probable dependence, rate as probable dependence.

Clinician's Rating of Reliability of Diagnostic Category Result

Please read notes below and circle applicable rating: High Medium Low

Notes

- Clinician's rating of reliability relates to the perception of the accuracy of the **diagnostic category** in which the person scores, based on the clinician's own knowledge, not whether or not the person answered each question truthfully (e.g., A person answers YES to Questions 13 and 14 and NO to questions 15 and 16; s/he will be categorized as probable dependence. Even though the clinician believes that' s/he was untruthful about questions 15 and 16 reliability is still rated as **high** if the clinician believes the category of probable dependence is accurate overall).
- Use the Moderate or Low reliability ratings in the following types of circumstances only: If a person has scored in a category which underestimates (or, in rare cases, may overestimate) the clinician's perception of his/her actual substance or gambling diagnosis (e.g., scores *no problem* when the clinician believes there is probable abuse or dependence (LOW), or scores *probable abuse* when the clinician believes there is probable dependence (MODERATE).
- Inconsistent or scattered scores are likely indicators of denial, defensiveness, or minimization, but do not necessarily result in an unreliable screening.

- Individuals can score positive for either abuse or dependence, even though they are currently abstinent; factors that contribute to the initiation or sustaining of abstinence are to be evaluated as part of the assessment.

Next Steps if the Person has a Positive Score

Data Collection

Any Yes answer on the MIDAS screening for an individual with a probable or definite mental illness diagnosis should result in identification of the individual as **having a co-occurring disorder** for the purpose of initial data collection, even though the diagnostic assessment may not yet have been completed, and whether or not the individual's substance use or gambling disorder is currently active.

Assessment

The MIDAS is a screening tool, not an assessment. Any Yes answer indicates that the individual has screened positively and indicates the need for an **integrated assessment of the individual's co-occurring mental illness and substance use or gambling disorder.** We recommend utilization of an **integrated longitudinal strength based assessment** (**ILSA)** process, or similar process incorporating mental health and substance use symptom screening, an integrated chronological history of both mental health and substance use/gambling issues, with emphasis on details regarding onset of issues, periods (particularly more recent periods) of stability and strengths/services contributing toward those periods of success, as well as details of current situation, including level of safety risk, acuity and level of care need, current symptoms and treatments, stages of change, disorder management skills, and presence of collateral problems/supports and contingencies.

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AC-OK Screen for Co-occurring Disorders (Mental Health, Trauma-related Mental Health Issues & Substance Abuse)

First Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____ Date of Screening: _____

During the past year:		
1. Have you been preoccupied with drinking alcohol and/or using other drugs?	Yes	No
2. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?	Yes	No
3. Do you, at times, drink alcohol and/or used other drugs more than you intended?	Yes	No
4. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less?	Yes	No
5. Do you, at times, drink alcohol and/or used other drugs to alter the way you feel?	Yes	No
6. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't?	Yes	No
7. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?	Yes	No
8. Have you experienced thoughts of harming yourself?	Yes	No
9. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?	Yes	No
10. Have you attempted suicide?	Yes	No
11. Have you had periods of time where you felt that you could not trust family or friends?	Yes	No
12. Have you been prescribed medication for any psychological or emotional problem?	Yes	No
13. Have you experienced hallucinations (heard or seen things others do not hear or see)?	Yes	No
14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone?	Yes	No
15. Have you experienced a traumatic event and since had repeated nightmares/ dreams and/or anxiety which interferes with your leading a normal life?	Yes	No

Instructions for the AC-OK Screen for Co-occurring Disorders (Mental Health, Trauma & Substance Abuse

"I'm glad you (called **or** came in); let's see how I can help. In your own words, what is going on, OR can you tell me a little about why you called (today)?"

"In order to (find the best services **or** determine the next best steps) for you, I'd like to ask you a few short yes-or-no questions to see if there is anything we may have missed. There are no 'right' or 'wrong' answers and these questions may or may not apply to your situation. Is this okay with you?"

- This screen should be used when a person first contacts the agency for services.
- This screen is only a tool to help identify potential areas that may need further assessment.
- Please note: This is NOT a diagnostic tool and should not be used as an assessment.
- Please read each question exactly as written in the order provided.
- If a potential crisis is identified during the screening, please follow your agency protocols.
- Immediately to assess for lethality and provide appropriate intervention.
- Positive indicators (one "YES" answer) in any three domains indicate that an assessment(s) is needed in that domain.

Scoring

Remember, one "Yes" answer on any of the three domains (Mental Health, Trauma-related Mental Health Issues, and Substance Abuse) indicates that an additional assessment(s) is needed in that domain.

- Mental Health Issues: 7, 8, 9, 10, 11, 12, 13
- Trauma-related Mental Health Issues: 14, 15
- Substance Abuse Issues: 1, 2, 3, 4, 5, 6

NIDA-modified ASSIST—Prescreen V1.0

This screening tool was adapted from the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) Version 3.0 developed and published by the World Health Organization (WHO) (available at: http://www.who.int/substance_abuse/activities/assist_v3_english.pdf)

INTERVIEWER ID | COUNTRY | CLINIC

PATIENT ID | DATE

INTRODUCTION ***(Please read to patient)***

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1
(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	**No**	**Yes**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING	INTERVENTION GUIDELINES
Once weekly or less or Fewer than 3 days in a row	**Brief Intervention including "risks associated with injecting" card**
More than once per week or 3 or more days in a row	**Further assessment and more intensive treatment***

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

Screening Resources

San Mateo Behavioral Health and Recovery Services Co-occurring Initiative:
http://www.smhealth.org/COD

COD Connecticut Statewide Implementation of Mental Health and Substance Use Screening Measures (Available in English and Spanish):
Mental Health Screening Form-III (MHSF-III)
Modified Mini
Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
CAGE-Adapted to Include Drugs (CAGE-AID)
http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802

Co-occurring Screening Training
http://www.ct.gov/dmhas/LIB/dmhas/COSIG/screeningtraining.pdf

Frequently Asked Questions
http://www.ct.gov/dmhas/lib/dmhas/cosig/ScreeningFAQs.pdf

Modified Mini User's Guide
http://www.ct.gov/dmhas/lib/dmhas/cosig/MMSusersguide.pdf

DMHAS Pilot Program Report
Results: In a statewide pilot with over 30 mental health and addiction treatment facilities and more than 2000 completed screens, 44.5% of people screened showed signs of having co-occurring disorders
http://www.ct.gov/dmhas/lib/dmhas/cosig/121406infobrief.pdf

Integrated Mental Health, Substance Abuse and Trauma Screening Tool
COJAC
The Co-occurring Joint Action Council (COJAC) determined that there is a significant need for a short and simple tool to screen individuals for co-occurring disorders (COD). The Screening Subcommittee undertook the effort of compiling a COJAC Screening tool (CST). The members of the subcommittee did a significant amount of research to locate appropriate questions for the tool and then spent several months reducing the number of questions to nine. There are three questions for addiction, three questions for mental health issues and three questions for trauma.
http://www.adp.cahwnet.gov/cojac/pdf/cojac_screening_tool.pdf
http://www.adp.cahwnet.gov/cojac/screening.shtml

PTSD/ Trauma Screening

The following are a few examples of normed and validated tools that are widely accepted in screening for trauma related issues.

Trauma Screening Questionnaire (TSQ)

A 10-item self-report measure designed to screen for posttraumatic stress disorder (PTSD). Each item is derived from the DSM-IV criteria and describes either a re-experiencing symptom (items 1-5) or an arousal symptom of PTSD (items 6-10). http://www.completepractitioner.com/assessment/PSD.pdf

Performance study of the Trauma Screening Questionnaire (TSQ) including comparisons with existing instruments:

Brewins, Chris R., Rose Suzanna, Andrews Bernice, *et al.* (2002) **Brief screening instrument for post-traumatic stress disorder.** *The British Journal of Psychiatry*, 181,158-162. http://bjp.rcpsych.org/cgi/content/full/181/2/158

The Addiction Website of Terence T. Gorski:
PTSD Checklist- Civilian
The PTSD Checklist – Civilian, and a separate PTSD Checklist – Military, is a 17-item self-report measure that assesses for symptoms of re-experiencing, avoidance, dissociation and hyperarousal.
http://www.tgorski.com/Terrorism/ptsd_checklist_civilian_version.htm
http://www.tgorski.com/Terrorism/ptsd_checklist_military_version.htm

Child Trauma Institute:
Child/Adolescent/Parent Trauma Measures for Research and Practice
Provides an overview of measurement issues for this population, as well as summaries of selected measures along with sample items and contact information.
http://www.childtrauma.com/mezpost.html

Impact of Events Scale *8-Item Child/Adolescent Scale (IES-8)
The IES-8 has probably been the most widely used measure of post-traumatic stress, with a focus on the classic avoidance and intrusion symptoms.
http://www.childtrauma.com/chmies8.html

Diagnostic Criteria for Disorders of Extreme Stress (DESNOS) or Complex Trauma

Both clinical consensus and research in the field have linked developmental or complex trauma with histories of interpersonal victimization, multiple traumatic events, and/or traumatic exposure of extended duration. In exploring the disparate adaptations to complex trauma, the DSM-IV PTSD taskforce highlights alterations in six areas of functioning: 1) regulation of affect and impulses; 2) attention or consciousness; 3) self-

perception; 4) relations with others; 5) somatization; and 6) systems of meaning ([1]van der Kolk, 2001, 375).

http://www.traumacenter.org/products/publications.php
http://www.traumacenter.org/products/pdf_files/DESNOS.pdf
(page 375)

[1]Luxenberg, T., Spinazzola, J., & van der Kolk, B. A. (2001) Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part I: Assessment. Directions in Psychiatry, 21, pp. 373-393. Long Island City, NY: The Hatherleigh Company, Ltd.

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Appendix H:
Traumatic Brain Injury Resources

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Trauma-Informed Webliography

Retrieved from San Mateo Health System Co-occurring Initiative: http://www.smchealth.org/cod. This information is provided as a resource and does not constitute an endorsement by ZiaPartners, Inc.

Research

National Child Traumatic Stress Network

http://nctsn.org

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

Creating Trauma-informed Systems

http://nctsn.org/nccts/nav.do?pid=ctr_top_trmainfo

The Service Systems Briefs Series addresses the impact of trauma on the daily functioning of children and adolescents, describes how systems currently approach child trauma, and introduces innovative and effective ways of serving traumatized children.

This section of NCTSN.org (http://nctsn.org/nccts/nav.do?pid=ctr_top) provides network resources on child traumatic stress arranged by topic. Resources can also be found arranged by audience (http://nctsn.org/resources/audiences).

Results of an NCTSN survey on complex trauma exposure, outcomes, and treatment approaches for impacted children and their families who received interventions and/or comprehensive assessment services in 2002 can be found here: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/Complex_TraumaintheNCTSN.pdf

National Center for Posttraumatic Stress Disorder

http://www.ptsd.va.gov/

The PTSD Information Center contains in-depth information on PTSD and traumatic stress for a general audience. We answer commonly asked questions

about the effects of trauma, including basic information about PTSD and other common reactions. You can find out about treatment and coping or view videos to learn more. The PILOTS database is an electronic index to the worldwide literature on PTSD and other mental-health sequelae of exposure to traumatic events. It is available to Internet users through the courtesy of Dartmouth College, whose computer facilities serve as host to the database. No account or password is required, and there is no charge for using the PILOTS database.

Clinician's Trauma Update Online Newsletter

http://www.ptsd.va.gov/professional/newsletters/ctu-online.asp

The Clinician's Trauma Update, *CTU-Online*, is an electronic newsletter produced by the National Center for PTSD. It provides summaries of clinically relevant publications in the trauma field. The summaries are presented in brief format with links to the full article when available. Content on treatment and assessment is emphasized. Publications on other topics are included if the content has significant clinical implications. CTU-Online is published 6 times per year.

Complex Trauma in Children and Adolescents

http://www.rtc.pdx.edu/PDF/fpW0702.pdf

This article provides a core background for understanding the psychological and physiological effects of multiple traumatic stress experiences on the developing brain. Steps for assessment and treatment are also discussed.

The Tapestry (final issue published Fall, 2003; archives available online)

http://www.wcdvs.com/publications/

SAMHSA and the Women, Co-Occurring Disorders and Violence Coordinating Center are committed to documenting the lessons learned from the Women, Co-occurring Disorders and Violence Study and disseminating this information in ways that help improve services and policies affecting women who are trauma survivors and who have co-occurring mental health and substance abuse disorders.

John Briere, PhD

http://www.johnbriere.com/articles.htm

Dr. Briere is author of a number of books, articles, and chapters in the areas of child abuse, psychological trauma, and interpersonal violence. Dr. Briere also has developed various psychological tests and assessments, including the *Trauma Symptom Inventory, Trauma Symptom Checklist for Children, Inventory of Altered Self*

Capacities, Detailed Assessment of Post-traumatic Stress, and the *Multiscale Dissociation Inventory*.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com/

These pages focus primarily on emotional trauma and traumatic stress, including PTSD (Post-traumatic Stress Disorder), whether following individual traumatic experience(s) or a large-scale disaster. New information is added to this site about once a month. The purpose of this award-winning site is to provide information for clinicians and researchers in the traumatic-stress field.

International Society for Traumatic Stress Study (ISTSS)

http://isstss.org

The International Society for Traumatic Stress Studies (ISTSS), founded in 1985, provides a forum for the sharing of research, clinical strategies, public policy concerns and theoretical formulations on trauma in the United States and around the world. ISTSS is dedicated to the discovery and dissemination of knowledge and to the stimulation of policy, program and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences.

Tension and Trauma-releasing Exercises (David Berceli, PhD)

http://www.traumaprevention.com/articles

A plethora of articles in common language relaying the effects that stress, anxiety, and trauma have on our mental wellbeing and our physical health.

