NO WRONG DOOR FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

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DMHAS MISSION AND VISION

The Connecticut Department of Mental Health and Addiction Services (DMHAS) is a health care agency whose mission is to promote the overall health and wellness of persons with behavioral health needs through an integrated network of holistic, comprehensive, effective, and efficient services and supports that foster dignity, respect, and self-sufficiency in those we serve.

DMHAS promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance use prevention and treatment throughout Connecticut.

WHAT WE KNOW

- More than half of individuals in DMHAS services have co-occurring MH and SU disorders.
- Integrated mental health and substance use services, at the same time, yields the best outcomes.
- Historically, it has not always been easy to integrate care due to silos in funding, higher education, data reporting, etc.
- DMHAS has made a lot of progress over the last 20+ years in delivering more integrated care.

LANGUAGE MATTERS

- Recovery friendly language focuses on the person, not the disease.
- Substance use disorder, person with addiction, person living with addiction or substance use disorder, person in recovery *vs.* Substance abuse, addict, junkie, substance abuser, recovering addict
- Mental health and substance use disorders are treatable health conditions and recovery is possible *vs.* Addiction is a failure of morals or will power.
- There are multiple pathways to recovery and there is always hope *vs.* Person is hopeless or needs to hit rock bottom.
- Recovery is not linear *vs.* Relapse is to be expected.
- Harm reduction is a recovery pathway *vs.* Recovery = abstinence.
- Medication is one of multiple pathways to recovery *vs.* Medication is a crutch, a person on medication is not sober/clean
- Words and phrases like “clean time” or “dirty urine” reinforce stigma and shame

INTEGRATED SERVICES:
ALL PROGRAMS TREAT INDIVIDUALS WITH COD

Mental Health Services / COD	Substance Use Services / COD
Inpatient psychiatric	Withdrawal management (formerly known as detox)
Residential programs (MH intensives, group homes, supervised housing, transitional)	Substance use disorder (SUD) residential treatment (3.7, 3.5, 3.3, 3.1)
Crisis services (mobile crisis, respite, peer respite, REST/crisis stabilization)	Recovery houses, sober housing
Community based programs (ACT, CSP, supported employment, supportive housing)	Opioid Treatment Programs (OTPs) (methadone)
Outpatient clinical services (therapy, medication management)	Outpatient / IOP

ALL TREATMENT COMPONENTS ARE INTEGRATED

- Screening
- Assessment
- Recovery plans
- Clinical and non-clinical services
- Medications
- Recovery support
- Discharge planning
- Crisis support

THERAPIES ARE INTEGRATED:
ADDRESS BOTH MH AND SU

- Motivational Interviewing
- Stages of Change
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization & Reprocessing (EMDR)
- Trauma treatment
- Individual and group modalities
- Family therapy

GUIDES TO INTEGRATED TREATMENT

- Integrated Dual Disorders Treatment (IDDT)
- Dual Disorders Capability in Mental Health Treatment (DDCMHT)
- Dual Disorders Capability in Addiction Treatment (DDCAT)

THE IMPORTANT PART…

- Not sequential or parallel mental health and substance use treatment/services
- Some examples:
  - In LMHA CSP and outpatient services, includes MH and SU. At some point person may need withdrawal management or SU IOP services.
  - In CMHC SATU – goal for that team provides both MH and SU services.
  - CVH WM or SUD residential treatment to address both MH and SU and discharge plans address both.

SOMETIMES…
A DISCONNECT CAN HAPPEN

CT has a robust treatment continuum to provide individuals with access to comprehensive behavioral healthcare

Ensuring that resources are available & accessible in real-time and known across the state

WHAT IS AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)?

- *The ASAM Criteria* is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.
- Formerly known as the ASAM patient placement criteria, *The ASAM Criteria* is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction.
- https://www.asam.org/asam-criteria/about-the-asam-criteria

DIMENSIONS AND LEVELS OF CARE

WHAT IS ADDICTION?

- Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.
- Compulsive repeated behavior despite negative consequences.

https://www.asam.org/quality-care/definition-of-addiction

6 DIMENSIONS

ASAM uses 6 dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services across all levels of care:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use or Continued Problem Potential
6. Recovery and Living Environment

https://www.asam.org/asam-criteria/about-the-asam-criteria

DIMENSION 1

Acute Intoxication/Withdrawal Potential

- Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency and recency of discontinuation or significant reduction of alcohol or other drug use?
- Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification, if medically safe? Has the patient been using multiple substances in the same drug class?

