



NYSHealth  
Center for Excellence  
in Integrated Care

# **Progress Report**

## **Annual Report**

### **Year 1** (14 months)

**November 1, 2008 – December 31, 2009**

**Grant #2008-2496857**

*Center for Excellence in Integrated Care for Individuals with  
Co-occurring Mental Health and Substance Use Disorders*

**Grant #2009-3426912**

*Expanding Technical Assistance Support & Reach of  
NYSHealth's Center for Excellence in Integrated Care*

## Executive Summary

CEIC has had an active and productive first 14 months of activity, with an array of developments, including announcements, surveys, product and website development, presentations, partnerships, and outreach activities. Most important, CEIC has delivered a large number of **Training (T)** and **Technical Assistance (TA)** activities, refined its implementation approaches by tailoring activities to the past accomplishments and current status of co-occurring disorders developments in a given region, and developed a strategic plan to reach and penetrate the state's 1200+ co-occurring disorders outpatient treatment programs. Specifically, CEIC has:

- (1) **Direct Provider TA** — delivered implementation training and technical assistance to **5** of the **State's 9 regions** (and completed other activities, including consultations in two counties of a 6<sup>th</sup> region), conducted **11 provider events (5 Leadership Forums, 5 Building Capability Forums, plus 1 Building Recovery Workshop)**, formed **10 Learning Collaboratives**, and provided intensive technical assistance in conducting DDCA[MH]T **on-site assessments at 95 OMH and OASAS outpatient clinics**.
- (2) **Promotion & Outreach** — launched an introductory **website** to provide a central location for contact, information, resources, and communication; promoted CEIC and its services through **19 presentations** to outside organizations; and conducted **100 meetings** (face-to-face and via conference calls) with representatives of outside agencies (e.g., State officials, Dual Recovery Coordinators, partner agencies, professional associations, and other interested parties) to advance interest and investment in CEIC and its statewide activities.
- (3) **Dual Diagnosis Capability** — provided a preliminary "Snapshot" of *Dual Diagnosis Capability* (DDC; based on the *Dual Diagnosis Capability in Addiction [Mental Health] Treatment* [DDCA[MH]T] Indexes) and determined that the system average is between **AOS/MHOS (Addiction or Mental Health Only Services)** and **DDC (Dual Disorders Capable)**. Thus, the greatest need is to move programs first to **DDC (Dual Disorder Capable)** and then to **DDE (Dual Disorder Enhanced)**.
- (4) **Preliminary Evaluation** — supplied a "*Preliminary Evaluation*" of the status of *Screening, Assessment and Evidence-Based Practices* in outpatient clinics and demonstrated an evaluation capability by amalgamating information from 4 existing OASAS surveys with CEIC independent DDCA[MH]T/DDC/MHT assessments. Using the DDCA[MH]T and OASAS *Local Services Survey*, follow-up data were obtained from a substantial sub-sample of programs and will, over time, provide critical information about the progress outpatient clinics make towards integrating care for co-occurring disorders. In brief, preliminary findings are:
  1. **Screening.** The majority of outpatient programs in New York State screen for the presence of a co-occurring mental health or substance use disorder using either a routine set of standard interview questions (e.g. bio-psychosocial) or a formal standardized instrument with established psychometric properties; however, standardized protocols to trigger further assessment and/or referral are implemented with considerable variation across programs.
  2. **Assessment.** Typically, the NYS Task Force recommended assessment domains are assayed in an intake interview or psychosocial assessment, with a section dedicated to additional assessment of co-occurring mental health or substance use problems, including continued documentation of progress; however, programs are less able to determine a diagnosis and will often rely on self-report or prior documentation in the client's records. Further, information contained in the assessment regarding the co-occurring disorder inconsistently informs treatment planning.
  3. **TA for Screening & Assessment.** In view of these findings, CEIC technical assistance in screening and assessment must include and surpass the implementation of screening instruments and assessment domains, to foster improvements in the quality of the information obtained and the integration of all information into treatment planning for the individual.
  4. **Evidence-Based Practices.** Although some interventions for co-occurring disorders are available, **significant use of the NYS recommended evidence-based treatment interventions is not apparent**. In advancing programs to an enhanced level (i.e., DDE), the greatest need is for training and technical assistance in the implementation of evidence-based practices.

- (5) **Year 2** — projected the increase in training and technical assistance activities for next year based on a model derived from activities (scheduled and completed) during the second 6 months of the first year. The model demonstrates a wider expansion of CEIC's reach and penetration based on an anticipated full calendar year of activities and the addition of a staff member to carry out these activities.
- (6) **Strategic Plan** — developed a strategic plan for an appreciable expansion of activity through the delivery of direct training and technical assistance (i.e., *Leadership Forums*, DDCA[MH]T Assessments, *Building Capability Forums*, *Learning Collaboratives*, *Building Recovery Workshops*, and Individual Technical Assistance). These direct methods are used in combination with other approaches, such as technological applications (i.e., a web-based learning system currently in development at the *Center for Practice Innovations*); training-of-trainers and migration of influence; the latter involves spread of influence from a critical mass of several collaborative cohorts within any given region (nodes) to other providers within that same region. This combination of approaches is highly effective and efficient.

This report continues to convey our optimism about accomplishing our goals. CEIC will employ staff and other resources to reach and penetrate the NY State system of 1200+ outpatient clinics to promulgate advances in treatment for co-occurring disorders. In so doing, CEIC will be improving the clinical care, health and well-being of New York State residents with co-occurring disorders.

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## Introduction

Co-occurring substance use and mental disorders (“co-occurring disorders” or COD) are common, yet despite evidence that interventions are effective, only a minority of persons with COD receive integrated treatment. In support of its mission to improve the health of New Yorkers, the **New York State Health Foundation** (NYSHealth or “the Foundation”) established, as a priority, improving integrated care for individuals with co-occurring mental and substance use disorders. Beginning November 1, 2008, the Foundation funded the **Center for Excellence in Integrated Care** (CEIC), through a contract to National Development and Research Institutes, Inc.<sup>1</sup> (NDRI); Stanley Sacks, PHD, is the Director of CEIC.

Building on the objectives of the Foundation and the recommendations of the New York State (NYS) Task Force on co-occurring disorders, the Center's main goal is to build the capacity of over 1200 outpatient clinics to provide integrated clinical care for people with co-occurring disorders that is recovery-oriented, person-centered, and culturally competent. Three clinical care goals are keyed to the recommendations of the Task Force; namely, to implement: (1) a *uniform and standardized* approach to screening; (2) a *domain* or component approach to assessment; and (3) the use of selected evidence-based practices for integrated treatment. CEIC's primary emphasis is on supporting providers, improving clinical systems of care, and facilitating the integration of services for New Yorkers with co-occurring disorders.