Traumatic Stress and Secondary Traumatic Stress, Compassion Fatigue and Vicarious Traumatization

http://www.proqol.org/Home_Page.php

From the website: "Professional quality of life is the quality one feels in relation to their work as a helper. Both the positive and negative aspects of doing one's job influence ones professional quality of life. People who work in helping professions may respond to individual, community, national, and even international crises. Helpers can be found in the health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, airline and other transportation staff, disaster site cleanup crews, and others who offer assistance at the time of the event or later. Understanding the positive and negative aspects of helping those who experience trauma and suffering can improve your ability to help them and your ability to keep your own balance." Site includes resource links.

International Society for the Study of Trauma and Dissociation

http://www.isst-d.org/

The International Society for the Study of Trauma and Dissociation is an international, non-profit, professional association organized to develop and promote comprehensive, clinically effective and empirically based resources and responses to trauma and dissociation and to address its relevance to other theoretical constructs. Site includes trauma FAQs and annotated bibliography.

Adverse Childhood Experiences (ACE) Study

http://www.acestudy.org http://www.cdc.gov/ace/index.htm

The Adverse Childhood Experiences (ACE) Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD, the ACE Study is perhaps the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma (ACEs), and health and behavioral outcomes later in life.

Presentations

SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center)

http://www.stopstigma.samhsa.gov/

http://www.promoteacceptance.samhsa.gov/teleconferences/archive/training/teleconference09102009.aspx

Social inclusion is a comprehensive approach to address multiple issues that people with mental health problems experience as individuals and as a group. Social inclusion is a positive goal for people with mental illnesses and it is achieved when positive outcomes from a good quality education, an adequate income, accessible and affordable health services, social and political participation, living in a safe community, good quality housing and a stable family are achieved simultaneously.

Video Documentaries

Cavalcade Productions, Inc.

http://www.cavalcadeproductions.com/

Cavalcade produces training videos for professionals working with clients who have experienced psychological trauma. They have released over sixty such videos

since they began this work in 1989, and their customers include therapists, social workers, foster family agencies, residential care facilities, colleges and universities, medical professionals, teaching hospitals, attorneys, and child abuse prevention organizations.

Healing Resources

http://www.healingresources.info/emotional_trauma_online_video.htm

This 30-minute documentary video about psychological or emotional trauma in children is taken from interviews conducted at the From Neurons to Neighborhoods community conferences. The documentary is an overview to help those who care about children recognize, prevent and heal psychological trauma. Internationally and nationally recognized authorities who work with children and teenagers in the field of emotional trauma, including Drs. Bruce Perry and Daniel Siegel, offer new insight and information about the origins of relationship/ developmental problems, as well as problems associated with PTSD later in life. New research on the brain is highlighted, as is information about how seemingly benign incidents bring about traumatic responses in young children. A central message of the documentary is that even though psychological trauma often goes unrecognized in children, emotional trauma is very responsive to relational repair.

Online Courses

Child Trauma Academy (Bruce Perry, MD)

http://www.childtrauma.org/

Child Trauma Academy is a not-for-profit organization based in Houston, Texas, working to improve the lives of high-risk children through direct service, research and education. We recognize the crucial importance of childhood experience in shaping the health of the individual, and ultimately, society. By creating biologically informed child and family respectful practice, programs and policy, CTA seeks to help maltreated and traumatized children.

http://www.childtrauma.org/index.php/training/live-online-training

The NMT Case-Based Training Series is a clinical case conference series led by Dr. Bruce Perry and attended by participants via the Internet. The Child Trauma Academy offers NMT Case-Based Training Series twice annually: WINTER and FALL. Each Series consists of ten 90-minute sessions for a total of 15 training hours. This teaching model has been useful for helping clinicians and frontline staff better understand the neurodevelopmental principles involved in many of the primary symptoms, as well as strengths, they see in the children they serve.

Trauma-focused Cognitive-Behavioral Therapy

http://tfcbt.musc.edu/

A web-based learning course for trauma-focused cognitive-behavioral therapy.

http://ctg.musc.edu/

A web-based learning course for using trauma-focused cognitive-behavioral therapy with childhood traumatic grief.

Training

Somatic Experiencing® Trauma Institute™ (Peter Levine, PhD)

http://www.traumahealing.com

The Somatic Experiencing® Trauma Institute™ is a non-profit, educational and research organization dedicated to the worldwide healing and prevention of trauma. We provide professional training in Somatic Experiencing® and outreach to under served populations and victims of violence, war and natural disasters.

Somatic Therapy (Babette Rothschild, MSW, LCSW)

http://www.somatictraumatherapy.com/

Babette Rothschild is a body-psychotherapist and specialist educator in the treatment of trauma and PTSD. The website contains links to articles, videos and PTSD links, as well as contact information to obtain a trainings schedule.

Hakomi Institute of California

http://www.hakomicalifornia.org/

The Hakomi Institute of California, L.L.C. is a professional educational organization dedicated to providing high quality trainings in Hakomi Experiential Psychology to a wide variety of clinical and non clinical professions. We offer workshops and trainings to professionals and the general populations. The Hakomi Method is used and applicable both as a psychotherapeutic process as well as in educational settings to facilitate self-exploration and personal growth.

Sensorimotor Psychotherapy Institute (Pat Ogden, PhD)

http://www.sensorimotorpsychotherapy.org/

The Sensorimotor Psychotherapy Institute (SPI) is an educational organization dedicated to the study and teaching of a somatic approach to clinical psychotherapy practice. Sensorimotor Psychotherapy is a body-oriented talking therapy that integrates verbal techniques with body-centered interventions in the treatment of

trauma, attachment, and developmental issues. SPI offers trainings and workshops for psychotherapists and allied professionals in Sensorimotor Psychotherapy and courses for body therapists on somatic resources. The courses taught by SPI are based on principles of mindfulness and mind/body/spirit holism and informed by contemporary research in neuroscience, attachment theory, trauma, and related fields.

Center for Post-trauma Therapy and Trauma Education

http://www.traumaterapiakeskus.com/front1.htm

Center for Post-trauma Therapy and Trauma Education is Finland's premier center for trauma psychology. The Center is located in Helsinki and provides information, education, consultation and treatment for individuals, families, workplaces and communities who suffer from the effects of trauma. The Center for Post-trauma Therapy and Trauma Education organizes annual workshops with international trauma specialists.

Seeking Safety (Lisa Najavits, PhD)

http://www.seekingsafety.org/

Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD. Trainings can occur via video, onsite training, attending an existing training, or by telephone consultation.

Stephanie Covington, PhD, LCSW

http://www.stephaniecovington.com/

Dr. Stephanie Covington is a clinician, author, organizational consultant, and lecturer. Recognized for her pioneering work in the area of women's issues, Dr. Covington specializes in the development and implementation of gender-responsive services in both the public and private sectors. She has published extensively, including six manualized treatment programs. Dr. Covington is based in La Jolla, California, where she is co-director of both the Institute for Relational Development and the Center for Gender and Justice.

Sidran Institute: Traumatic Stress Education and Advocacy

http://www.sidran.org/

Many adults and children who have experienced or witnessed violent or traumatic events suffer severe and disabling symptoms of distress. The developmental, emotional, and psychological injuries caused by violence and trauma are frequently underestimated. Our programs and activities focus on the early recognition and treatment of trauma-related stress in children, in order to promote healthy growth and development; the understanding and treatment of adults suffering from traumatic stress to promote psychological health and recovery; and the promotion of trauma-informed systems of care in agencies providing mental health, counseling, substance abuse, or rehabilitative services in order to improve care and outcomes.

Our goal at Sidran is to create an environment in which advocacy and survivor self-determination can flourish. We provide educational programming in jargon-free language, make all training and workshops accessible for lay audiences as well as professionals, and eliminate the stigma-producing divisions that are often problematic in traditional treatment settings. At Sidran, there is no "us" and "them"—only "us"—and together we are committed to fostering growth-promoting relationships at all levels.

The Trauma Center at Justice Resource Institute (Bessel van der Kolk, MD)

http://www.traumacenter.org/

The Trauma Center is a program of Justice Resource Institute (JRI), a large nonprofit organization dedicated to social justice by offering hope and promise of fulfillment to children, adults, and families who are at risk of not receiving effective services essential to their safety, progress, and/or survival. The Trauma Center provides comprehensive services to traumatized children and adults and their families at the main office in Brookline, MA. In addition to clinical services, The Trauma Center offers training, consultation, and educational programming for post-graduate mental health professionals. Our Certificate Program in Traumatic Stress Studies has state-of-the-art seminars, lectures and supervision groups. Our monthly Lecture Series is open to all mental health professionals.

Janina Fisher, PhD

http://www.janinafisher.com/

This website is devoted to the understanding and treatment of the legacy of trauma: attachment failure, neglect, physical or sexual abuse in childhood, war exposure, sexual assault, medical trauma, and domestic or community violence. It is intended

for use by mental health clinicians and other healing professionals, as well as by survivors of trauma, and includes links to resources, trainings and webinars.

Trauma First Aide

http://traumafirstaide.com/index.html

Trauma First Aide Associates, LLC is an organization of social workers, trauma therapists, nurses, and mind/body practitioners experienced in working with trauma survivors and teaching Trauma First Aide©. We are dedicated to reducing the effects of trauma through trauma education to diverse populations including health care providers, business and community leaders and the public. Our focus is on trauma education, early intervention, and the prevention of secondary traumatization by building resilience in the nervous system.

The International Trauma-Healing Institute

http://www.traumainstitute.org/

Trauma is an everyday event both natural and widespread. Trauma impacts victims of "ordinary" events such as traffic accidents, falls, illnesses, school violence, as well as "extraordinary" events, natural disasters, wars, and terrorist attacks. The Institute acts to serve as a national and international resource center bringing continuing awareness to the issue of trauma as well as providing training models, training materials, workshops, seminars, courses, consulting services and trainers. ITI provides a clearer understanding of the multifaceted nature of trauma and the broad range of effective short-term treatment techniques to enable coping with and healing trauma.

Trauma Resource Institute

http://www.traumaresourceinstitute.com/

The mission of the Trauma Resource Institute is to take people from despair to hope through simple skills-based interventions based on cutting-edge research about the brain; to expand access to treatment by training the front-line service providers and responders who do the hardest work with the least resources; and to build local capacity in diverse communities nationally and internationally so each may develop trauma resolution strategies that respond to their unique cultural needs.

National Center for Children Exposed to Violence

http://www.nccev.org/

It is the mission of the National Center for Children Exposed to Violence (NCCEV) to increase the capacity of individuals and communities to reduce the incidence and

impact of violence on children and families; to train and support the professionals who provide intervention and treatment to children and families affected by violence; and to increase professional and public awareness of the effects of violence on children, families, communities and society.

Community Connections

http://www.communityconnectionsdc.org/web/page/589/interior.html

Community Connections provides an array of consultation and training programs to human service agencies and systems throughout the country. We specialize in the areas of Trauma-Specific Treatment Approaches, Implementation of Trauma-Informed Systems, and the Integration of Mental Health, Substance Abuse, and Trauma Services. The Trauma Recovery and Empowerment Model (TREM) group intervention was developed at Community Connections in the 1990s by clinicians led by Dr. Maxine Harris. Based in both clinical experience and the research literature, TREM has become one of the major trauma recovery interventions for women.

Trauma-informed Care Resources and Information

The Anna Institute

http://www.annafoundation.org/TIC-RESOURCES.html

National Trauma Consortium

http://www.nationaltraumaconsortium.org/services.html

The National Trauma Consortium represents people and organizations who recognize the damage that interpersonal violence does to individuals and to society, who want to do something about it, and who area committed to working in partnership with people who have experienced trauma.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org/publicationsmisc.cfm

(Scroll for trauma-informed care articles.) NASMHPD serves as the national representative and advocate for state mental health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state to state sharing.

SAMHSA's National Center for Trauma-informed Care

http://www.samhsa.gov/nctic/

SAMHSA's National Center for Trauma-Informed Care (NCTIC) is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

Institute for Health and Recovery

http://www.healthrecovery.org/services_and_products/

http://www.healthrecovery.org/about_us/publications/default.asp

The Institute for Health and Recovery is a service, research, policy, and program development agency. IHR's mission is to develop a comprehensive continuum of care for individuals, youth, and families affected by alcohol, tobacco, and other drug use, mental health problems, and violence/trauma.

The Sanctuary Model

http://www.sanctuaryweb.com/publications.php

The Sanctuary Model represents a theory-based, trauma-informed, evidence-supported, whole-culture approach that has a clear and structured methodology for creating or changing an organizational culture. The objective of such a change is to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. As an organizational culture intervention, it is designed to facilitate the development of structures, processes, and behaviors on the part of staff, clients and the community-as-a-whole that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the victims of traumatic experience and extended exposure to adversity.

State Trauma-informed Care Initiatives and Policy

Iowa Consortium for Mental Health, Trauma-informed Care Resources

http://www.healthcare.uiowa.edu/icmh/TraumaInformedCare.htm

Building Trauma-informed Mental Health Service Systems: Blueprint for Action

http://www.annafoundation.org/07-08BBYSTATE.pdf

State accomplishments, activities and resources (December, 2007, draft)

NASMHPD Position Statement on Services and Supports to Trauma Survivors

http://www.nasmhpd.org/general_files/position_statement/NASMHPD TRAUMA Positon statementFinal.pdf

Connecticut Department of Mental Health & Addiction Services, Trauma Initiative

http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335292

The primary goal of the Trauma Initiative is to deliver behavioral health care that is sensitive and responsive to the needs of men and women who have experienced psychological trauma. Training and professional development with clinicians and clinical case managers in the DMHAS system of care is preparing them to provide screening, education, and treatment groups. Trauma services are being developed based on the guiding principle that treatment must be informed by a sound scientific, clinical, culturally relevant, and humanistic understanding of the impact and impairment caused by traumatic stress.