DIMENSION 2

Biomedical Conditions & Complications

- Are there current physical illnesses, other than withdrawal, that need to be addressed because they are exacerbated by withdrawal, create risk or may complicate treatment?
- Does the client have any current untreated severe medical problems that may interfere with treatment?
- Does the client have any illness or require medical attention that may interfere with treatment? E.g., hypertension, diabetes, the need for dialysis or chemotherapy

DIMENSION 3

Emotional/Behavioral/Cognitive Conditions & Complications

- The third dimension explores an individual's thoughts, emotions and mental health issues. These include: dangerousness/ lethality, BH that interferes with recovery efforts, social functioning, ability for self-care and course of illness.
- Psychiatric Diagnosis
- Current psychiatric medications and are they complying with treatment?
- What is the client's current mental status?

DIMENSION 4

Readiness to Change

- How ready is the client to change (stage of readiness to change)?
- How accepting is the client towards treatment?
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

DIMENSION 5

Relapse, Continued Use, Or Continued Problem Potential

- What skills does the client possess to cope with/or control using? Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use if discharged?
- How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others? What is the patient's ability to remain abstinent or psychiatrically stable, based on their history? What is the patient's current level of craving and how successfully can he or she resist using?

DIMENSION 6

Recovery/Living Environment

- Problems with Primary Support Group
- Problems with Social Environment
- Educational Problems
- Occupational Problems
- Housing Problems
- Economic Problems
- Legal Problems
- Transportation Problems
- Childcare Problems

SUBSTANCE USE DISORDER

System of Care in CT

SUBSTANCE USE DISORDER SYSTEM OF CARE

- Medically Managed Intensive Inpatient Services, Withdrawal Management (4.0)
- Medically Monitored High-Intensity Inpatient Services, Withdrawal Management (3.7 D)
- Medically Monitored Intensive Inpatient Services(3.7)
- Medically Monitored Intensive Inpatient Services, Co-occurring Enhanced (3.7RE)
- Clinically Managed High-Intensity Residential Services (3.5)
- Clinically Managed High-Intensity Residential Services (3.5) (Pregnant and Parenting)
- Clinically Managed Population-Specific High-Intensity Residential (3.3) Services
- Clinically Managed Low-Intensity Residential Services (3.1)
- Recovery Houses
- Women's Recovery Support Programs (Pregnant and Parenting)
- Outpatient (PHP, IOP, Outpatient, Methadone Maintenance)

WITHDRAWAL MANAGEMENT

Two Types: Medically Managed and Medically Monitored

- **Medically *Managed*-** 24 hour medical and nursing supervision on-site due to the significant history (Hx) of use, psychiatric symptoms, or types of substances used. Only the 2 DMHAS-operated WM (CVH Blue Hills and Merritt Hall) provide this LOC.
- **Medically *Monitored*-** 24 hour nursing supervision is provided with access to on-site medical evaluation by a medical provider (MD not required on-site 24/7).
- An alcohol or benzodiazepine withdrawal management admission may also happen in a hospital- based setting due to the associated risks to the client.

MEDICALLY MONITORED WITHDRAWAL MANAGEMENT PROVIDERS IN CT

- Recovery Network of Programs (RNP) First Step (Bridgeport)
- Cornell Scott-Hill Health Center SCRC (New Haven)
- Rushford (Middletown)
- SCADD (New London)
- Stonington Institute (North Stonington)
- InterCommunity- formerly ADRC (Hartford)
- MCCA (Danbury)

OVERDOSE RISK

Current focus is on induction over detoxification

Client titrated up to initial dose of a medication for opioid use disorder (MOUD) and transferred to a community provider

Following an opioid detox a client is at higher risk for overdose as their tolerance has decreased

Understanding safe use practices and being open to talking about relapse is important and in many cases lifesaving

Connection to aftercare is essential to continue to enhance support network

MOUD can help with cravings

INTENSIVE RESIDENTIAL LOC (3.7)

- Residential program for individuals with substance use disorders or co-occurring SUD/MH disorders
- Expectation of 30 hours of treatment per week
- Client must be able to actively participate in a variety of psycho-ed and treatment groups
- Psychiatric and medical conditions should be stable
- Usually post-WM
- LOS- determined based on meeting medical necessity, typically up to 28 days

INTENSIVE RESIDENTIAL PROVIDERS

CASA (Bridgeport)