The focus of this report is on the activities and accomplishment of the center for the 14 month period from November 1, 2008 – December 31<sup>st</sup>, 2009. For these progress reports, CEIC and Foundation staff (Jacqueline Martinez and Kavita Das) established a format to support clear and rapid communication of information in three areas -- *goals, activities/accomplishment and next steps*. This report maintains that format, and has been separated into four main sections: (A) **CEIC Services, Items 1 through 7**; (B) **CEIC Outreach, Coordination and Collaboration, Items 8 through 11**; (C) **CEIC Projection of Future Activities, Item 12**; and (D) **Advancing the Project, Item 13**. A table has been included at the end of sections A (**CEIC Services**) and B (**CEIC Outreach, Coordination and Collaboration**) to condense and summarize the accomplishments of the 14-month start-up period.

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<sup>1</sup> The contract is through NDRI State, an arm of NDRI established primarily to encompass non-federal activities.

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## A. CEIC Services

### 1. Regional Leadership Forums

#### Goal

The forums are intended to: (1) present the key components of screening, assessment, and selected evidence-based practices, recommended by the COD Task Force; (2) generate county leadership “buy-in” to the implementation of the Task Force recommendations; (3) discuss a potential change process to be followed (e.g., *The Change Book*, Addiction Technology Transfer Center [ATTC; 2004]); (4) build the relationship between CEIC and the Regions, Counties, and clinics; (5) introduce the tools CEIC will be making available to assist with implementation; and (6) review the current status of co-occurring disorders developments in the region, existing plans for future activity, and Technical Assistance (TA) needs. The sections below provide a review of *Activities/Accomplishments*, and conclude with *Next Steps*.

*Leadership Forums* formally introduce CEIC services to identified County, OASAS, and OMH and, in some cases, provider leaders from the particular region. The Forum takes the form of a consultation, whereby CEIC can gain an understanding of developments in co-occurring disorders that have taken place, which gives us the opportunity to demonstrate how CEIC can complement those efforts. The Forum concludes with the initiation of a planning process that identifies provider agencies, organized into cohorts of from 14 to 20 (14 is considered to be the optimal size, but considerable variation occurs,) to continue working with CEIC.

In May, 2009 we began to use two mechanisms to plan our future work with providers, taking into account both regional and provider developments. The consultation process at *Leadership Forums* is intended to obtain a better understanding of key regional issues affecting providers. We have also initiated informal advisory groups following the forums to help identify programs for the TA cohorts and to serve as a long-term liaison for local activities. CEIC planned to conduct five (5) forums during the first project year, using a regional structure to organize all of the counties in the state. Since the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) have different regional breakdowns, we elected to use the regional system developed by the Conference of Local Mental Hygiene Directors (CLMHD) with one slight alteration.<sup>2</sup> This system has the advantage of grouping county mental health and substance abuse directors into regions, each of which has an elected chair to serve as the pivotal contact person during forum planning. Five *Leadership Forums* have now been completed —Northeastern, North Country, Long Island, Western and NYC Regions — We are currently planning for the Finger Lakes, Central, Mohawk Valley, and Mid-Hudson Regional forums to be held in 2010.

#### Activities/Accomplishments

**As of 12/31/2009, CEIC has completed 5 *Leadership Forums* covering 5 of the 9 Regions of NY State. These 5 Regions contain 32 counties and a total population of 14.8 million.**

- |                            |  |                             |
|----------------------------|--|-----------------------------|
| ○ January 30 <sup>th</sup> | — Northeast Region <i>Leadership Forum</i>     | — 9 counties, pop 1,061,509 |
| ○ April 10 <sup>th</sup>   | — North Country Region <i>Leadership Forum</i> | — 7 counties, pop 425,871   |
| ○ May 26 <sup>th</sup>     | — Long Island Region <i>Leadership Forum</i>   | — 2 counties, pop 2,753,913 |
| ○ July 22 <sup>nd</sup>    | — Western Region <i>Leadership Forum</i>       | — 9 counties, pop 2,341,452 |
| ○ October 15 <sup>th</sup> | --- NYC Region <i>Leadership Forum</i>         | — 5 counties, pop 8,214,426 |

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<sup>2</sup> The County Directors of Community Services, advised us to include Hamilton County in the North Country Region, rather than in the Mohawk Valley Region; this advice was based on the interest and involvement of Hamilton County in the activities of the North Country Region and reflects the naturally occurring grouping as opposed to a grouping imposed using geographical criteria only.

During our consultation with leadership in NYC, it was recommended that we follow-up individually with each of the boroughs in order to gain maximum penetration across the service system in NYC. It was recommended that this be accomplished via separate presentations to each of the borough council meetings on both the mental health and substance abuse side, which are attended by providers. To date, the CEIC has presented at the following borough council meetings:

- ▲ November 9, 2009 — Manhattan Substance Abuse Council Meeting
- ▲ November 16, 2009 — Brooklyn Substance Abuse Council Meeting
- ▲ November 18, 2009 — Bronx Substance Abuse Council Meeting
- ▲ December 16, 2009 — Queens Substance Abuse Council Meeting

## Next Steps

- **The Remaining 4 Regions.** By mid-2010, conduct *Leadership Forums in the four remaining regions* — Finger Lakes, Central, Mohawk Valley, and Mid-Hudson — currently, *recruiting programs to be organized into cohorts*.
- **NYC Borough Council Meetings** — the CEIC has been scheduled to present at the following borough council meetings during the first quarter of 2010:
  - January 7, 2010 — Queens Mental Health Council Meeting
  - January 14, 2010 — Manhattan Mental Health Council Meeting
  - January 25, 2010 — Staten Island Substance Abuse Council Meeting
  - January 26, 2010 — Brooklyn Mental Health Council Meeting
  - February 11, 2010 — Staten Island Mental Health Council Meeting
  - March 17, 2010 — Bronx Mental Health Council meeting TBD

## 2. Co-occurring Capability — On-Site Assessment and Technical Assistance (TA) recommendations for Improvements

### Goal

Once a cohort of provider agencies is constituted, CEIC schedules an on-site *Dual Diagnosis Capability in Addiction [Mental Health] Treatment* (DDCA[MH]T) assessment with each agency. The site visit is a technical assistance activity, which lasts about three (3) hours, consisting of meetings with key administrative and clinical staff, a review of program materials, and direct observation of clinical activities. At the conclusion of the site visit, each agency receives a preliminary impression of their capability; shortly thereafter, a written report is provided that contains detailed observations and recommendations for increasing co-occurring capability, along with the program score sheet and its corresponding graphic representation. With very few exceptions, the response to these TA site visits has been highly positive.