Maine Department of Behavioral and Developmental Services, Office of Trauma Services

The Maine DMHMRSAS Office of Trauma Services (OTS) was created in 1995 to address the needs of recipients of public mental health and substance abuse services with histories of trauma. It expanded in 1998 to increase capacity for statewide training and education, to continue survivor/consumer involvement, to establish community support and advocacy, to initiate additional services, and to develop a program of self-care for providers who work with trauma survivors.

A Plan for Improving Behavioral Health Services for Persons with Histories of Trauma

http://www.annafoundation.org/APLAN.pdf

Comprehensive Strategic Plan for Creating a System of Care Responsible to the Needs of Trauma Survivors

http://www.annafoundation.org/MMHCSAP.pdf

In Their Own Words is the work of over 200 courageous women and men in the State of Maine who have dared to hope that the truth and wisdom of their experience will be heard by those in power giving input as to what hurts, what helps, and what is needed from our service systems for healing and recovery.

http://www.annafoundation.org/ITOW.pdf

Missouri Department of Mental Health Trauma Initiative

http://dmh.mo.gov/mentalillness/initiatives/TraumaInit/

Ohio Department of Mental Health, Trauma-informed Care

http://mentalhealth.ohio.gov/what-we-do/promote/trauma-informed-care/index.shtml

Pennsylvania Office of Mental Health and Substance Abuse Services

http://www.nasmhpd.org/general_files/publications/ntac_pubs/Responding to Childhood Trauma - Hodas.pdf

Paper: *Responding to Childhood Trauma: The Promise and Practice of Trauma-informed Care* (Gordon Hodas, MD. 2006.)

South Carolina Department of Mental Health

http://www.state.sc.us/dmh/trauma/position_statement.htm

Position statement on services for trauma survivors in South Carolina.

San Mateo County Health System Co-occurring Initiative, Trauma-informed Care Resources

http://www.smchealth.org/cod

Trauma-informed Advocacy

Witness Justice: Help and Healing for Victims of Violence

http://www.witnessjustice.org/

Witness Justice provides information and support, connection through our virtual community, and direct assistance to any survivor who may have questions in the aftermath of violence. Our expert corps of volunteers, comprised of leading experts from around the country, is available to offer suggestions or potential solutions to tough problems or obstacles that survivors face. Through our website, Witness Justice also offers a host of training resources for service providers. In an effort to fill gaps in victim services, we conduct research and outreach to identify unaddressed survivor needs and the impact of violence on families, communities,

and our nation. When we identify a gap, need, or unaddressed population, we work to meet those needs and gaps and, when necessary, we advocate with legislators, state systems, and other organizations to foster positive social change that will provide the best potential for survivors' healing and justice.

Strength to Heal

http://strengthtoheal.com/

This website provides resources for survivors of trauma, Post Traumatic Stress Disorder (PTSD), addiction, sexual, physical, emotional and spiritual abuse as they continue on their healing journey. It also provides informative articles and links that will lessen the feelings of isolation as one heals from this trauma. Clinicians share their healing tools working with survivors of trauma, PTSD and addiction, as well as survivors and caregivers give their perspective on healing.

Empirically Supported Treatments and Promising Practices

The National Child Traumatic Stress Network

http://nctsn.org/

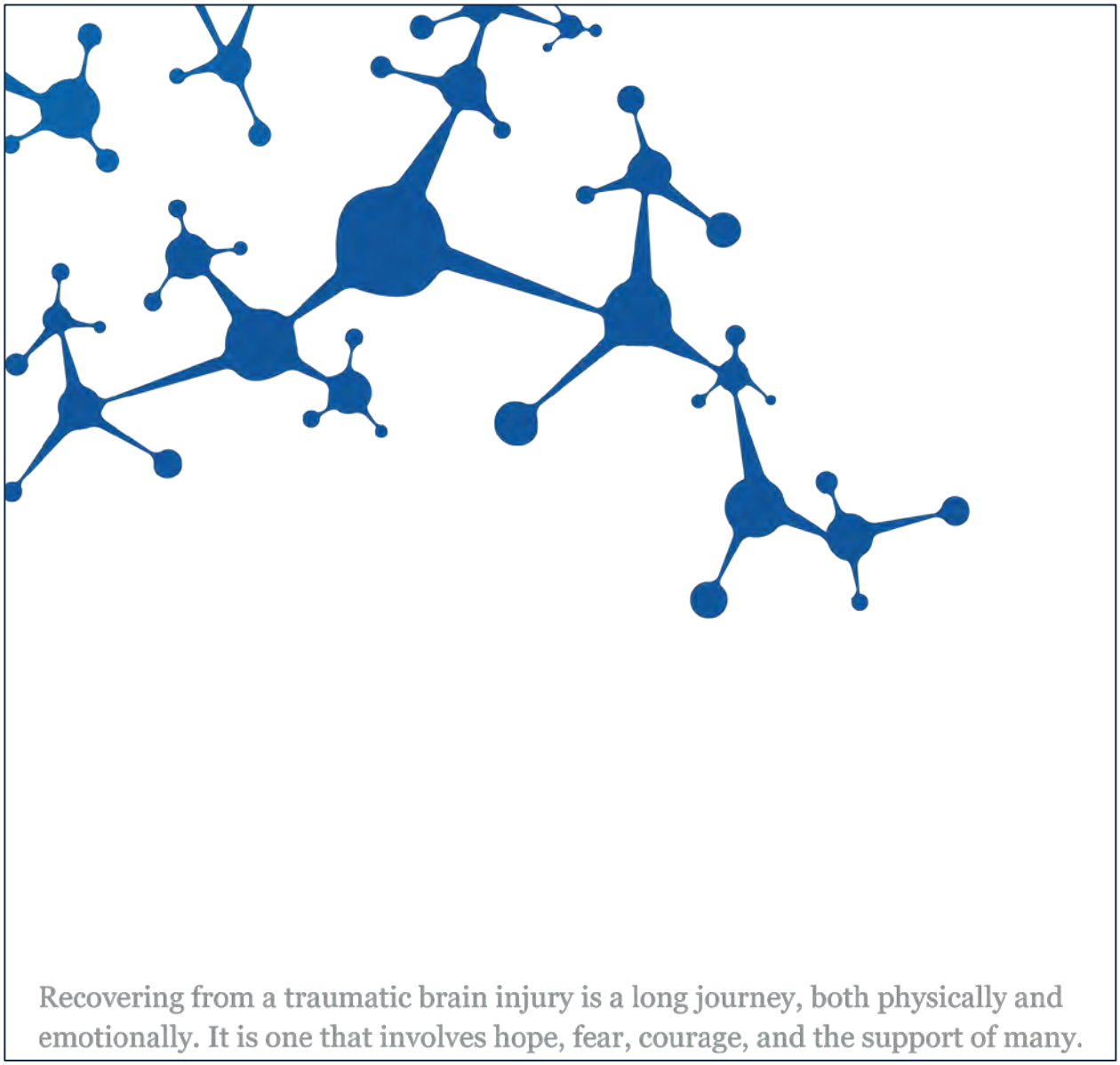
Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

NCTSN Learning Center for Child and Adolescent Trauma (http://learn.nctsn.org/)

Trauma-informed Interventions: Clinical and Research Evidence and Culture-specific Information Project (http://www.nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf)

Treatments that Work: Papers, treatment models, documents, audio-video resources (http://www.nctsn.org/resources/audiences/parents-caregivers/treatments-that-work)


POLYTRAUMA/TBI
SYSTEM OF CARE
HELPING VETERANS
GET BACK TO LIVING
VA
HEALTH
CARE
Defining
EXCELLENCE
in the 21st Century



Recovering from a traumatic brain injury is a long journey, both physically and emotionally. It is one that involves hope, fear, courage, and the support of many.

Thanks to improvements and innovations in battlefield medicine and protective gear, America's Servicemembers injured in Iraq, Afghanistan, and elsewhere are surviving at higher rates than ever before.

While many of them are facing challenges from their injuries, including Traumatic Brain Injury (TBI), the Department of Veterans Affairs (VA) is meeting these challenges with specialized treatments, extended care, and advances in rehabilitation treatments.

TRAUMATIC BRAIN INJURY

Seeing it, Treating it, Understanding it

"Polytrauma" describes injuries to multiple body parts and organs, often occurring as a result of blast-related exposures. The use of improvised explosive devices (IED) and other weapons has been a major cause of polytrauma injuries.

TBI is the signature injury of polytrauma. It often occurs in combination with other conditions, such as amputation, auditory and visual impairments, spinal cord injury, musculoskeletal injury, and post-traumatic stress disorder (PTSD). Due to the severity and complexity of their injuries, Veterans and Servicemembers with polytrauma benefit from the coordinated and integrated clinical and support services that the VA Polytrauma System of Care offers.


While TBI wounds are often invisible, the treatments may be complex, and the effects far-reaching. Difficulties after a TBI can persist long after the physical injuries appear to be healed.

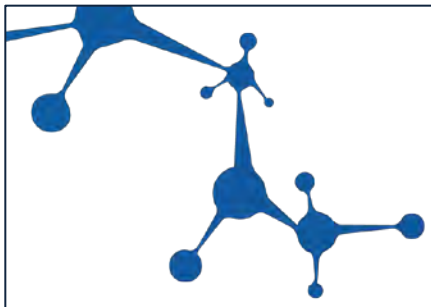
VA POLYTRAUMA SYSTEM OF CARE

A Network of Specialists and Resources

VA's Polytrauma System of Care is for Veterans and Servicemembers with multiple injuries that result in physical, cognitive, and/or psychological impairments and functional disability. This state-of-the-art system of care provides comprehensive, compassionate, high-quality, and inter-disciplinary care to patients and their families. Teams of clinicians from a range of fields develop and implement an individually-tailored rehabilitation plan to foster recovery as quickly and as completely as possible.

VA provides assistance to Veterans and Servicemembers through its integrated Polytrauma Rehabilitation Centers, Polytrauma Transitional Rehabilitation Programs, Polytrauma Network Sites, Polytrauma Support Clinic Teams, and Polytrauma Points of Contact located throughout the nation.

Each patient responds differently to rehabilitation, because each polytrauma injury is unique. Some patients treated in the polytrauma programs are able to return to work or active duty, while others will continue to need VA's supportive services and care.



TBI IS AS SERIOUS AS ANY BATTLEFIELD INJURY

A TBI occurs when the head is exposed to a significant external force. This could happen when the head hits a windshield during a car accident. It could happen when a piece of shrapnel enters the brain. Or, it could happen when the body is exposed to the explosion of an IED.

When a TBI occurs, the initial severity of injury can range from mild (the person experiences a brief change in mental status or consciousness) to severe (the person has an extended period of unconsciousness or memory loss after the injury). Regardless of the initial severity, the effects of TBI and polytrauma can be significant and long lasting. Rehabilitation services delivered across the Polytrauma System of Care can help to improve the effects of TBI and polytrauma and begin the process of returning individuals back to full functioning.

Though it weighs barely three pounds, the brain has the enormous job of controlling our entire body. It regulates all of our physical movement and sensation, our ability to think, how we act and feel, and allows us to communicate.

KNOW THE SIGNS AND SYMPTOMS

Individuals who sustain a TBI may experience a variety of effects, most of which are visible just after the injury, but some that take days or weeks to fully appear. For most people, these will generally fade as time goes by.

- *Physical effects* may include fractures, weakness, difficulty eating, trouble speaking, limited vision, fatigue, a loss of hearing, and walking or balance difficulties.
- *Behavioral effects* may include irritability, low frustration tolerance, anxiety, depression, and inappropriate or disinhibited behaviors.
- *Cognitive effects* may include difficulties with attention and concentration, memory loss, thinking problems, and social skills deficits.

Whether a TBI is mild, moderate, or severe, persistent symptoms can have a profound impact on the injured survivor and those who serve as caregivers.

WHO SHOULD BE SCREENED?

VA offers TBI screenings to all Veterans who served in the combat theaters of Iraq or Afghanistan since September 11, 2001. The screenings help determine whether a Veteran should have a follow-up comprehensive evaluation to establish medical diagnoses and to initiate appropriate treatments as soon as possible.

For many reasons, it may be difficult for a Veteran to know when to seek care following an injury to the brain (e.g., confusion, amnesia for the events surrounding the injury). Generally, if someone you know who has been injured or isn't acting like themselves, a medical evaluation is advised.

If you believe that you may have a TBI or know someone who does, contact your local VA and ask for the polytrauma/TBI point of contact. Visit www.polytrauma.va.gov for a full listing of facilities and contacts in the Polytrauma System of Care.