RNP-Horizons (Bridgeport)

CVH (Middletown)

Rushford- ITP (Middletown)

InterCommunity (Hartford)

Blue Hills (Hartford)

Gilead/Farrell Treatment Center(New Britain)- men only

MCCA-McDonough (Danbury)

McCall-Carnes Weeks (Torrington)

CO-OCCURRING ENHANCED (3.7E)

- Specialized program to treat individuals with more significant co-occurring disorders
- On-site psychiatric services
- Expectation of 30 hours of treatment/week with a focus on co-occurring disorders
- LOS- based on meeting medical necessity, typically 28 days (average)
- Three programs:
  - **New Prospects** (Recovery Network of Programs) Bridgeport
  - **McAuliffe** (CT Renaissance) males only - Waterbury
  - **Milestone** (CHR) females only - Putnam

INTERMEDIATE TREATMENT LOC (3.5)

Residential program for individuals with substance use disorders or co-occurring disorders

Expectation of 20 hours of treatment per week

- Again, client must be able to engage in this level of service

Psychiatric and medical conditions should be stable

LOS based on meeting medical necessity, typically up to 90 days

INTERMEDIATE LOC PROVIDERS

APT
(New Haven)

Liberation Programs
Liberation House
(Stamford)
Men only

Rushford
Stonehaven
(Middletown)

CHR
Roots to Recovery
(Willimantic)
Men only

SCADD
Lebanon Pines
(Lebanon)
Men only

Youth Challenge
Phase 1 Program
(Hartford)
Men only

McCall
(Waterbury)
Men Only

McCall
Hanson House
(Torrington)
Women only

InterCommunity
(Hartford)

PREGNANT AND PARENTING (3.5)

- Specialized LOC with the purpose of providing support to women during pregnancy, while parenting and/or during the reunification process
  - Reunification must be the established goal at time of admission
- 20 hours of treatment services per week –Individualized length of stay based on treatment plan
- Children can reside with mom in the program
- Services provided at:
  - Liberation Programs- Families In Recovery Program (Norwalk)
  - CHR- New Life (Putnam)
  - APT- Amethyst House (New Haven)
  - InterCommunity - Coventry House (Hartford)
  - Wellmore (Waterbury)

LONG-TERM CARE (3.3)

MCCA-Trinity Glen

(2 programs)

- *Men's Program (Sharon)*
- *Women's Program (Kent)*

Programs are geared towards individuals who have cognitive impairments due to SUD

Clients must be able to participate in 20 hours of treatment

Program length of stay

TRANSITIONAL (3.1)

- Low intensity LOC with focus on re-integration into the community
- Expectation of engaging in 5 hours of services per week
- Focus is on building independent living skills and promoting personal responsibility and accountability.
- Many individuals are involved in: employment, education, volunteerism, etc.
- LOS- based upon meeting medical necessity, typically up to 90 days

TRANSITIONAL HOUSE PROVIDERS (3.1)

CASA (Bridgeport)

McCall (Torrington)

SCADD (Norwich, New London)

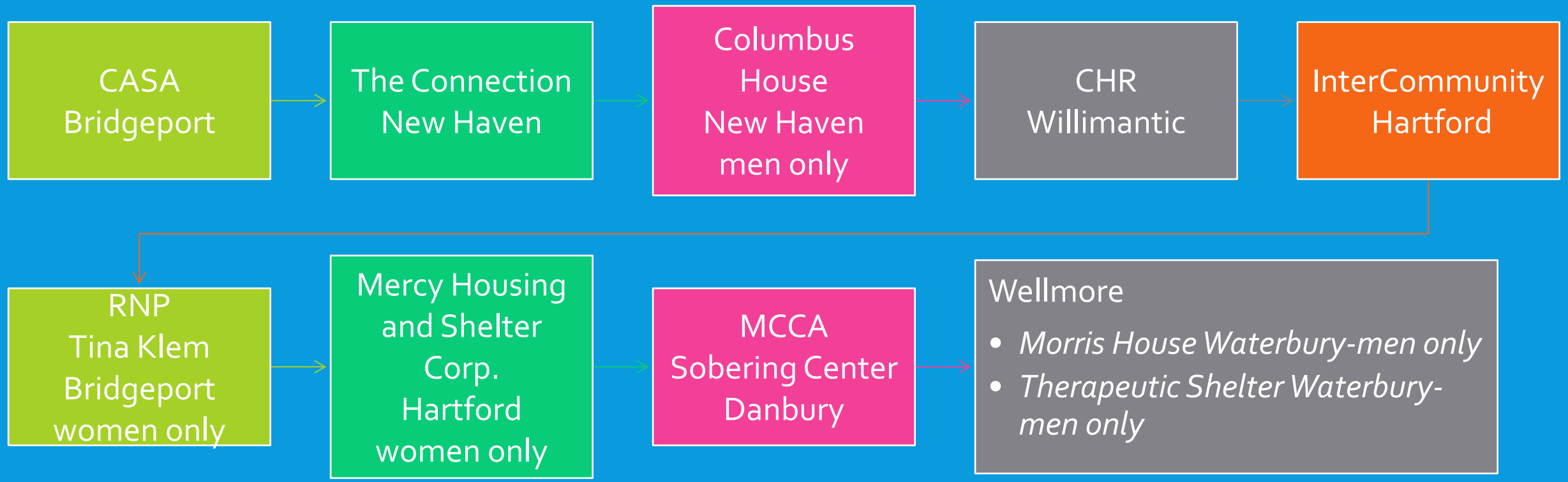
*Youth Challenge (Hartford)