### Activities/Accomplishments

**As of 12/31/2009, CEIC has completed an on-site assessment of co-occurring capability in, and technical assistance to, 95 outpatient clinics — 43 OMH-licensed mental health settings and 52 OASAS-licensed substance abuse settings — located in 18 counties, and across 6 of New York State's 9 Regions.**

▲ Northeast	—	20 providers	—	Albany, Columbia, Greene, Rennselaer, Saratoga, Schenectady, Schoharie Counties
▲ North Country	—	14 providers	—	Clinton, Essex, Franklin, Hamilton Counties
	—	7 providers	—	Jefferson & St. Lawrence Counties
▲ Long Island Cohort I	—	16 providers	—	Suffolk County
	—	8 providers	—	Suffolk County
	—	14 providers	—	Nassau County
	—	1 provider	—	Nassau County
▲ Western	—	5 providers	—	Monroe County
▲ New York City	—	6 providers	—	New York County
▲ Mid-Hudson	—	4 providers	—	Orange County

### Next Steps

- Long Island (Suffolk County) Cohort II — complete on-site assessment of co-occurring capability in an additional 5 programs that will complete the second collaborative cohort, Suffolk County, Long Island Region.
- Long Island (Nassau County) Cohort II — complete on-site assessment of co-occurring capability in an additional 13 programs that will complete the second collaborative cohort, Nassau County, Long Island Region.
- NYC (All Counties) Cohort I — complete on-site assessment of co-occurring capability in 20 programs that will comprise the first collaborative cohort of the NYC Region. CEIC will continually form cohorts in NYC for the remainder of **this year and** the project.
- Finger Lakes, Mohawk Valley, Central, & Mid-Hudson — Continue this activity, extending into the remaining Regions and incorporating other counties across NYS and within NYC for the duration of the year and throughout the life of the Center.

## DDCA[MH]T “Snapshot” of System

**Description of Figure A.2-1.** Figure A.2-1 shows the DDCA[MH]T averages for “Overall Score” and across seven dimensions (program structure, program milieu, screening/assessment, treatment, continuity of care, staffing, and training) for a “convenience” sample (i.e., a sample selected “for convenience” from programs slated to receive technical assistance, rather than selected specifically for its “representativeness”) of 95 programs from 6 regions in New York State. The DDCA[MH]T rates programs on a 1-5 scale —

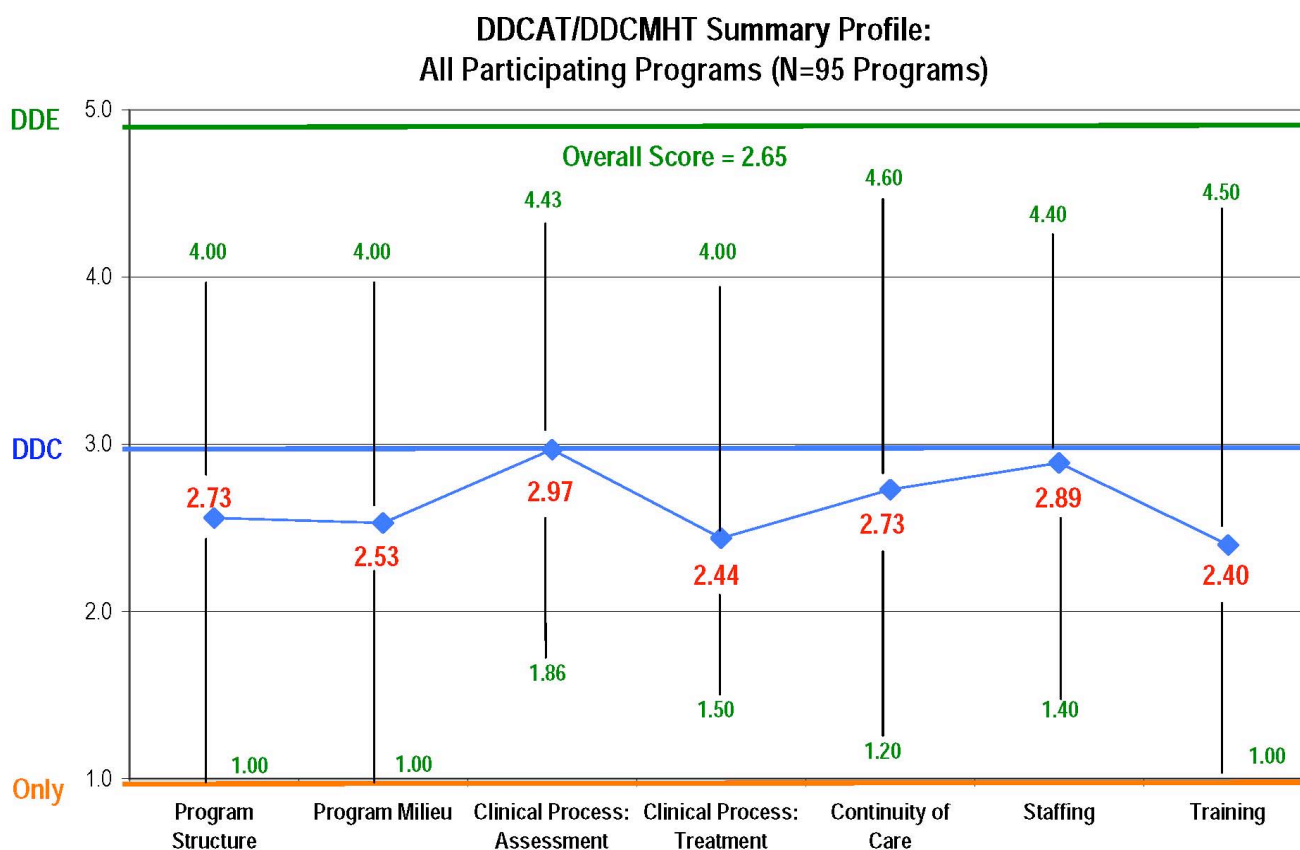
1= *Addiction or Mental Health Only Services (AOS/MHOS)*;

3= *Dual Disorder Capable (DDC)*; and

5= *Dual Disorder Enhanced (DDE)*.

Overall, programs are operating between “Addiction or Mental Health Only Services” (AOS/MHOS) and “Dual Disorder Capable” (DDC) services (average overall score=2.65). Programs average below 3 on all seven dimensions, ranging from 2.40 for “Training” to 2.97 for “Assessment.” (The vertical line for each dimension depicts the range of scores on that domain.) Programs were rated highest on the domains of assessment (which includes screening), continuity of care, and staffing, and lower on the domains of program structure, program milieu, treatment, and training.