Those at particular risk for a TBI are those who were involved in a:

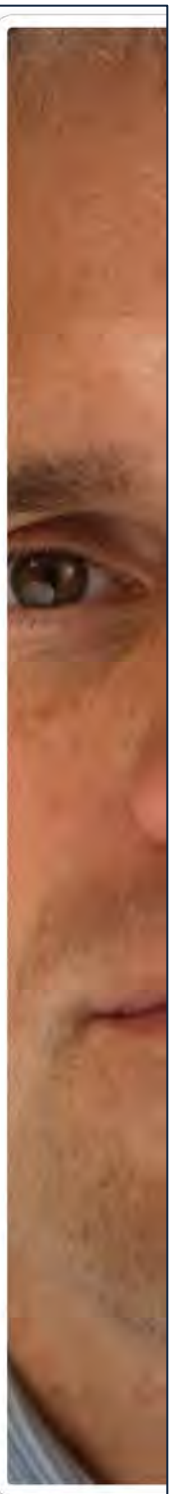
- Blast or explosion (e.g., IED, RPG, land mines, grenades)
- Vehicular accident/crash
- Fragment wound above the shoulder
- Fall

THE ROAD TO RECOVERY

Rehabilitation

Each TBI is unique and each person responds differently to rehabilitation. Some persons have lengthy stays in an inpatient program, while others receive their care through outpatient services. Some persons treated in the polytrauma programs are able to return to active duty, pursue school, or return to work, while others will continue to need supportive services and care for longer periods of time. VA's Polytrauma System of Care provides an integrated system of specialized rehabilitation programs, including:

- Brain Injury Rehabilitation
- Emerging Consciousness Program
- Blind and Low Vision Rehabilitation
- Amputation Rehabilitation
- Mental Health and Psychological Support
- Substance Abuse Services
- Driver Rehabilitation Program
- Assistive Technology Rehabilitation
- Pain Management
- Community Reintegration Services
- Vocational Rehabilitation
- Residential Transitional Rehabilitation Program




"The Polytrauma System of Care is individualized and tailored to meet each patient's needs. It's not a single pill, medication, or exercise. It's about learning who the patient is and helping them find a new normal for themselves and their loved ones."
– Dr. Shane McNamee
Chief, PM&R Services
McGuire VA Medical Center

FINDING A NEW NORMAL

How Best to Support those You Love

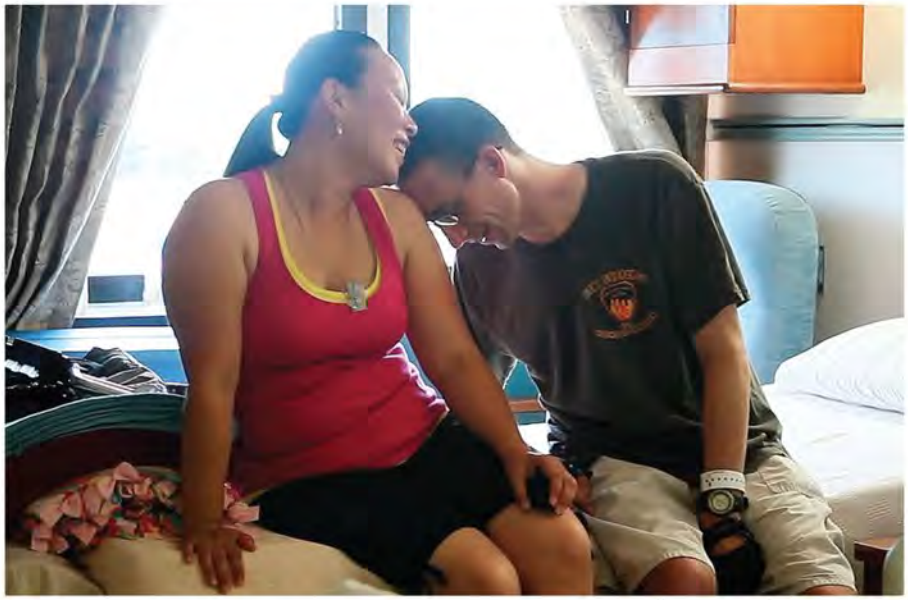
VA's Polytrauma System of Care strongly advocates family involvement throughout the rehabilitation process. VA strives to ensure that patients and their families receive all the necessary support services to enhance the rehabilitation process, while minimizing the inherent stress associated with recovery from polytrauma and TBI.

VA offers multiple levels of clinical and logistical support for patients and their families. VA assigns a dedicated case manager to each patient and family at a Polytrauma Rehabilitation Center. The ratio of case managers to patients at these centers is approximately 1:6, so that they can provide individualized, hands-on care for their patients.

FOR MORE INFORMATION

The Polytrauma System of Care Website provides extensive information and background on TBI, related benefits and services, and treatment facilities and rehabilitation programs. It also offers multimedia materials including videos and imagery, as well as links to key partners and resources.

LEARN MORE at www.polytrauma.va.gov



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Traumatic Brain Injury Screening:
An Introduction

August 2006

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For more information on this publication and other technical assistance, visit HRSA's MCHB Federal TBI Program at http://mchb.hrsa.gov/programs/traumaticbraininjury/index.html

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Traumatic Brain Injury Screening: An Introduction

Exactly what is traumatic brain injury?

A traumatic brain injury (TBI) is caused by either a blunt or penetrating impact to the head or the dramatic force of sudden deceleration. It is associated with any of the following symptoms or signs: decreased level of consciousness, amnesia, neurologic or neurospsychologic abnormalities, skull fracture, intracranial lesions, or death.[1]

The Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control estimates that *at least* 5.3 million children and adults in the United States have experienced a TBI significant enough to create long-term or lifelong need for help in performing daily activities.[2] Of the 1.4 million who sustain a TBI each year in the United States, 50,000 die; 235,000 are hospitalized with TBI and survive; and 1.1 million people are treated and released from hospital emergency departments.[3]

TBI screening—why is it important?

Given its high prevalence, identification of TBI is critical in delivering appropriate services and supports to those who need them. Screening is an effective method for identification of potential positives, which are those factors consistent with a probable history and/or etiology of TBI. But it is only a small, though helpful, first step in improving the lives of the literally millions of individuals who knowingly or unknowingly have TBI.

Each agency, provider, and organizational screener will use a positive screen differently depending upon his or her particular role within the State systems. However, no matter where each operates in the systems, the screener's major, ongoing effort is (and should be) concentrated on what's done as a result of the screen, i.e., how best to connect individuals with services and supports they need to go about their daily lives and for which they are eligible. For some, a positive screen will help establish a probable basis for neuropsychological testing which may ultimately lead to an official, medical diagnosis.

Screening instruments are extremely important because traumatic brain injuries are often overlooked or misdiagnosed frequently from a lack of awareness of brain injuries and the resulting consequences. Often, an individual with TBI seeking services from a State agency or community organization does not present with a TBI, but with a co-occurring disorder (such as a mental and/or behavioral health issue or substance use), an unknown

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[1] Thurman D, Sniezek J, Johnson D, Greenspan A, Smith S *Guidelines for Surveillance of Central Nervous System Injury*. Atlanta: Centers for Disease Control and Prevention, 1994.

[2] Thurman D, Alverson C, Dunn K, Guerrero J, Sniezek J. Traumatic brain injury in the United States: a public health perspective. Journal of Head Trauma Rehabilitation 1999; 14(6):602-15.

[3] Langlois JA, Rutland-Brown W, Thomas KE *Traumatic brain injury in the United States: emergency department visits, hospitalizations, and deaths*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2004.

cause, or an important need (such as assistance with school, employment, or housing).[4] Often the screening questions trigger an individual's or family member's memory of an incident (e.g., care crash, fall, or physical abuse) which could have caused a TBI, but was not recognized at the time of injury.

Screening for TBI among people accessing State and community services and supports helps enormously in defining the size of this population. It also aids in data collection. Whatever the use, screening is an important first step in coordinating appropriate resources and services for people who need them. While implementing TBI screening may require adjusting your State agency's or community organization's way of doing things, the benefits of this effort far outweigh the costs. A number of screening instruments may be used and/or adapted for a variety of settings. See pages 5 and 6 of this document for a *Table of Brain Injury Screening Instruments* that briefly describes a number of screening instruments that could be added to or adapted for existing applications or eligibility processes.

What kinds of screening instruments are used for TBI?

Screening instruments range from basic tools, which are extremely brief and general, to more lengthy and comprehensive tools. Either type may be targeted or focused to the type of services or supports being applied for or accessed. The type of personnel who may be conducting the screening ranges from entry-level intake workers to primary care practitioners, as well as individuals, family members, and caregivers.

Basic screening instruments are designed to be very concise in order to facilitate quick use. They can be adapted for different populations and/or support systems. See the table for the basic screening instruments used in Maryland, Michigan, and New Hampshire.

Targeted or focused screening instruments are developed by and used within single service delivery systems that readily encounter individuals with TBI. These include education, developmental disabilities, social services, mental health, substance abuse, and military. See the table for the targeted screening instruments used in Alabama, Alaska, Colorado and the Defense and Veterans Brain Injury Center.

Much longer, comprehensive screening instruments can have many different uses within multiple systems. Although they may contain general information, they are more thorough and far reaching than basic screening instruments. For example, a comprehensive screening instrument that includes information on TBI resources, pre-enrollment, and follow-up services may also be used by information and referral systems. Other comprehensive tools include clinical and functional assessments as well as waiver level-of-care determination instruments, but are outside the scope of this document.

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[4] For information on screening as a means to reduce "social failure" by those with "hidden" TBI see: Mt. Sinai Medical Center, New York TBI Model System. *TBI Research Review: Policy & Practice: Unidentified Traumatic Brain Injury*. 2006: No. 2. (available at: http://www.mssm.edu/tbicentral/resources/publications/tbi_research_review.shtml)

Regardless of type, most TBI screening instruments contain a few key questions that may indicate a probable TBI. For example:

1. Have you ever had an injury to your head or face?
2. Have you ever lost consciousness?
3. Has there been a change in your behavior?
4. Are you having difficulty concentrating, organizing your thoughts, or remembering?

What are the costs of implementing a TBI screening process?

Before adapting or creating a screening instrument, consider these over-riding costs:

- research and consultation;
- TBI education and interviewer training;
- question integration and translation;
- data processes; and
- referral and network building.

State agencies in both Maryland and Michigan have successfully adapted and utilized existing screening instruments.

In Michigan, the TBI Project Director wanted a screening instrument that would help social service and mental health intake workers identify individuals with potential traumatic brain injury. After considerable research, they opted to adapt the *HELPS TBI* screening instrument, originally developed by staff at the International Center for the Disabled. They felt it would be most useful to front-line staff, limited by time constraints. A nationally recognized expert in TBI—Wayne A. Gordon, PhD, of the Research and Training Center on Community Integration of Individuals with Traumatic Brain Injury—was consulted regarding modifications. Michigan's resulting, modified version of the *HELPS* instrument includes instructions for use specific to local resources.[5] Based on the responses they receive, agency screeners can offer information and resources useful to individuals and families in their specific areas.

Maryland adopted a TBI screening instrument developed by John Corrigan, PhD, and his colleagues at the Ohio Valley Center for Brain Injury Prevention and Rehabilitation. The Maryland TBI Project Director researched several screening instruments before deciding on Dr. Corrigan's. Dr. Corrigan consulted with Maryland on the adaptation and Sonia Quintero, formerly of the Brain Injury Association of America, translated the resulting *Brief TBI Screening* into Spanish. The six-item *Brief TBI Screening* has been used in Maryland's outreach and training activities in partnership with a public health center that provides a variety of medical and mental health services to low-income clients. It was also incorporated into Maryland's *TBI 101* presentation and provided to over 20 mental health and human services agencies in a two-county area.

[5] Michigan's modified *HELPS* instrument is included in module 3 of its online training site: *Traumatic Brain Injury & Public Services in Michigan* which is available at http://www.mitbitraining.org.

Maryland offers the following success story from a large provider of public mental health services regarding the great benefit of their *Brief TBI Screening* and *TBI 101* training. This provider is also using Maryland's screening instrument as a template to incorporate TBI screening into his own enrollment assessment forms:

> Thank you so much. I can tell you so much was learned through the trainings, and as an organization, we are able to look at the bigger picture with people. In our rehabilitation planning meetings, I hear staff from all departments questioning and talking about TBI histories. This in turn is helping us ask the right questions of providers and ultimately get people the help they need.
>
> One psychiatrist is really taking a look at someone who has been very verbally and physically aggressive, and questioning how significant the past TBIs are. This person, who is diagnosed as bipolar with psychotic features, has been non-responsive to typical anti-psychotic medications. Now this person is being referred for a neuropsychological evaluation.
>
> We were so close to having to ask this person to leave, but instead we have been able to find ways to support this individual when we have been unable to come into the home because of the increased aggression. We made use of the partial-hospitalization program, and set up times for her to meet staff in the afternoon in the club when others members have gone home. We have also gained some trust with her, and she is looking into advance directives, because she knows she does not want to go to the hospital by force anymore. She wants help before it gets that bad.
>
> So, I thank you again for everything, and please know what a difference you have made.

What are some tips for screening individuals with TBI?

There are important considerations when working with individuals with TBI.

- Interviewing individuals with TBI can be somewhat difficult due to cognitive challenges that can affect insight, memory, and ability to concentrate. Some individuals may be unable to accurately report information or details surrounding their injury. Individuals with TBI often experience fatigue which may affect their ability to sit through a lengthy questionnaire.

- It is best to use an approach that allows the interviewer flexibility in rewording the questions and permission to probe to obtain the most helpful information. Prompts in the form of examples may be useful. For example, Maryland created a *TBI Screening Tip Sheet* for interviewers with follow-up questions for each screening question.

Ideally, every State agency and community service screening for TBI will learn the number of individuals and families with TBI they have in the system and will be in a better position to provide appropriate, timely services and supports to a greater percentage of the people who need them.

# # #

Table of Brain Injury Screening Instruments

(From an electronic version of this document, place the cursor over a Web address until it changes to a "pointing hand" then click the link to open the file.)