InterCommunity Clayton House (Glastonbury)

RECOVERY HOUSES

- This is ***different*** from a sober house
- This LOC differs from Halfway House (3.1) given that the recovery house provides a "safe" place for individuals awaiting beds at a higher/lower LOC
- Up to a 90 day LOS; not treatment, not a licensed program
- Treatment often occurs in the community- OTP, IOP, or PHP
- Individuals often are working, pursuing education, etc.

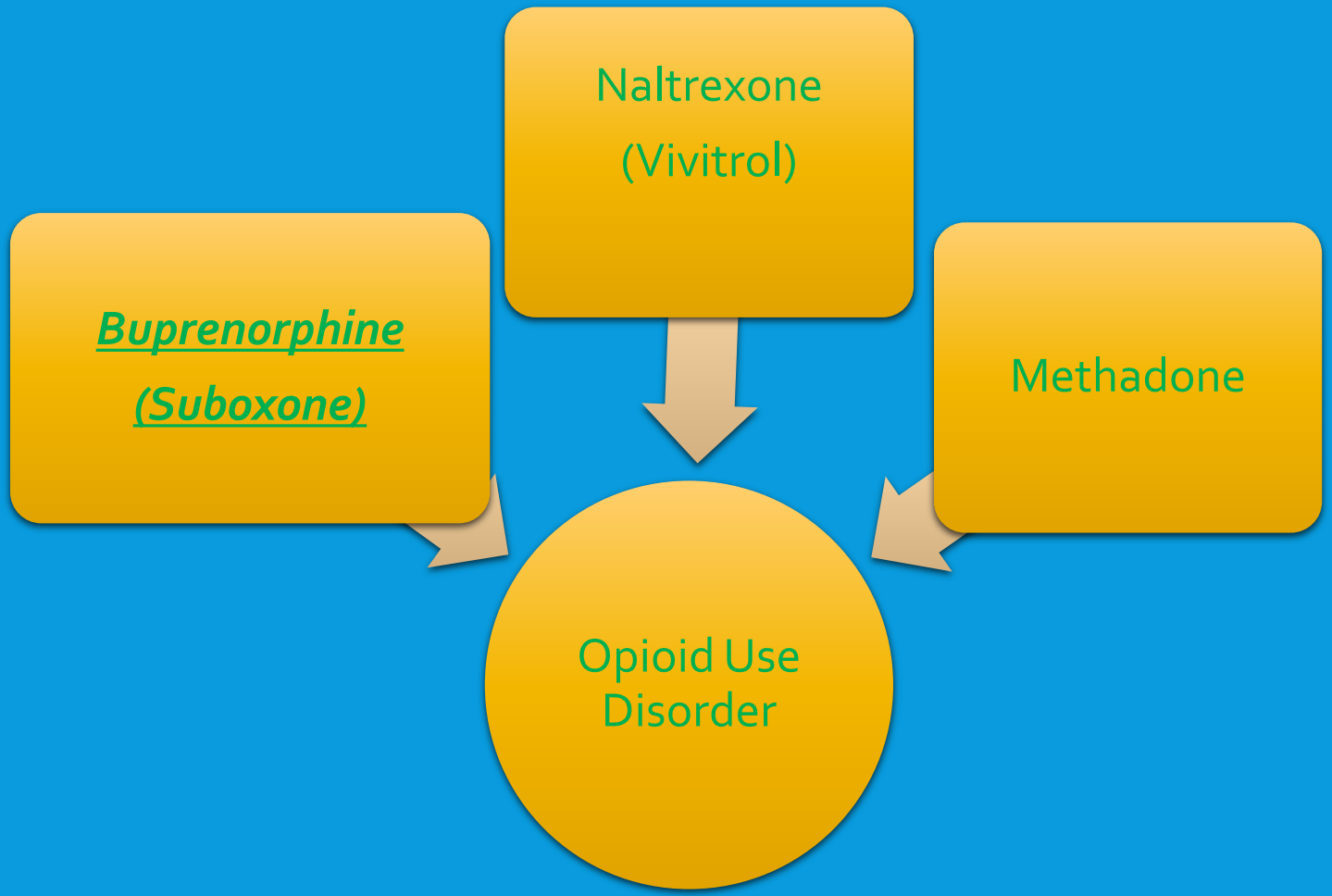
RECOVERY HOUSES



MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

MEDICATION ASSISTED TREATMENT (MAT)

MEDICATIONS FOR ADDICTION TREATMENT (MAT)



MOUD/MAT

- MOUD/MAT assists in normalizing brain chemistry, blocking the euphoric effects of opioids and/or alcohol, relieving physiological cravings, and normalizing body functions, without the negative and euphoric effects of the substance used.
- Dose will likely need to be adjusted during pregnancy (increased) and postpartum (decreased) as MOUD/MAT may be metabolized different during that time.
- Research shows that the mortality rate of untreated individuals using heroin is 15 times higher compared to individuals receiving methadone maintenance treatment (who have a similar mortality rate to the general public)
- DMHAS acts as the State Opiate Treatment Authority (SOTA) and works in collaboration with the methadone provider network to ensure adhere to all Federal regulatory standards
- 42 OTPs including DOC programs. One new program to open in Feb '25, plus 2 mobile OTPs to be operational in 2025

OPIOID TREATMENT PROGRAMS (OTPS)

- Opioid Treatment Program
- Methadone Maintenance programs
- Withdrawal Management programs if utilize methadone protocol
- 21,903 individuals served in 2020 in CT
- 52 OTPs in CT
  - 11 withdrawal management programs
  - 42 methadone maintenance clinics
    - 1 located in VA
    - 7 OTPs located within DOC facilities (6 PNP, 1 DOC)
- Highly regulated medication and treatment model

ROLE OF THE SOTA: 1 PER STATE