**Figure A.2-1.** On-site co-occurring capability assessments—Summary profile for 95 sites



**Other Observations.** The following sections summarize some qualitative impressions of CEIC staff in each of the seven dimensions as determined through the site visit assessments of co-occurring capability.

### **Program Structure**

1. Mission statements generally do not reflect the fact that most programs are indeed providing some type of service or treatment to individuals with co-occurring disorders;
2. Programs are enthusiastic about making changes but are unsure about the language to use to be consistent with their license. CEIC technical assistance helps to resolve this question by suggesting language to convey that they treat the other disorder in the context of their primary treatment.

### **Program Milieu**

3. Program and individual clinicians usually expect and welcome individuals with both mental and substance use disorders to treatment;
4. Literature and client education materials are typically available for the primary disorder only and much less available for the second or co-occurring disorder. Our post-site-visit feedback indicates that programs are actively broadening their client literature.

### **Clinical Process: Assessment (includes Screening)**

5. Programs tend to admit clients whose symptom acuity is low to moderate and who are also primarily stable; for substance abuse clinics these tend to be clients that are in remission.
6. Programs tend to admit clients with a co-occurring disorder that is also of low to moderate severity;
7. Almost all programs have, as a minimum, a routine set of standard interview questions designed to screen for the co-occurring disorder, and **many use a standardized formal screening instrument with established psychometric properties**. The site visit and *Building Capability Forum* help providers to initiate the use of one of the State-recommended screeners if they have not already done so;
8. Almost all programs customarily assess clients for a co-occurring disorder; however, that assessment is not routinely linked to a positive result on the screen or to treatment planning;
9. Formal psychiatric diagnosis based on a clinical interview is not always obtained, depending on staffing resources and capability, with the greatest impediment being the availability of staff qualified to formulate a diagnosis in OASAS clinics;
10. Information regarding the co-occurring disorder is generally reflected in the narrative section of the assessment and, if present, is typically updated in progress notes and treatment reviews;
11. Assessment of an individual's readiness for treatment is generally not incorporated;

### **Treatment**

12. Treatment plans typically address the co-occurring disorder[s] but tend to regard the co-occurring disorder[s] as secondary, though a systematic secondary focus remains variable;
13. The interactive course of both disorders is generally not well addressed in treatment plans;
14. Emergency procedures for management of clinical crises tend to be communicated verbally as in-house guidelines and are infrequently codified;
15. Stage-wise treatment is generally not assessed or explicit in the treatment plan;
16. Many substance abuse treatment agencies have the capability to provide medication on-site for the mental disorder[s] while fewer refer to a collaborating service provider; mental health agencies do not generally provide medications related to the treatment of substance use disorders;
17. Specialized interventions with co-occurring disorders content tend to be based on the judgment and capability of an individual clinician and generally are not indicative of the routine use of evidence-based practices;



18. Although the treatment of co-occurring disorders is evident in many clinics, **significant use of the State's recommended Evidence-Based Treatments is not apparent.** With the majority of programs engaged in the process of moving to co-occurring capable (DDC), CEIC has been able to promote the addition of dual recovery groups and psycho-educational groups, and to provide assistance in enhancing the mental health or substance abuse content of the interventions that are already in place.
19. Education about co-occurring disorders is presented in generic form and content, and typically conveyed individually; when conveyed to a group, co-occurring information is informally integrated;
20. Clinicians incorporate family education and support variably;
21. Specialized interventions to facilitate the use of peer support groups, when available, are usually off-site and variably recommended;
22. Peer recovery supports for patients with co-occurring disorders are not commonly available. CEIC is now conducting *Building Recovery Workshops* for the collaborative cohorts (formed subsequent to the *Building Capability Forums*) to strengthen this feature of programming.

### Continuity of Care

23. Disorders that co-occur are usually addressed as secondary in the planning process for off-site referral;
24. Most clinicians usually assure that the appropriate referral is made and follow up to the extent possible;
25. Connections to peer recovery supports in the community are sometimes made depending on availability;
26. Medication is typically made available until a connection can be made with another provider off-site.

### Staffing

27. Limited access to a psychiatrist is a barrier for many substance abuse programs — those with access either have a psychiatrist on staff or collaborate with a mental health clinic;
28. Few clinical staff possess a license, certification or a formal determination of competency in the area of the co-occurring disorder[s];
29. Supervision or consultation is variably provided by a staff member or consulting professional;
30. Case reviews, when needed, emphasize and support co-occurring disorders treatment;
31. Alumni supports for clients with co-occurring disorders are not readily available;
32. The collaborative cohorts CEIC is building have considerable potential to overcome some of these deficits in developing cooperative agreements between substance abuse and mental health service providers. The *Building Capability Forum* discusses this potential and the *Learning Collaborative* explores ways of achieving the desired outcome.

### Training

33. Direct care staff are variably trained with respect to prevalence, common signs and symptoms, and screening/assessment — management typically encourages staff to participate, but does not have a formalized agency administrative training plan;
34. Direct care staff members are variably cross-trained.

### 3. Technical Assistance — Building Capability Forums, Building Recovery Workshops & Learning Collaboratives

#### Goal

When all agencies in the cohort have been assessed on site, CEIC convenes a "***Building Capability Forum for Providers***," which brings the cohort agencies together at a convenient venue. Early in the forum, aggregate results from the DDCA[MH]T Technical Assistance site-visit assessments are reviewed to identify a number of shared themes and to provide practical assistance on how to improve their current capability. At the conclusion of the *Building Capability Forum*, the participating providers are offered a *Building Recovery Workshop* and then invited to participate in a "Learning Collaborative" that CEIC supports through off-site technical assistance.

#### Activities/Accomplishments

CEIC completed six (6) *Building Capability*<sup>3</sup> or *Building Recovery Workshop* events (itemized below), attended by 70 providers and subsequently organized into 8 Learning Collaboratives. Another 2 Learning Collaboratives were organized from other Technical Assistance events and consultations that were held in Albany (20 programs; Northeastern Region), and in Monroe County (5 programs; Western Region), which results, to date, in a total of 10 Learning Collaboratives representing 95 providers.