STATE OR ORGANIZATION	TITLE	SERVICE SYSTEM	TARGET AUDIENCE	RESPONDENT	# OF QUESTIONS	INSTRUC-TIONS INCLUDED?	WEB ADDRESS
Alabama	*Brief Screening for Possible Brain Injury*	Rehabilitation Services	Domestic Violence	Adult Individual	10 with 11 follow-up questions	Yes	**PDF:** https://tbitac.norc.org/download/AL%20--%20Brief%20Screening%20for%20Possible%20BI.pdf
Alaska	*Screening Tool for Dual-Diagnosis and TBI*	Health & Social Services	Mental Health & Substance Abuse	Adult Individual	40	Yes	**DOC:** https://tbitac.norc.org/download/AK%20--%20Dual%20Diagnosis%20screening.doc **PDF:** https://tbitac.norc.org/download/AK%20--%20Dual%20Diagnosis%20screening.pdf
Associated Therapists	*Amen Brain System Checklist*	Mental Health	Mental Health	Adult Individual	114	Yes, minimal	**PDF:** https://tbitac.norc.org/download/amen_checklist.pdf
Colorado	*Preliminary Screening Tool for Identification of Acquired Brain Injury*	Education	School Aged Children	Parent or Guardian	40	Yes	**PDF:** https://tbitac.norc.org/download/CO-Prelim_Screening_Tool_and_Guidelines.pdf
Defense & Veterans Brain Injury Center (DVBIC)	*Post Deployment Injury Questionnaire*	Military Medical Center	Soldiers & Veterans	Adult Individual	22		**DOC:** https://tbitac.norc.org/download/Vets%20--%20Post%20Deployment%20Screening.doc **PDF:** https://tbitac.norc.org/download/Vets%20--%20Post%20Deployment%20Screening.pdf
Defense & Veterans Brain Injury Center (DVBIC)	*Brain Injury Guideline Reference Card*	Military Medical Center	Soldiers & Veterans	Adult Individual	41	Yes	**DOC:** https://tbitac.norc.org/download/Vets%20--%20BI%20Guideline%20Ref%20Card.doc **PDF:** https://tbitac.norc.org/download/Vets%20--%20BI%20Guideline%20Ref%20Card.pdf
Iowa	*Iowa Head Injury Screening Instrument*	Health	Mental Health & Substance Abuse	Adult Individual	14	Yes	**DOC:** https://tbitac.norc.org/download/IA_screeninginstrument.doc **PDF:** https://tbitac.norc.org/download/IA_screeninginstrument.pdf
Kansas	*Client, Assessment, Referral, and Evaluation Form; and Training Manual Excerpt*	Aging	Older Adults	Adult Individual or Caregiver	11 with multiple follow-up questions		**PDF:** https://tbitac.norc.org/download/KS_BI_Screening_Tool.pdf
Maryland	*Brief TBI Screening (Spanish version also available)*	Health & Mental Hygiene	Mental Health & Substance Abuse	Adult Individual	9		**DOC:** https://tbitac.norc.org/download/MD%20--%20TBI%20Screening-English.doc **PDF:** https://tbitac.norc.org/download/MD%20--%20TBI%20Screening-English.pdf

Table of Brain Injury Screening Instruments

(From an electronic version of this document, place the cursor over a Web address until it changes to a "pointing hand" then click the link to open the file.)

STATE OR ORGANIZATION	TITLE	SERVICE SYSTEM	TARGET AUDIENCE	RESPONDENT	# OF QUESTIONS	INSTRUC-TIONS INCLUDED?	WEB ADDRESS
Maryland	*TBI Screening Tip Sheet*	Health & Mental Hygiene	Mental Health & Substance Abuse	Adult Individual	7 with multiple follow-up questions		**DOC:** https://tbitac.norc.org/download/MD%20--%20Tip%20Sheet%20for%20TBI%20Screening.doc **PDF:** https://tbitac.norc.org/download/MD%20--%20Tip%20Sheet%20for%20TBI%20Screening.pdf
Michigan	*HELPS Brain Injury Screening Tool*	Community Health	Social Services & Mental Health	Adult Individual	7	Yes	**DOC:** https://tbitac.norc.org/download/MI%20--%20TBI%20Screening.doc **PDF:** https://tbitac.norc.org/download/MI_HELPS_BI_Screening_Tool_Instr.pdf
Minnesota	*Identification of Persons with a Traumatic Brain Injury*	Human Services	State Operated Services	Medical Staff	4		**PDF:** https://tbitac.norc.org/download/MN_TBI_Screen_and_Policy.pdf
Mount Sinai School of Medicine	*Brain Injury Screening Questionnaire (BISQ)*	Multiple	Various	Adult Individual or Parent	113		**WEB PAGE:** http://www.mssm.edu/tbicentral/resources/technical_screening.shtml
National Association of State Head Injury Administrators (NASHIA)	*Traumatic Brain Injury Facts: TBI & Older Adults*	Aging	Older Adults	Caregiver, Service Provider, Family Member	10		**PDF:** https://tbitac.norc.org/download/tbifactsheet--older%20adults.pdf
New Hampshire	*Screening for Traumatic Brain Injury*	Developmental Services	Mental Health	Adult Individual	9		**PDF:** https://tbitac.norc.org/download/NH-Screening_Tool.pdf
New Mexico	*Brain Injury Screening Form*	Community Services	Substance Abuse	Adult Individual	6 with 13 follow-up questions		**DOC:** https://tbitac.norc.org/download/NM%20--%20BI%20Screening%20+CD.doc **PDF:** https://tbitac.norc.org/download/NM%20--%20BI%20Screening%20CD.pdf
Ohio	*Columbus Public Schools Brain Injury Screen*	Education	School Aged Children	Parent or Guardian	22		**DOC:** https://tbitac.norc.org/download/columbuspubschoolscreen.doc **PDF:** https://tbitac.norc.org/download/columbuspubschoolscreen.pdf
Ohio Valley Center for Brain Injury Prevention & Rehabilitation	*TBI Screening*	Prevention & Rehabilitation	Community Professionals	Adult Individual	35		**PDF:** https://tbitac.norc.org/download/OH%20--%20TBIScreening.pdf
Texas	*Brain Injury Screening*	Health	Health Services	Adult Individual or Parent	80		**PDF:** https://tbitac.norc.org/download/TX%20--%20BI%20Screening.pdf
Virginia	*Domestic Violence & TBI Tip Card*	Rehabilitative Services	Domestic Violence	Adult Individual	8		**DOC:** https://tbitac.norc.org/download/vadvtipcard.doc **PDF:** https://tbitac.norc.org/download/vadvtipcard.pdf

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Appendix I: Examples of Psychopharmacology Practice Guidelines

Example 1: Practice Guidelines for Co-occurring Mental Health and Substance Use Disorders

Developed by Kenneth Minkoff, MD, with invaluable assistance from Terry Schwartz, MD, Jeff Rowe, MD, and other members of the Psychopharmacology Committee of the San Diego County CCISC Project. Based on the psychopharmacology guidelines in Minkoff (2001), Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders, Illinois Behavioral Health Recovery Management Project (www.bhrm.org).

Resources

- Psychopharmacology Practice Guidelines (www.bhrm.org)
- Geppert and Minkoff: The Place of Medications in Recovery from Addiction (Hazelden)
- Foundation Associates modules on taking medication
- Psychopharmacology Bibliography (see page 388)

Background

Individuals with co-occurring psychiatric and substance disorders represent a challenging population associated with poorer outcomes and higher costs in multiple domains. In addition, the prevalence of comorbidity is sufficiently high that we can say that comorbidity is an expectation, not an exception throughout the system of care. Consequently, individuals with co-occurring issues cannot be adequately served with only a few specialized programs; rather, the expectation of comorbidity must be addressed throughout the system of care.

The Comprehensive Continuous Integrated System of Care (CCISC) (Minkoff & Cline, 2004) is a model for system design that permits any system to address this problem in an organized manner within the context of existing resources. The basic premise of this

model is that all programs become co-occurring programs meeting minimal standards of co-occurring capability, and all clinicians (including psychopharmacology prescribers) become co-occurring clinicians meeting minimal standards of co-occurring competency, but each program and each clinician has a different job.

The job of each program is based first on what it is already designed to do, and the people with co-occurring issues who are already being seen. The goal is to organize the program infrastructure to routinely provide matched services to those individuals within the context of the program design, which in turn defines specific clinical practices for clinicians working within that setting that define their competency requirements. The service-matching in this model is based on a set of evidence-based principles in the context of an integrated philosophic model that makes sense from the perspective of mental health and addiction treatment. These principles in turn have been used to develop practice guidelines that define the process of assessment and treatment-matching at the clinical level, and outline the "job" of each program in the system as well.

The comprehensive CCISC practice guidelines were initially developed by Kenneth Minkoff, MD, in 2001, based on work of a consensus panel that led to a SAMHSA report in 1998 entitled "Individuals with Co-occurring Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula" (Minkoff, 1998). The 2001 updated version of the practice guideline section of the report is being used by the Behavioral Health Recovery Management Project in the Illinois, and is available online at *www.bhrm.org*. The current document is an update of the psychopharmacology section of that document. The need for this document is based on the recognition that although there are psychopharmacology guidelines that have been developed for the treatment of individuals with a variety of mental illnesses or substance disorders, most practitioners have neither training or experience in an organized approach to individuals who have various combinations of mental health and substance conditions who commonly present in clinical practice, particularly in public sector settings.

General Principles

The seven general principles of CCISC are designed to provide a welcoming, accessible, integrated, continuous, and comprehensive system of care to people with co-occurring issues. These principles and their psychopharmacology application are listed below.

Principle 1. Co-occurring is an expectation, not an exception.

All psychiatrists need to develop comfort with the likelihood that any person requiring psychopharmacologic evaluation may also have a substance use disorder, and be able

to incorporate this expectation into every clinical contact, beginning with assessment and continuing throughout the treatment process. Consequently, it is necessary to have an organized evidence-based approach to assessment and treatment of individuals who present with co-occurring conditions of any type. In addition, given the expected complexity of many people with co-occurring issues, it is helpful to routinely organize access to **peer consultation** (defined below) as a valuable way for prescribers to obtain help and guidance when treating people with unusual or complicated clinical situations.

Principle 2. Successful treatment is based on empathic, hopeful, integrated and continuing relationships.

Successful psychopharmacology is not an absolute science governed by the application of rigid rules. Rather, it is best performed in the context of an empathic, hopeful relationship, which integrates ongoing attention to both psychiatric and substance use disorders. Emphasis needs to be placed on an initial integrated (both mental health and substance use) evaluation and continuous re-evaluation of diagnoses and treatment response.

Practitioners of psychopharmacology in mental health settings should not underestimate the importance of ongoing inquiry regarding co-occurring substance use, continued encouragement of healthy decision-making regarding substance use, and support to other caregivers who are engaged with the person and his or her family in addressing these issues.

Principle 3. Treatment must be individualized utilizing a structured approach to determine the best treatment. The national consensus "four quadrant" model for categorizing individuals with co-occurring disorders can be a first step to organizing treatment-matching.

Both High Severity	MI Low Severity SUD High Severity
MI High Severity SUD Low Severity	Both Low Severity

This model divides individuals throughout a service system into four quadrants based on high and low severity of each disorder. Psychopharmacologic strategies may need to be adjusted based on type and level of severity of each illness in COD. In particular, individuals with high-severity mental illness are more likely to be considered high-priority mental health clients with Serious and Persistent Mental Illness (SPMI) and associated disability who are a high priority for continuing engagement in

psychopharmacologic treatment in the mental health system. Individuals with high-severity substance use disorders generally are those with active substance dependence (addiction), as opposed to those with lower severity disorders, such as substance abuse. Pharmacologic strategies for either mental illness or substance use disorder may vary, depending on the severity of the mental illness and the diagnosis of dependence versus abuse (see below).

Principle 4. Case management and clinical care (in which we provide for individuals that which they cannot provide for themselves) must be properly balanced with empathic detachment, opportunities for empowerment and choice, contracting, and contingent learning.

As most individuals cannot legally prescribe their own medication, the ability to receive medication for the treatment of co-occurring disorders is a vital aspect of the integrated treatment relationship. Given that treatment involves learning, the psychopharmacologic treatment relationship needs to balance ongoing necessary continuity of care (see below) with opportunities for **contingent learning** (negotiation of type, quantity, and duration of treatment with any medication) without threat of loss of the treatment relationship. This contingent learning may require a "trial-and-error" process and several attempts before successful. Contingency plans are most effective in the context of a good therapeutic alliance.

Principle 5. When mental illness and substance use disorder co-exist, each disorder is "primary", requiring integrated, properly matched, diagnosis-specific treatment of adequate intensity.

Thus, in general, psychopharmacologic interventions are designed to maximize outcome of two primary disorders, as follows:

- **For diagnosed psychiatric illness**, the individual receives the most clinically effective psychopharmacologic strategy available, regardless of the status of the comorbid substance disorder. (Note: Special considerations apply for utilization of addictive or potentially addictive medications that may have psychiatric indications, such as benzodiazepines and stimulants. See below.)
- **For diagnosed substance disorder**, appropriate psychopharmacologic strategies (e.g., disulfiram, naltrexone, acamprosate, opiate maintenance) are used as ancillary treatments to support a comprehensive program of recovery, regardless of the status of the comorbid psychiatric disorder (although taking into account the individual's cognitive capacity and disability).

Within the application of the above rules, there is some evidence for improvement in certain addictive disorders reported with several medications that also have common psychiatric indications (e.g., SSRIs, buproprion, topiramate). Although there is little evidence to support selecting one medication for any combination as a "magic bullet," the prescriber may want to consider the possible impact on a co-occurring substance use disorder when choosing medication for a psychiatric disorder.

Principle 6. Both serious mental illness and substance dependence are primary biopsychosocial disorders that can be treated in the context of a "disease-and-recovery" model. Treatment must be matched to the (non-linear) phase of recovery (acute stabilization, engagement/motivational enhancement, active treatment/prolonged stabilization, rehabilitation/recovery) and stage of change or stage of treatment for each disorder.

Psychopharmacologic practice may vary depending on whether the individual is requiring acute stabilization (e.g., detoxification) versus relapse prevention or rehabilitation. In addition, within the psychopharmacologic relationship, individuals may be engaged in active treatment or prolonged stabilization of one disorder (usually mental illness), which may provide an opportunity for the prescriber to participate in provision of motivational strategies regarding other comorbid conditions.

Principle 7. There is no one correct approach (including psychopharmacologic approach) to individuals with co-occurring disorders. For each individual, clinical intervention must be matched according to the need for engagement in an integrated relationship, level of impairment or severity, specific diagnoses, phase of recovery and stage of change.

This principle provides the framework for practice guidelines and treatment-matching generally, including the application of the practice guidelines to psychopharmacologic practice.

Clinical Practice Guidelines

The following clinical practice guidelines were developed using the principles of CCISC. These guidelines include both illustrations of practices, as well as a sequence for prioritization of clinical activities.

Welcoming

All psychopharmacologic practitioners should strive to welcome individuals with co-occurring issues into treatment as a-high risk, high-priority population, and to engage them in empathic, hopeful, integrated and continuing treatment relationships in which outcomes of psychopharmacologic intervention can be optimally successful.