- State Opioid Treatment Authority (SOTA) designated by the governor or another appropriate official to exercise authority within the state for governing treatment of opiate addiction with medication to treatment opioid use disorder (OUD). Specifically, methadone or buprenorphine.
- In Connecticut, the position resides within the Department of Mental Health and Addiction Services, Community Service Division
- SOTA is responsible to provide approval to SAMSHA for any new certified OTPs
- SOTA is responsible to ensure that the OTPs adhere to 42 CFR part 8

42 CFR PART 8

- SAMHSA issued revised regulatory standards which was the first "major" revision to the Opioid Treatment Program (OTP) reg since 2001
- Released with effective date of 4-2-24, implementation date of 10-2-24
- The goal was to reframe the TX experience, increase access, individualized care ("not one size fits all")
- Focus is on a culture shift in care and service delivery
- Themes include "shared decision making", flexibility, trust, attempts to decrease stigma (language) and practitioner judgement
- Awareness that State regulations may be more stringent, and States may need to explore components that will be adopted/implemented

CONNECTION TO CARE

Real time bed availability

- www.ctaddicitionservices.com
  www.ctmentalhealthservices.com

Access Line

- *Information on walk-in assessment centers throughout the state at www.ct.gov/dmhas/walkins or 1-800-563-4086*
- *Screening & Warm hand off to WM services*
- *Transportation available*

Carelon

- *http://www.ctbhp.com/medication-assisted-treatment.html*
- *Includes Interactive Map of all MAT providers*

SUMMARY

- Integrated MH and SU services at every juncture
- For those served in DMHAS LMHAs, time limited SU services may be needed at another agency. Important to continue to integrate care during that time.
- Systemic changes in CT substance use services over the past two years with 1115 waiver. Important to understand the ASAM criteria in order to make referrals to those time-limited SU services.

FOR QUESTION OR MORE INFORMATION

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