- ▲ Five (5) *Building Capability Forums* were completed to follow-up with 56 providers.
  - July 30, 2009 — North Country — Clinton, Essex, Franklin, Hamilton Counties
  - September 23, 2009 — Long Island Cohort I — Suffolk County
  - October 22, 2009 — North Country — Jefferson & St. Lawrence Counties
  - November 9, 2009 — Long Island Cohort I — Nassau County
  - November 13, 2009 — Mid-Hudson — Orange County (TA request; cf. item 4)
- ▲ One (1) *Building Recovery Workshop* was completed that included 14 providers.
  - November 13, 2009 — North Country — Clinton, Essex, Franklin, Hamilton Counties

#### Next Steps

- ▲ Three (3) *Building Capability Forums* to be scheduled following the completion of site visits in:
  - Long Island (2) — Cohort II — Suffolk County  
— Cohort II — Nassau County
  - NYC (1) — Cohort I — All Counties (King, Queens, Bronx, NY, Richmond)
- ▲ Six (6) *Building Recovery Workshops* to be scheduled in:
  - North Country (1) — Cohort II — Jefferson & St. Lawrence Counties
  - Long Island (4) — Cohort I — Suffolk County  
— Cohort I — Nassau County  
— Cohort II — Suffolk County  
— Cohort II — Nassau County
  - New York City (1) — Cohort I

<sup>3</sup> One *Building Capability Forum* was conducted in conjunction with an individual TA consultation (Item 3 below). The forum was held in Orange County (Mid-Hudson Region); 5 programs (of 6 included in the original consultation) formed a Learning Collaborative.

▲ **Learning Collaborative** calls to be scheduled with:

- North Country (2) — Cohort I — Clinton, Essex, Franklin, Hamilton Counties  
— Cohort II — Jefferson & St. Lawrence Counties
- Long Island (4) — Cohort I — Suffolk County  
— Cohort I — Nassau County  
— Cohort II — Suffolk County  
— Cohort II — Nassau County
- NYC (1) — Cohort I

- Continue to extend these activities (Forums, Workshops, and development of Learning Collaboratives) to other regions and counties within NYC and across the State for the duration of the year and throughout the life of the Center.

## 4. Individual Technical Assistance and Training-of-Trainers (ToT)

### Goal

**Individual Technical Assistance.** CEIC employs a technical assistance request form and, when a completed request is received, a consultation is held. A planning format guides the process, permitting both CEIC and the requestor to track the progress. Agencies are encouraged to submit individual requests especially when some wider strategic gain can be identified such that surrounding services in other agencies will also benefit. Requests from counties associated with a co-occurring disorders project, or originating from counties where a provider forum is not scheduled in the near future, are most suitable for individual technical assistance and optimize the use of CEIC resources.

**Training-of-Trainers (ToT)** based on the *Inservice Training* curriculum that was developed in association with SAMHSA's Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-occurring Disorders*, are a means of rapidly disseminating knowledge and skills; by training trainers, the effect is multiplied since each person trained is then capable of training many more persons. NDRI staff were involved in two TIP 42 ToTs that were held in New York State immediately prior to the formation of CEIC; these ToTs trained about 50 trainers, which alleviated the need for CEIC to deliver a ToT during its first year of operations. In consultation with OASAS, CEIC is considering holding up to two TIP 42 ToTs during the second year of operations, depending on both interest and need.

### Activities/Accomplishments

**CEIC received numerous inquiries for general information and Technical Assistance; comprehensive consultations were conducted with five (5) agencies, including over 40 providers.**

- ▲ **April 9, 2009** — received from Kathy Ayers-Lanzillotta, Director of Catholic Charities in Long Island, requesting on-site expert consultation involving a presentation focused on ways to increase co-occurring capability in Catholic Charities substance abuse treatment programs. This was attended by approximately 30 direct service providers from Catholic Charities and partner programs in Suffolk County (**Long Island Region**). The on-site technical assistance was completed on May 20, 2009.
- ▲ **April 13, 2009** — received from Brad White, Dual Recovery Coordinator in Columbia County (**Northeastern Region**) requesting a review of COD capability for Columbia County's Recovery Services and Mental Health Center. These two assessments were conducted respectively on May 6, 2009 and June 12, 2009.
- ▲ **April 20, 2009** —received from Barry Hawkins, Director of Chemical Dependency Services, Orange County Department of Mental Health (**Mid-Hudson Region**) requesting a review of COD capability of various agencies involved in the Community of Solutions Initiative in Port Jervis, NY. This resulted in an on-site assessment of co-occurring capability completed in 6 individual programs, the final of which was completed on July 9, 2009. (A *Building Capability Forum* was also conducted 11/13/09; cf. item 3.)

- ▲ **October 12, 2009** — received from Dr. Ryan Bell, Psychiatrist II, Rochester Psychiatric Center, in Monroe County (**Western Region**) requesting on-site consultation to inform implementation of a co-occurring capable treatment model for a newly opened outpatient clinic. This consultation was conducted on September 23, 2009.
- ▲ **December 9, 2009** — received from Kelly Magennis, Community Mental Health Educator, Cornell Cooperative Extension of Jefferson County (**North Country Region**) requesting a 60-minute presentation on co-occurring capabilities and community strengths and weaknesses. The presentation will be based on the results from individual assessments of five providers in Jefferson County. This event has been scheduled for February 11, 2010.

## Next Steps

- CEIC will continue to process additional requests in a timely fashion.
- Two TIP 42 ToTs are being considered for 2010, one in early spring, and the other in the summer, depending on feasibility, interest, and the advice of OASAS.

## 5. CEIC's Mental Health and Substance Abuse Practices Survey

### Goal

The goal is to provide data from the Mental Health and Addiction outpatient programs in the areas of screening, assessment and evidence-based practices (i.e., the specific areas target by the Foundation, State OMH and OASAS and the Center). Achieving this goal provides information on the current status of programs in these areas and supplies baseline information for the evaluation of future change.

### Activities/Accomplishments

**CEIC staff constructed a survey instrument, upon request of the Foundation, to target the areas of screening, assessment, and evidence-based practices, after a review of existing instruments; Surveys were completed at approximately 80% of the 95 sites (i.e., 76) where DDCA[MH]Ts have been completed.**

### Next Steps

- Continue to administer this survey to all participating agencies.
- Analyze data to augment information used for the “snapshot” of co-occurring practices in the system.

## 6. Working Guide for Screening, Assessment & Evidence-Based Practices

### Goal

- To produce a “Working Guide” for implementing screening, assessment, and evidence-based practices.