Access

Because of the importance of engaging individuals in treatment as quickly as possible, and because (as will be noted below) initial diagnostic evaluation is based significantly upon historical data, **there should be no arbitrary length of sobriety requirement for access to comorbid psychiatric evaluation. Initial evaluations should only require that the person be able to carry on a reasonable conversation, and not require that alcohol or drug levels be below any arbitrary figure**. Referral for psychopharmacologic evaluation should occur as quickly as possible (based on triage of acuity and dangerous risk factors). Maintaining existing non-addictive psychotropic medication during detoxification and early recovery is strongly recommended as substance abuse increases the risk of destabilization of the mental illness.

Safety

The first priority in the evaluation process is to maintain safety, both for the person and the treatment staff. Psychopharmacologic intervention can be vital in this effort. In situations involving acutely dangerous behavior, it may be necessary to utilize antipsychotics and other sedatives (including benzodiazepines) to establish behavioral control. In acute withdrawal situations requiring medical detoxification, use of detoxification medications for addicted people with psychiatric issues is no different than for people with addiction only.

Integrated Assessment (ILSA™)

Assessment and diagnosis of individuals with CODs is based on a process of **integrated longitudinal strength-based assessment (ILSA™)**. (See Center for Substance Abuse Treatment, Treatment Improvement Protocol #42, 2005.). This begins as soon as the person is welcomed into care, immediate safety established, and the capacity to obtain a history (from person or collaterals) is present. This process incorporates a careful chronological description of both issues; including emphasis on onset, interactions, effects of treatment, and contributions to stability and relapse of either disorder. As with all psychiatric disorders, obtaining information from family members and collateral caregivers can be extremely helpful. Particular attention to assessing previous

periods of sobriety or limited use for presence of psychiatric symptoms, and history of medication responses with or without sobriety can be useful.

Diagnosis of persistent psychiatric disorders in people with co-occurring issues can be difficult given the overlap of symptoms with substance use disorders. Information about the presence of symptoms and need for continued psychiatric treatment either prior to onset of substance use disorder, or during periods of abstinence or low substance use of 30 days or longer can be vital in making a meaningful psychiatric diagnosis. These periods of time can occur at any time in the person's history *after the onset of illness*, and do not have to be current.

Diagnostic and treatment decisions regarding psychiatric illness are ideally made when the comorbid substance disorder is stabilized, ideally for 30 days or longer. Nonetheless, thorough assessment (as described above) can provide reliable indications for diagnosis and immediate initiation or continuation of psychopharmacologic treatment, even for individuals who are actively using. This is particularly true for individuals with more serious and persistent mental illness and more severe symptomatology, regardless of diagnosis.

Diagnostic and treatment decisions regarding substance disorder are best made when the comorbid psychiatric disorder is at baseline. Nonetheless, thorough assessment can provide reliable information about the course and severity of substance disorder, even for an individual whose mental illness is destabilized, and can provide reliable indications for diagnosis and immediate initiation or continuation of psychopharmacologic treatment (e.g., opiate maintenance).

Finally, integrated assessment during periods of stabilization may also provide evidence that justify rescinding a previously-made diagnosis, and carefully discontinuing medication that may seem to have no further indication, either because the condition for which treatment was initiated has completely resolved (e.g., substance-induced psychosis), or because further evaluation indicates that justification for the diagnosis no longer exists.

Continuity

Provision of necessary non-addictive medication for treatment of psychotic illness and other known serious mental illness must be initiated or maintained regardless of continuing substance use. Individuals whose substance use appears to be significantly risky warrant closer monitoring or supervision, not treatment discontinuation. Peer consultation is indicated when the treating psychiatrist is considering medication discontinuation due to ongoing substance use for an individual with known or probable serious and persistent mental illness, including persistent substance induced issues.

In people with active substance dependence or substance-dependent people in early recovery, non-addictive medication for any psychiatric issues may be initiated or maintained, provided reasonable historical evidence for the value/need for the medication is present.

Over time, within the context of a continuing psychopharmacologic relationship, continuing re-evaluation of diagnosis and psychopharmacologic regimes is recommended, both to insure appropriate continuity of stabilizing medication for established issues, as well as to insure discontinuation of medication for issues that have resolved, discontinuation of medication that is not effective, and cautious discontinuation of treatment for issues whose diagnosis appears to be no longer supported (while maintaining awareness that there is always a risk of recurrence in discontinuing medication, even for asymptomatic individuals).

Consultation for Prescribers

It is highly recommended that every system establish a mechanism for expert and/or peer consultation to assist both psychopharmacology prescribers and other members of the treatment team in making decisions regarding challenging people. Consultation provides a framework for obtaining clinical support, as well as for reviewing clinical decision-making from a risk-management standpoint. Furthermore, work with people who have CODs can be both frustrating and very rewarding, and the peer consultation process can be a vehicle for both recognizing special effort by clinicians, as well as to support the clinical team when dealing with particularly challenging cases. Examples of appropriate cases for expert or peer consultation include (but are not limited to):

* Continuation of treatment with benzodiazepines (beyond detoxification) in people with known substance dependence.
* Discontinuation of psychiatric medications for a substance-using person with a serious, persistent psychiatric illness.
* Unilateral termination of clinical care for any person with co-occurring disorder.

Psychopharmacological Treatment Strategies

General Principles

In people with psychotic presentations, with or without active substance dependence, initiation of treatment for psychosis is generally urgent.

In people with known active substance dependence and non-psychotic presentations, it is recommended to utilize the integrated longitudinal assessment process to determine probability of a treatable mental health diagnosis before medication is initiated. It can

be very difficult to make an accurate diagnosis and effectively monitor treatment without this first step. It is understood that all diagnoses are "presumptive" and subject to change as new information becomes available. If there is uncertainty about diagnosis after reasonable history-taking, evidence for initial efforts to discontinue substance use may need to occur prior to initiation of psychopharmacology, in order to establish a framework for further diagnostic evaluation. **However, for high-risk people, with or without psychosis, developing a treatment relationship is a priority, and there should not be an arbitrary length of time required before treatment initiation takes place, nor should absolute diagnostic certainty be required. Individuals with reasonable probability of a treatable disorder can be treated.**

Psychotropic medications, particularly for anxiety and mood issues, should be clearly directed to the treatment of known or probable psychiatric issues, not to medicate feelings. It is important to communicate to people with addiction that successful treatment of a comorbid anxiety or mood disorder with medication is not intended to remove normal painful feelings (such as normal anxiety or depressed feelings). The medication is meant to help the person feel his or her painful feelings accurately, and to facilitate the process of developing healthy capacities to cope with those feelings without using substances. If psychotropic medications are used for mental illness in individuals with addiction, or if medication is used in the treatment of the addiction itself, the following precepts may be helpful to communicate to the person:

> "The use of medication for either type of disorder does not imply that it is no longer necessary for the person to focus on the importance of his/her own work in recovery from addiction. Consequently, utilizing medication to help treat addiction should always be considered as an ancillary tool to a full addiction recovery program."

Addicts in early recovery have great difficulty regulating medication; fixed-dose regimes, not PRN's, are recommended in the treatment of mood and anxiety issues.

Just as in individuals with single issues—and perhaps more so—it is important to engage people with co-occurring issues as much as possible in understanding the nature of the illness or illnesses for which they are being treated, and participating in partnership with prescribers in determining the best course of treatment. For this reason, most established medication algorithms (e.g., TMAP) and practice guidelines recommend that medication education and peer support regarding understanding the risks and benefits of medication use be incorporated into standard treatment practice. This is certainly true for individuals with co-occurring issues, for whom information provided by peers may be particularly helpful in making good choices and decisions regarding both taking medication and reduction or elimination of substance use.

Diagnosis-specific Psychopharmacological Treatment for Mental Illness

- Psychotic Disorders

  Use the best psychotropic agent available for the condition. Improving psychotic or negative symptoms may promote substance recovery. This includes treatment of substance-induced psychoses, as well as psychosis associated with conventional psychiatric issues.

  * **Atypical neuroleptics**: Consider olanzapine, risperidone, quetiapine, aripiprazole, ziprasidone or clozapine. In addition, it is well-documented that clozapine has a direct effect on reducing substance use in this population, beyond any improvement in psychotic symptoms, and therefore may be specifically indicated for selected people.
  * **Typical neuroleptics**: Consider use in adjunct to the atypicals, especially in situations of acute agitation, unresolved psychosis, and acute decompensation.
  * Many individuals with co-occurring issues will benefit from depot antipsychotic medications. Both typical and atypical neuroleptics (e.g., risperidone) are available in depot form. There have not been specific studies about the use of depot risperidone in individuals with co-occurring substance use disorder, but there is no apparent contraindication to its use.

- Major Depression

  The relative safety profile of SSRIs (and to a somewhat lesser extent SNRIs such as venlafaxine), other newer-generation antidepressants and possibly buproprion (though higher-seizure risk must be considered) make their use reasonable (risk-benefit assessment) in the treatment of individuals with co-occurring disorders. SSRIs have been demonstrated to be associated with lower alcohol use in a subset of alcohol-dependent people, with or without depression. The use of tricyclic antidepressants (TCAs) and MAO inhibitors (MAOIs) can be more difficult and possibly more dangerous in the COD population if there is a risk of active substance use.

- Bipolar Disorder

  Use the best mood stabilizer or combination of mood stabilizers that match the needs of the person. Be aware that rapid cycling and mixed states may be more common, hence consider valproate, oxycarbamazepine, carbamazepine or olanzapine (and other atypicals) in people who may have these variants.

- ADHD

  Initial treatment recommendations, in early sobriety, have included buproprion. Recently, atomoxetine has been available, and may be a reasonable first choice, though there have not been specific studies in co-occurring populations. In both adolescents and adults, there is clear evidence that if stimulant medications are necessary to stabilize ADHD, then these medications can be used safely once addiction is adequately stabilized and/or the person is properly monitored, and will be associated with better outcomes for both ADHD and substance use disorder.

- Anxiety Disorders

  Consider SSRIs, venlafaxine, buspirone, clonidine and possibly mood stabilizers such as valproate, carbamazepine, oxycarbamazepine, gabapentin, and topiramate, as well as atypical neuroleptics. There is evidence of effectiveness of topiramate for nightmares and flashbacks associated with PTSD.

For people with known substance dependence (active or remitted), the continuation of prescriptions for benzodiazepines, addictive pain medications, or non- specific sedative/hypnotics is not recommended, with or without comorbid psychiatric disorder. On the other hand, medications with addiction potential should not be withheld for carefully selected people with well-established abstinence who demonstrate specific beneficial responses to them without signs of misuse, merely because of a history of addiction. However, consideration of continuing prescription of potentially addictive medications for consumers with diagnosed substance dependence is an indication for both careful discussion of risks and benefits with the person (and, where indicated, the family) and documentation of expert consultation or peer review.

Sleep disturbances are common in mental illness as well as substance use issues in early recovery. Use of non-addictive sedating medications (e.g., trazodone) may be used with a careful risk-benefit assessment.

Psychopharmacologic Strategies in the Treatment of Substance Use Disorders

There is an increasing repertoire of medications available to treat substance use disorders, including medications that appear to directly interrupt the core brain processes associated with lack of control of use. All of these medications have demonstrated effectiveness in populations who may also have psychiatric disorders, including severe mental illnesses.

- Disulfiram
  - Disulfiram interferes with the metabolism of alcohol via alcohol dehydrogenase, so that individuals who use alcohol will get ill to varying degrees when taking this medication. This can be a valuable tool in assisting individuals to resist impulsive drinking, but generally must be combined with additional recovery programming and/or positive contingencies. Disulfiram should not be used to coerce sobriety in any person.
  - As a dopamine beta-hydroxylase inhibitor, Disulfiram occasionally will exacerbate psychosis, necessitating adjustment of antipsychotic medication.
  - As a dopamine beta-hydroxylase inhibitor, Disulfiram has also been found to reduce cocaine craving and cocaine usage in some studies.
- Opiate Maintenance Treatment
  - Methadone and LAAM are well-established treatments for opiate dependence, and have been found to be successful in individuals with a wide range of psychiatric comorbidity, in the context of methadone treatment programs. Methadone dosing is now informed by the capacity to measure trough levels. The prescriber must be aware that there are enzymatic interactions that affect the interaction of methadone with various psychotropics, the details of which are beyond the scope of these guidelines, but which should be reviewed when such combinations are being initiated.
  - Buprenorphine has been more recently introduced for opiate maintenance, does not require participation in a formal "program," like methadone, and can be provided in office-based settings by physicians who have addiction specialization and/or who have had an eight-hour training. Oral buprenorphine is provided combined with naloxone to prevent diversion for parenteral use. It is a mixed μ-opiate receptor agonist and a k-receptor antagonist that appears to be easier to utilize, with fewer side effects, and less severe abuse or withdrawal risk, than methadone. Although not well-studied in the co-occurring disordered population, all indications in the literature indicate that it is effective. Again, there are a range of interactions that may occur with enzymes that metabolize psychotropic medication that need to be reviewed when initiating treatment.
  - Naltrexone
    - **Opiate dependence**: Naltrexone is a relatively long-acting opiate blocker that can be effective given three times weekly for opiate dependence, particularly when combined with significant contingencies to support adherence.

  - **Alcohol dependence**: Naltrexone has been demonstrated to be effective in reducing alcohol use through reducing craving and loss of control, presumably by affecting endogenous opiate pathways that are involved in the development of the brain disorder of alcohol dependence. Naltrexone has been demonstrated to be effective in individuals with schizophrenia and other mental illnesses in preliminary studies.

* Acamprosate has been available in Europe for several years and has recently been approved in the US. It reduces alcohol usage through an impact on endogenous GABA pathways. The combination of acamprosate plus naltrexone is reportedly more effective than either alone.
* Bupropion for nicotine dependence appears to have an effect on reward pathways associated with nicotine use. Nicotine replacement for nicotine dependence includes nicotine patch, gum, and nasal spray, which most closely mimics the effects of smoking in nicotine delivery. Bupropion and nicotine replacement combined tend to result in better outcomes than either alone.
* Topiramate for alcohol dependence (one study) has some potential value through its effect on GABA receptors.
* Desipramine for cocaine craving has yielded very inconsistent findings.
* Dopaminergic agents for cocaine craving have also yielded inconsistent findings, with risk of exacerbation of psychosis.
* Serotoninergic agents (e.g., SSRIs) have been found in some studies to have a beneficial effect in reducing alcohol use in non-depressed alcoholics, particularly in certain subtypes of alcohol dependence.

General Strategies for Managing Interactive Effects of Substance Use on Psychiatric Symptoms and Interventions

The effects of substances on psychiatric presentations and on psychiatric treatment are quite variable. Discussion of the effects of each type of substance on psychiatric symptoms and medications is included in most textbooks, and is beyond the scope of these guidelines. The prescriber should keep in mind that the best way to evaluate the effect of a pattern of substance use on a particular person is to get a good history from that person and collaterals. Although there are unquestionably unpredictable risks that may be attached to continuing substance use in individuals receiving psychiatric care, the risks of poor outcome associated with not treating a known mental illness appear to significantly outweigh the risks of continuing treatment in a person who is continuing

to use substances. Individuals who engage in risky behavior should be monitored more closely, not discontinued from necessary psychiatric or medical treatment.

Special Stage-specific Strategies

- Motivational Interventions

  In clinical situations where the psychiatric diagnosis and/or severity of substance disorder are unclear, psychotropic medications may be initiated if there is a reasonable indication, and used as part of a strategy to facilitate engagement in treatment and the creation of contingency contracts to promote abstinence.

- Contingency Management Interventions

  Within the context of a psychopharmacologic relationship where necessary medication is provided, interventions that may be considered optional or discretionary can be linked to incremental progress in addressing substance use issues. In addition, in individuals receiving benzodiazepines, emergence of substance use can be addressed by creating contingency plans that allow the individual to maintain benzodiazepine dosage only if abstinence is maintained. Slow reduction of dosage can offer multiple opportunities for the person to regain the original dosage by re-establishing abstinence. Evidence of severe overuse or overdosage with benzodiazepines, however, is usually an indication for discontinuation, often in a hospital setting.

- Continuing Evaluation and Re-evaluation

  It is important not to expect that diagnostic certainty can be obtained at the beginning of treatment. Individuals may begin on medication for a presumed diagnosis during periods of substance use, and once they have stopped using, the presumed diagnosis may appear to clear up, necessitating the discontinuation of medication. Conversely, once individuals stop using, psychiatric issues may emerge or worsen, requiring the initiation of medication. It is important to maintain an open-minded stance and to consider all possibilities. Each person must be considered as an individual, and continuity of care provides an opportunity to become increasingly more accurate about diagnosis and treatment over time.

Example 2: Guidelines for the Use of Psychotropic Medications for Individuals with Developmental Disabilities and Mental Health Conditions

The following items are a synopsis of materials presented by Reiss, S., & Aman, M. (1998). *Psychotropic medication and developmental disabilities: The international consensus handbook*. Columbus, OH: The Ohio State University Nisonger Center.

Reiss, et al., Recommend the Following Guidelines as "Do's"

- Consider any substance prescribed to improve or stabilize mood, mental status, or behavior as a psychotropic medication.
- Use psychotropic medication within a coordinated multidisciplinary care plan.
- Use psychotropic medication based on a psychiatric diagnosis or a specific behavioral-pharmacologic hypothesis and only after conducting complete diagnostic and functional assessments.
- Obtain written informed consent from the individual or guardian and establish a therapeutic alliance involving all decision-makers.
- Track treatment efficacy by defining objective index behaviors and quality of life outcomes and measure them using empirical methods.
- Monitor for side effects using standardized assessment instruments.
- Monitor for tardive dyskinesia using standardized assessment instruments if antipsychotic or other dopamine-blocking medications are prescribed.
- Conduct clinical and data reviews on a regular and systematic basis.
- Strive to use the lowest optimal effective dose.
- Evaluate drug and monitoring practices through a peer or team quality review or improvement group.

Reiss, et al., Recommend the Following Guidelines as "Don'ts"

- Don't use psychotropic drugs excessively, for convenience, as a substitute for meaningful psychosocial services, or in quantities that interfere with quality of life activity.

- Avoid frequent drug and dose changes.
- Avoid intraclass polypharmacy and minimize interclass polypharmacy to the degree possible in order to decrease the likelihood of patient noncompliance and side effects.
- Minimize to the degree possible:
    - Long-term PRN orders.
    - Use of long-acting sedative-hypnotics (e.g., chloral hydrate).
    - Long-term use of short-acting sedative-hypnotics (e.g., temazepam).
    - Long-term use of benzodiazepine antianxiety medications (e.g., diazepam).
    - High antipsychotic medication doses.
    - Long-term use of anticholinergic medication (e.g., benztropine).

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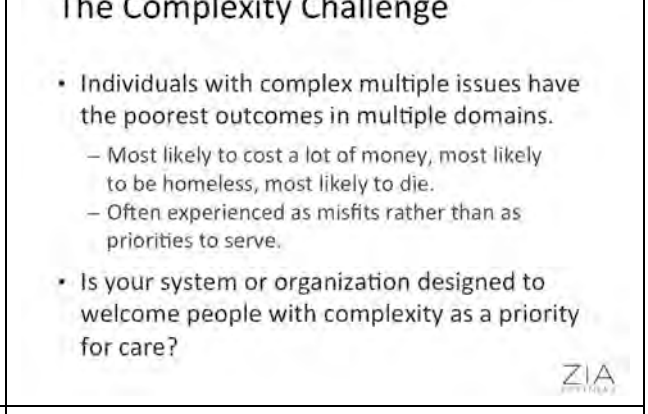
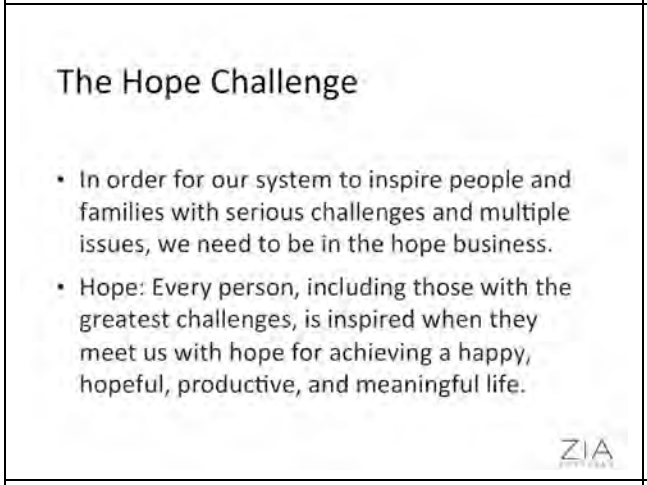
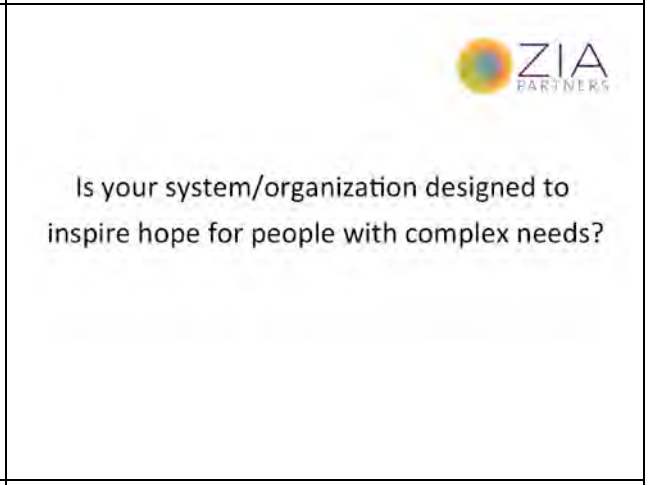
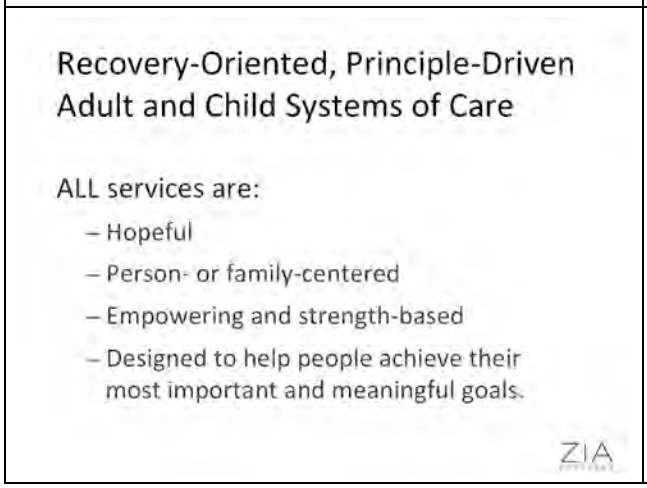
Appendix J: Core Slides









What is a System?

Sets of nesting Russian dolls
that are not quite so nesting:

Systems
within systems
sitting next to other systems
within systems.

ZIA

Transformation

- Involves EVERY system, subsystem, and sub-sub-system in a common process to achieve a common vision, with EVERY dollar spent and EVERY policy, procedure and practice.
- In a provider agency, that means the agency as a whole, every program in the agency, and every person delivering care is working toward a common vision.

ZIA

Comprehensive, Continuous Integrated System of Care

CCISC

- All programs in the system become welcoming, recovery-oriented, trauma-informed, and complexity-capable or multi-occurring capable.
- All persons delivering care become welcoming, recovery-oriented, trauma-informed, and complexity-capable.
- 12-Step Program of Recovery for Systems

ZIA

Recovery-Oriented Complexity Capability

Each program organizes itself,
within its mission and resources,
to deliver integrated, matched,
hopeful, strength-based
best practice interventions for multiple issues
to individuals and families with complex needs
who are coming to the door.

ZIA

Recovery-Oriented Complexity Capability

- CCISC Program Self-Assessment Tools: COMPASS-EZ™, COMPASS-ID™, COMPASS-PH™, COMPASS-PH/BH 50™, COMPASS-Prevention™
- 12 Steps for Programs Developing Multi-occurring or Complexity Capability

ZIA

Recovery-Oriented Complexity Competency

Each person providing clinical care is helped to develop core competency, within their job and level of training, licensure or certification, to become an inspiring and helpful partner with the people and families with complex needs that are likely to already be in their caseloads.

ZIA

Recovery-Oriented Complexity Competency

- CCISC Clinician Self-Assessment Tool: CODECAT-EZ™
- 12 Steps for Staff Developing Multi-occurring or Complexity Competency

ZIA

ZIA PARTNERS

Is this your vision?

How do we get there clinically?

Research-based recovery-oriented principles of successful intervention that can be applied to any population in any program by any person delivering care.

ZIA

As a system or organization, how do we get there?

Quality Improvement

- Recovery process for systems
- Horizontal and vertical quality improvement partnership
- Empowered Change Agents
- Anchoring value-driven change into the "bureaucracy"
- Serenity Prayer of System Change

ZIA

Vision-Driven Quality Improvement Challenge

- How well is your system, agency or program organized to empower staff as partners in vision-driven quality improvement?
- How well are you organized to build inspiration:
  - In the face of complex challenges in your program?
  - To provide services that effectively and efficiently match the complex challenges of your clients?

ZIA

ZIA PARTNERS

Principles Made Simple

Principle #1

Complexity is an expectation.

- Welcome people with complexity as priority customers.
- Remove access barriers that make it hard to be welcomed.
- See all the complex issues: integrated screening and documentation.

ZIA

Principle #2

Recovery partnerships are empathic, hopeful, integrated, and strength-based.

- Hopeful goals for a happy life.
- Work with all your issues step by step over time to achieve success.
- Build on strengths used during periods of success.

ZIA

Principle #3

All people with complex issues are not the same.

- Different programs have different jobs.
- All programs partner to help each other with their jobs, and their populations
- 4-Quadrant model (HI/HI, HI/LO, LO/HI, LO/LO) for MH/SA, MH-SA/PH or MH-SA/DD may help with service mapping and matching.

ZIA

Principle #4

For people with complexity, all multi-occurring conditions are primary.

Integrated multiple primary condition-specific best practice interventions are needed.

ZIA

Principle #5

Parallel process of recovery for multiple conditions

- Recovery of the *person* with one or more conditions.
- Recovery involves:
  - Addressing each condition over time.
  - Moving through stages of change for *each* condition.
- Integrated services involve stage-matched interventions for *each* condition.

ZIA

Principle #5 (continued)

Stages of Change

Issue-specific, not person-specific.

- **Pre-contemplation:** You may think this is an issue, but I don't—and even if I do, I don't want to deal with it, so don't bug me.
- **Contemplation:** I'm willing to think with you and consider if I want to change, but have no interest in changing, at least not now.

ZIA

Principle #5 (continued)

Stages of Change

- **Preparation:** I'm ready to start changing but I haven't started, and I need some help to know how to begin.
- **Early Action:** I've begun to make some changes, and need some help to continue, but I'm not committed to maintenance or to following all your recommendations.

ZIA

Principle #5 (continued)

Stages of Change

- **Late Action:** I'm working toward maintenance, but I haven't gotten there, and I need some help to get there.
- **Maintenance:** I'm stable and trying to stay that way as life continues to throw challenges in my path.

ZIA

Principle #6

Adequately supported, adequately rewarded, skill-based learning for each condition.

- Small steps of practical learning
- Self-management skills and "asking for help" skills
- Rounds of applause for each small step of progress

ZIA

Principle #7

There is no one correct intervention or program.

In CCISC,
every program, policy, practice, etc.,
is organized to match interventions
based on the principles.