### Activities/Accomplishments

**The “*Clinical Pathways Resource Guide*” was finalized and has been included with the supporting resources for all Building Capability Forums and other appropriate activities.**

- CEIC produced a *Working Guide for Implementing Screening, Assessment and Evidence-Based Practices*. For each module, the guide derives its content selection from the NYS COD Task Force “*Clinical Care Subcommittee*” discussions, and from reviews of the literature (Alexander & Haugland, 2000; TIP 42, CSAT [Sacks & Reis], 2005; Drake, O’Neal, & Wallach, 2008). The guide consists of four implementation modules:

- (A) **screening**, which presents a uniform approach with standardized instruments for both mental health and addiction outpatient settings (e.g., the Modified Mini Screen and K-6);
- (B) **assessment**, which imparts a domain or component approach to assessment (e.g., presenting problems, current symptoms and functioning, diagnostic impressions on all five axes of the DSM-IV);
- (C) **treatment planning**, which conveys development and use of a recovery oriented, person-centered, “Individualized Treatment Plan” (in development); and
- (D) implementation of selected **evidence-based treatments**

- The guide contains three additional elements, consisting of:
  - (1) the *Change Process* (from ATTC, 2004);
  - (2) a *Menu* of implementation targets; and
  - (3) a guide for implementing “COD Capable” services.

## Next Steps

- Make the *Clinical Pathways Resource Guide* available online when the full web site is launched. (The *Center for Practice Innovation*, is developing web-based TA materials, which should be available shortly (cf., item 11). It is anticipated that these materials will become CEIC’s primary TA resource.)

## 7. Website Development & Expansion

### Goal

To provide a central location for contact, information, resources, and communication.

### Activities/Accomplishments

**An introductory website was launched, replacing the contact page at <http://www.nyshealth-ceic.org> (with redirect from [nyshealth-ceic.com](http://nyshealth-ceic.com)); a short video describing CEIC and its activities is included. The permanent site has been coded and a beta site created, and content is in development.**

- Development team (Calfoloves Media Design) continues to work with us in developing the CEIC website; branding has been established and standard templates are in use for documents and presentations.

### Next Steps

- Our original plan was to have the permanent site up and running by the end of the project year (October 31, 2009); however, since CEIC activities continued to evolve, we decided it would be better to delay the switch to the permanent site until we were satisfied the content represented CEIC and its activities accurately. The expanded (permanent) site is expected to launch on or before July 1, 2010.
- Future development (late in the second year or early in the third year of the project) will consider the addition of a forum (using either discussion or blog software) to support *Learning Collaborative* activities and information sharing. The forum would permit online discussions of topics posted by CEIC staff. Again, we had planned to include this feature with the launch of the permanent site, but decided that it would be better to postpone until we have a better idea of how the collaboratives will develop and a better sense of their needs. It is also unclear whether our audience has sufficient computer interest to participate in any online interactive elements; this should become apparent as more collaboratives are formed.
- We are considering a variety of “value-added” possibilities for the second year —
  - ▲ composing blast email to announce the permanent site launch (with and without a video component);
  - ▲ assisting with initial use of the content management system by placing content;
  - ▲ increasing image use on the site by shooting a training session and gathering additional stock photos;
  - ▲ constructing tags, keywords, and introductory text for all pdf documents to be posted on the site; and
  - ▲ acquiring advice on tailoring language and style of content to suit the target audience.

**Table (A)1-7. Summary of CEIC Services — 11/01/08 through 12/31/09 (14 months)**

Service Item	NYS Regions (9 in total)	Number / highlight
1. <i>Regional Leadership Forum</i>	5 – Northeast, North Country, Long Island, Western, NYC	<ul style="list-style-type: none"> <li>▪ 5 <i>Leadership Forums</i> have been conducted;</li> <li>▪ 5 of the 9 Regions of NY State have been covered, including 32 counties with a total population of 14.8 million residents</li> </ul>
2. <i>Co-occurring Capability On-site Assessment &amp; TA</i>	6 – Northeast, Western, NYC, Mid-Hudson, Long Island, NYC	<ul style="list-style-type: none"> <li>▪ 95 providers/programs (43 OMH-licensed mental health settings and 52 OASAS-licensed substance abuse settings) had on-site TA assessment visits;</li> <li>▪ 6 of 9 regions and 18 counties</li> </ul>
3. <i>Building Capability Forums / Building Recovery Workshops</i>	5 – North Country, Long Island, Mid-Hudson, plus Western, Northeastern	<ul style="list-style-type: none"> <li>▪ 6 events in 3 Regions involved 8 counties and 71 providers;</li> <li>▪ other TA events &amp; consultation involved 24 providers in 2 regions;</li> <li>▪ resulted in a total of 10 <i>Learning Collaboratives</i></li> </ul>
4. Individual TA	5 – Northeastern, Long Island, Mid-Hudson, Western	<ul style="list-style-type: none"> <li>▪ 5 counties (one in each of 5 Regions) requested and were provided specific individual technical assistance;</li> <li>▪ 5 agencies and over 40 providers were served</li> <li>▪ staff have responded to numerous other general inquiries about CEIC and its activities</li> </ul>
5. <i>MH &amp; SA Practices Survey</i>	6 – Northeast, North Country, Western, Mid-Hudson, Long Island, NYC	<ul style="list-style-type: none"> <li>▪ at the request of the Foundation, surveys were conducted at approximately 80% of the 95 (=76) programs that completed DDCA[MH]T assessments</li> </ul>
6. <i>Working Guide for Implementing Screening, Assessment &amp; EBPs</i>	6 – Northeast, North Country, Western, Mid-Hudson, Long Island, NYC	<ul style="list-style-type: none"> <li>▪ distributed at Forum events and to be available online once the permanent site has launched</li> </ul>
7. Website Development	All 9 Regions	<ul style="list-style-type: none"> <li>▪ Introductory site launched;</li> <li>▪ permanent, expanded site in beta;</li> <li>▪ content in development for launch on or before July 2010</li> </ul>

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## **B. CEIC Outreach, Coordination and Collaboration**

### **8. Continued Promotional Activities**

#### **Goal**

To promote the Foundation and the Center to the field and to the public in order to maximize access to CEIC's services.

#### **Activities/Accomplishments**

**CEIC was the subject of 19 presentations to various organizations over the 14-month period.**

- Individual presentations were cited in the 4 quarterly reports completed over the project year. In November and December 2009, one additional presentation was given:
  - ▲ December 9, 2009 — Stan Sacks gave a presentation on CEIC and CEIC activities to the Columbia University Psychiatry Fellows at the request of Susan Deakins, MD.