ZIA

Principles Made Simple

Summary

- Welcoming, empathic, hopeful, continuous, integrated recovery partnerships
  - Addressing multiple primary issues
  - Providing adequately supported, adequately rewarded, strength-based, skill-based, stage-matched, community-based learning for each issue
  - Moving toward the goal of a happy, meaningful life

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Step 1

- Welcome all staff into an empowered partnership.
- Define a vision for all programs and all staff.
- Define the vision as related to core values:
  - Welcoming, hope and recovery
  - Matching services to the needs and dreams of the people and families with complexity.

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Steps 2, 3, 4

- **Step 2:** Define your CQI "Recovery Team" for the agency.
- **Step 3:** Identify Change Agents from each program to represent the voice of front-line staff and consumers.
- **Step 4:** Engage all staff as partners in improving their own competency.

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Step 5

- Perform a system/agency/program baseline self-assessment.
  - Engage staff in a "democratic" conversation.
  - Evaluate program policy, procedure, practice (not people).
  - Use a structured tool to guide the conversation.
  - Rounds of applause for finding improvement opportunities.

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Step 5 Tools

- **COMPASS-EZ™** for MH/SA in BH programs
- **COMPASS-PH/BH 50™** for primary health in BH programs
- **COMPASS-PH™** for BH in primary health programs
- **COMPASS-ID™** for BH in intellectual disability service
- **COMPASS-Prevention™** for prevention and early intervention programs

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Step 6

- Achievable Quality Improvement Plan for each program
  - Small measurable steps in the direction of the vision.
  - Progress not perfection.
  - Rounds of applause for each step of progress.
  - Share success in the QI team; identify and remove barriers.
  - Anchor changes in policy, procedure, and paperwork.

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Steps 7, 8, 9

- **Step 7:** Welcoming individuals and families with complex needs.
- **Step 8:** Seeing the complexity in the people we serve: integrated screening and counting.
- **Step 9:** Establishing hopeful goals for a happy life. Identify periods of strength and success.

ZIA

For Systems, Agencies and Programs

12 Steps of Recovery: Steps 10, 11, 12

- **Step 10:** Integrated hopeful, person- or family-centered strength-based assessment for multi-occurring primary issues.
- **Step 11:** Stage-matched interventions, skills training , and celebrating small steps of success with big rounds of applause.
- **Step 12:** Integrated stage-matched person-centered "recovery" planning.

ZIA


ZIA
PARTNERS
What will be your next small step of success as a system, agency or program?
And let's give each other a round of applause!!!

Mission and Vision

- In order to enhance services for those individuals and families with co-occurring mental health and substance use issues we, ICORN, will collaborate as a team to support each individual member's efforts to develop services, agencies, and systems of care which are more welcoming, accessible, integrated, continuous, and comprehensive while guiding and supporting staff to be more comfortable and confident in providing hope and assistance to individuals with co-occurring issues, and their families, so they may obtain the quality of life they desire. **The impact of our collective expertise and advocacy will ultimately unite, shape, and change our system of care so that it becomes more responsive to individuals and families with co-occurring issues and needs.**

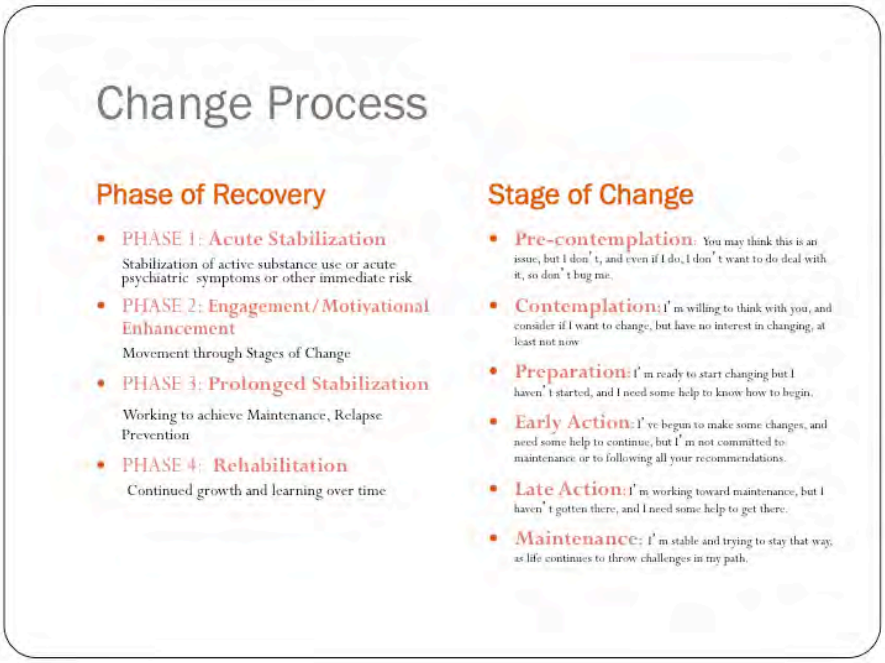
Changing the World

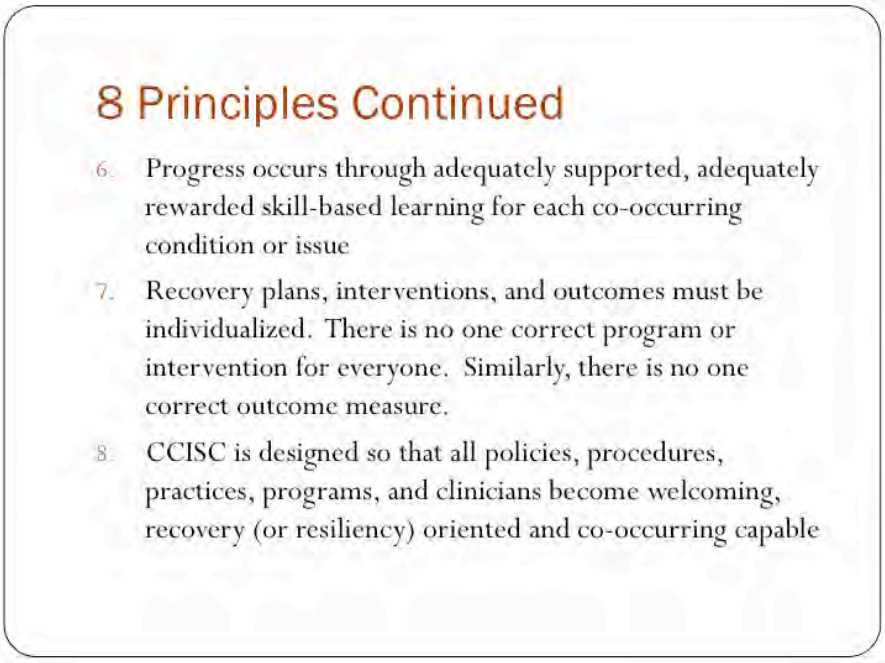
Welcoming, recovery-oriented, trauma-informed, culturally fluent, comprehensive, continuous, integrated systems of care for individuals with co-occurring conditions.

- Systems
- Programs
- Clinical Practice
- Clinician (Direct Service Staff)

8 Principles of CCISC Model

1. Co-Occurring issues and conditions are an expectation
2. The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship
3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations
4. When co-occurring issues and conditions co-exist, each issue or condition is considered primary
5. Recovery involves moving through stages of change and phases of recovery each co-occurring condition or issue


Change Process
Phase of Recovery
PHASE 1: Acute Stabilization
Stabilization of active substance use or acute psychiatric symptoms or other immediate risk
PHASE 2: Engagement/Motivational Enhancement
Movement through Stages of Change
PHASE 3: Prolonged Stabilization
Working to achieve Maintenance, Relapse Prevention
PHASE 4: Rehabilitation
Continued growth and learning over time
Stage of Change
Pre-contemplation: You may think this is an issue, but I don't, and even if I do, I don't want to do deal with it, so don't bug me.
Contemplation: I'm willing to think with you, and consider if I want to change, but have no interest in changing, at least not now
Preparation: I'm ready to start changing but I haven't started, and I need some help to know how to begin.
Early Action: I've begun to make some changes, and need some help to continue, but I'm not committed to maintenance or to following all your recommendations.
Late Action: I'm working toward maintenance, but I haven't gotten there, and I need some help to get there.
Maintenance: I'm stable and trying to stay that way, as life continues to throw challenges in my path.

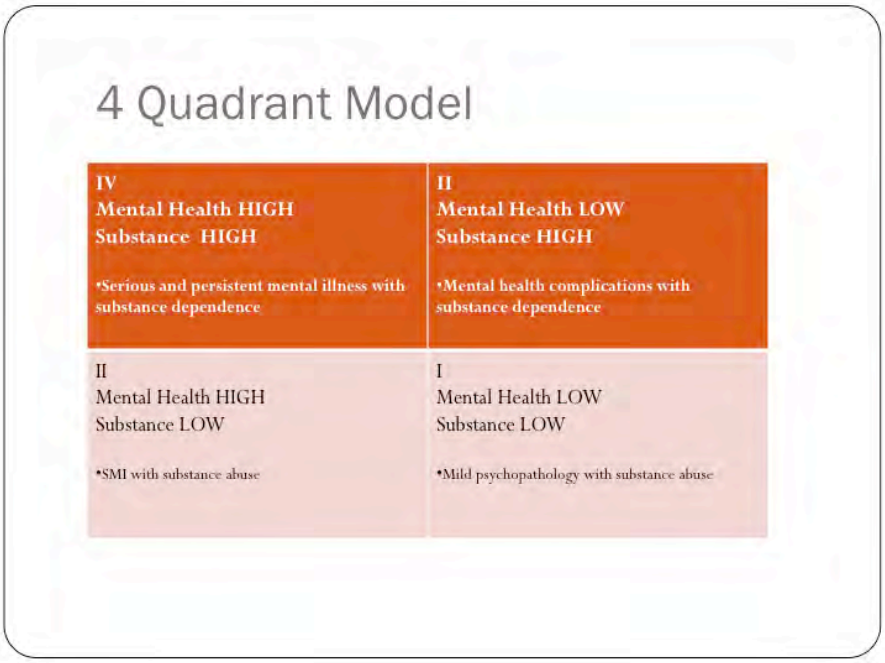

8 Principles Continued
6. Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue
7. Recovery plans, interventions, and outcomes must be individualized. There is no one correct program or intervention for everyone. Similarly, there is no one correct outcome measure.
8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery (or resiliency) oriented and co-occurring capable

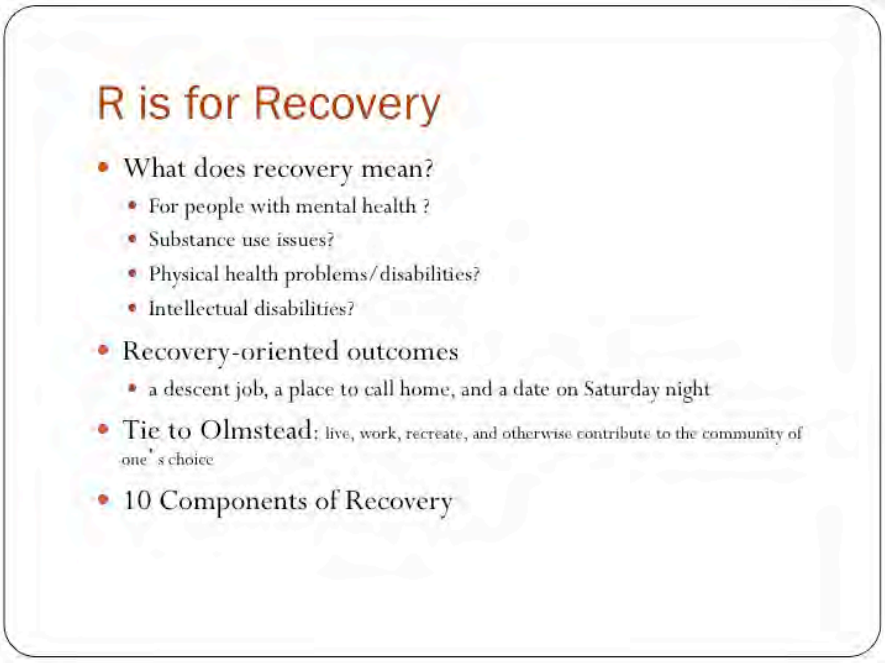
I is for Iowa

- Statewide effort
- Challenges of Iowa's disabilities system are not unique to Iowa
- Strategies and approaches ICORN advocates are being explored in other places (MO, SD, etc)
- Statewide and local
- ICORN as a resource for state-level decision making

Co is for Co-Occurring

- From dual diagnosis (MH and SA) to Co-occurring
- Research demonstrates substantially better outcomes with more integrated treatment vs. sequential or parallel treatment
- Humans are complex. The system of care should be set up with this as the expectation
- No wrong door policy
- 4 quadrant model


4 Quadrant Model
IV
Mental Health HIGH
Substance HIGH
•Serious and persistent mental illness with substance dependence
II
Mental Health LOW
Substance HIGH
•Mental health complications with substance dependence
II
Mental Health HIGH
Substance LOW
•SMI with substance abuse
I
Mental Health LOW
Substance LOW
•Mild psychopathology with substance abuse


R is for Recovery
What does recovery mean?
For people with mental health ?
Substance use issues?
Physical health problems/disabilities?
Intellectual disabilities?
Recovery-oriented outcomes
a descent job, a place to call home, and a date on Saturday night
Tie to Olmstead: live, work, recreate, and otherwise contribute to the community of one's choice
10 Components of Recovery

N is for Network

- Breaking down silos
- Creating efficiencies
- Develop relationships
- Change Agents (across the state, local communities)

How to get involved

- Attend quarterly meetings
- Find out who in your community is already involved
- Join local community efforts
- WIKI – icorn.communitymentalhealthcenter.org
- Contact member of ICORN leadership (contact info on WIKI) or Brenda Hollingsworth
- Tools

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Appendix K: Bibliographies

Multi-occurring Conditions Resource Bibliography

Compiled by Kenneth Minkoff, MD and Christie A. Cline, MD, MBA

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Appendix L: Internet Resources

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