#### **Next Steps**

- Continue to publicize the Center and plan future activity through presentations as requested.
- Promote the Center through CEIC activities.
- Staff presentations to promote CEIC and CEIC activities during the second year of activities has begun. To date, presentations are planned at the following venues/events:
  - ▲ NYAPRS, 6<sup>th</sup> annual Executive Seminar on Systems Transformation, to be held in Albany, NY, on April 22, 2010. Topic is "Integrated Dual Disorders Care Innovations."
  - ▲ Behavioral Health Services Research annual conference, "The Quality of Behavioral Healthcare: A Drive for Change through Research," to be held in Clearwater Beach, FL on April 12, 2010
  - ▲ ASAP 12th annual conference "Meeting the Challenges of Tomorrow: Serving Communities in New York State" to be held October 17-20, 2010 (date of presentation to be determined).

## 9. Activities with Partners & the Implementation Steering Committee

### Goal

- ▲ To review the purpose, approach, and current status/activities of CEIC.
- ▲ To discuss additional partners, and other approaches and activities that would maximize reach and impact.

### Activities/Accomplishments

**CEIC held its first Implementation Steering Committee meeting in January 2009 and continued communication with our partners concerning CEIC activities via distribution of our reports, e-mail exchange and phone calls; a second meeting for the current project year is being considered. Contracted services were delivered by our partners over the course of the first project year, and renewal contracts have been finalized for the second year's activities. In the process of these deliberations, CEIC reviewed activities and accomplishments from our various quarterly reports and discussed plans for the upcoming year.**

- NYAPRS (New York Association of Psychiatric Rehabilitation Services) is fully engaged in CEIC DDCAT/DDCMHT, Forum activities and joint presentations at NYAPRS conferences. NYAPRS has taken on additional responsibilities in conducting *Building Recovery Workshops* with each of the cohorts, which are designed to provide guidance on how to increase peer recovery supports in outpatient services. Accomplishments of the past year have been reviewed and a subcontract with NYAPRS is in place for the second year.
- CLMHD (New York State Conference of Local Mental Hygiene Directors) continues to assist CEIC to achieve its goals, particularly in planning for regional implementation rollout (e.g. *Leadership* forums). A subcontract is in place for the second year for CLMHD to continue assisting with these activities.
- NKI is involved in DDCAT administration, OASAS data discussions and exploration of potential data sources from OMH. Plans for the second year have been established and a subcontract is in place. NKI is expected to continue their existing activities, with Mary Jane Alexander especially involved in all matters relating to evaluation.
- CEIC confers regularly with ASAP about implementation roll-out, and planning of ASAP conference presentations; a subcontract is in place for year 2.
- CEIC participated at the MHANYS Annual Conference, October 30<sup>th</sup>. MHANYS continues its interest in CEIC activities and in offering to assist promotional activities in any way possible (e.g., through participation in conferences, access to space and equipment in Albany, information distribution using MHANYS website and eblasts), and to continue in an advisory role.
- NeATTC has concluded their activities for the year, and a subcontract is being discussed for Year 2. The role of NeATTC will likely consist of the provision of additional assistance with the on-site DDCA[MH]T assessments, and advisory activities especially in the areas of recovery and evaluation.
- CEIC maintains regular consultation contact with Dr. Richard Rosenthal, Senior Advisor and a subcontract for Year 2 is in place. Dr. Rosenthal will lead CEIC activities (e.g., presentations and discussions) that coordinate with various addiction medicine organizations, and will lead CEIC efforts in systemic regulatory and fiscal areas as needed in relation to statewide plans.

### Next Steps

- Continue regular contact and consider the utility and feasibility of holding a meeting of the Implementation Steering Committee to review past accomplishments and to discuss future plans.



## 10. Continued Coordination with OMH and OASAS

### Goal

To maintain contact, cooperation and coordination with State Agencies.

### Activities/Accomplishments

Regular contact was successfully maintained with both State agencies throughout the course of the report period. This consisted of several meetings, circulating of our reports and regular e-mail and phone contact with Jeff Gleba (OMH) and Pat Lincourt (OASAS), both officially designated as State Coordinators with CEIC; CEIC continues to maintain periodic contact with Drs. Sederer and McCorry.

### Next Steps

- CEIC will maintain regular contact with the two State offices (OMH and OASAS), using the mechanisms described above.

## 11. *Center for Practice Innovations* (CPI) Co-occurring Disorders Web-Based Training Initiative

The *Center for Practice Innovations* (CPI; a division of the Columbia Psychiatric Institute [PI], supported by OMH and OASAS), formerly known as the "Evidence-Based Practice Technical Assistance Center" (EBP-TAC), is developing co-occurring disorders-focused web-based training. CPI has partnered with experts at the Dartmouth Psychiatric Research Center to develop 35 half-hour modules that are designed for practitioners, clinical supervisors and agency leaders, and delivered online. According to the CPI website ([www.nyebpcenter.org](http://www.nyebpcenter.org)), access extends to the more than 1200 OMH and OSAS licensed clinics across NYS. The online modules "will use personal recovery stories, clinical vignettes, and expert panel presentations to inspire the learner, identify the need for integrated treatment for COD, provide knowledge and skills for practitioners, demonstrate ways for supervisors to assist practitioners, and suggest ways in which agency leaders can support this innovation." The co-occurring disorders modules are expected to include training in Integrated Dual Disorders Treatment, Assertive Community Treatment, Supported Employment, Wellness Management and Recovery, and Family Consultation. In the meeting of January 21, 2009, with OMH, CEIC, CPI and Dartmouth, It was agreed that CEIC would use the modules, as available, for its primary resource material.

The coordination of these two initiatives fosters the integration of product development and direct technical assistance, while promoting the most efficient use of resources. It assures both dissemination of online materials and access via technology to this state-of-art and science material for CEIC and its programs; thereby expanding CEIC's capacity to reach and penetrate the 1200+ outpatient clinics in New York State.

### Activities/Accomplishments

- A meeting with CPI, OMH and OASAS took place on September 17<sup>th</sup>, 2009, to coordinate CEIC and CPI initiatives.
- It was decided to convene a follow up meeting of the two Centers, plus OMH and OASAS, to coincide with the roll-out of the modules, and to follow-up on discussions among the training and technical assistance staff of the two Centers.

### Next Steps

- ▲ CPI is filming expert panel sessions for their online materials; John Challis has been invited to participate on the co-occurring disorders panel to be held on March 3, 2010.
- ▲ CEIC and CPI will discuss continued coordination of effort.

**Table (B)8-11. Summary of Outreach, Coordination & Collaboration —**

11/01/08 through 12/31/09 (14 months)

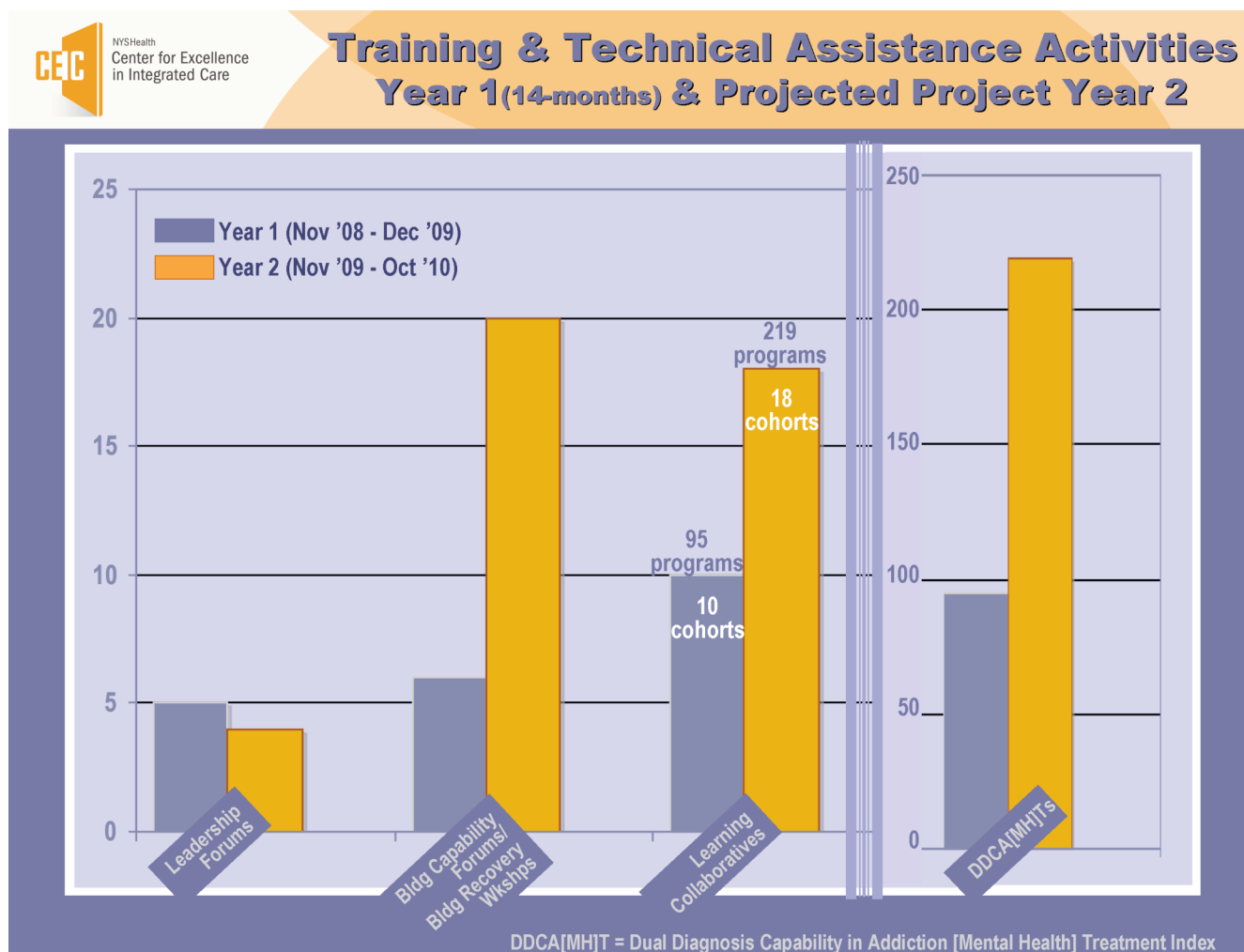
<b>Outreach, Coord/Collab</b>	<b>NYS Regions (9 in total)</b>	<b>Number / highlight</b>
<b>8. Continued Promotional &amp; Outreach Activities</b>	All 9 Regions	<ul style="list-style-type: none"><li>▪ 19 presentations to a variety of organizations and groups;</li><li>▪ Attendees from across NYState (and some from outside NYS)</li><li>▪ conducted <b>100 meetings</b> (face-to-face and via conference calls) with representatives of outside agencies.</li></ul>
<b>9. Activities with Partners &amp; the Implementation Steering Comte</b>	All 9 Regions	<ul style="list-style-type: none"><li>▪ Contracts with 6 main partners representing members statewide;</li><li>▪ Agreements with other collaborators; e.g., R. Rosenthal.</li></ul>
<b>10. Continued Coordination with OMH and OASAS</b>	All 9 Regions	<ul style="list-style-type: none"><li>▪ Regular contact maintained with both NYS Offices (OMH, OASAS);</li><li>▪ J. Gleba (OMH) and P. Lincourt (OASAS) designated liaison representatives.</li></ul>
<b>11. OMH Co-occurring Disorders Training Initiative</b>	All 9 Regions	<ul style="list-style-type: none"><li>▪ With the support of OMH, the Center for Practice Innovations (CPI), formerly EBP-TAC, is producing online modules for training in co-occurring disorders;</li><li>▪ CEIC, OMH, OASAS, and CPI are cooperating on this effort through regular contact, coordination and cooperation in the content and implementation of these modules.</li></ul>

## C. Projection of Future Activities

### 12. On-site Technical Assistance

**Figure C.12-1** shows CEIC's projected Year 2 activity (in comparison with the 14-month Year 1 activity) across several major technical assistance categories. It demonstrates CEIC's plan to expand (i.e., double) its direct TA reach and penetration and suggests that, with similar training and technical assistance activity in the subsequent two years, CEIC will provide direct training and technical assistance to the vast majority of New York State's outpatient programs.

**Figure C.12-1.** Summary of CEIC Services in 2009 and Projected for 2010 (Project Year 2)



## D. Advancing the Project

### 13. Strategic Plan — Reach & Penetration

CEIC has an ambitious **Strategic Plan** to reach and penetrate over 1200 mental health and substance abuse clinics throughout New York State (see **Figure D.13-1**, below). The plan involves the delivery of direct training and technical assistance (i.e., *Leadership Forums*, DDCA[MH]T Assessments, *Building Capability Forums*, *Learning Collaboratives*, *Building Recovery Workshops*, and Individual Technical Assistance, as described above). These direct methods are used in combination with other approaches, such as technological applications (i.e., use of a web-based learning system currently in development by the Center for Practice Innovations [CPI]), training-of-trainers and migration of influence; the latter involves spread of influence from a critical mass of several collaborative cohorts within any given region (nodes) to other providers within that same region. This combination of approaches is not only highly effective and efficient, but also is vital to the longer-term sustaining of the effort.

**Figure D.13-1.** Strategic Plan — Reach & Penetration

