A ROADMAP FOR BECOMING CO-OCCURRING COMPETENT

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LEARNING OBJECTIVES

• Recognize the role of the Chronic Disease Model in addressing the treatment of SUD and Co-occurring conditions

• Create a plan for integrating EBP Models into a System of Care focused on LOC needs ... supporting Value Based Program development

• Understand the use of transformational change principles in order to accomplish your goals
OUTCOMES

• Develop a path for INTEGRATING Behavioral Health Services – eliminating SILOS in systems of care

• Explore how to engage with a key partner: the Criminal Justice and Civil Court System

• SETTING YOUR SYSTEM UP FOR SUCCESS BY ENGAGING LEADERSHIP TO LINE STAFF IN ADOPTING A NEW WAY OF APPROACHING TREATMENT
CHRONIC DISEASE PERSPECTIVE

MH and SUD are Chronic Diseases of the Brain

• Chronic Disease Model
  • There is no “cure” but there is treatment
  • There is a pattern of relapse, remission, progression and disability
  • Treatment is medically driven and multimodal requiring life style changes
  • Continuous focus on improving EBP

• Family Impact of Chronic Diseases
  • Grieving process
  • Supporting Recovery
  • Life Style impact
BRAIN DISORDER

• Genetic and exposure/experientially driven impairments with permanent changes
  • Limbic system – memory, emotional tone and salience
  • Prefrontal Cortex – faulty input

• MH – Perception, Mood and Cognition

• SUD – Reward System
  • Craving
  • Diminished assessment of consequences
  • Inability to abstain from destructive behavior
“DO YOU REALLY WANT TO KNOW”

• Barriers
  • Preconceptions
  • Silos
  • Too close to home

• What you need to ask … assume the answer is yes
  • Review all substances, quantity and duration
  • Discuss impact on functioning, relationships and admissions

• Data
  • UDS with quantitative measure when appropriate
  • Screening Tools
  • Ongoing monitoring
ASSESSING TREATMENT NEED

• ASAM Criteria
  • Intoxication/withdrawal potential
  • Physical Health
  • Mental Health
  • Readiness to change
  • Risk of Relapse
  • Recovery Environment

• Four Quadrant Models
  • MH and SUD disease burden
  • Motivation – Intrinsic vs. CJ
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INITIAL MEDICATION MANAGEMENT

• Rescue Treatment – Narcan
  • Should trigger attempts to engage with treatment
  • Provide to patients leaving detoxification services

• Detoxification
  • Opioids - Uncomfortable
    • Symptomatic
    • Short term substitution
    • Transition to Brain Stabilization
  • Alcohol/Sedative Hypnotics – Life Threatening
    • Substitution - Benzodiazepines
    • Vitamins
INTERMEDIATE AND LONGTERM MEDICAL MANAGEMENT

• Post Acute Withdrawal – short term symptom management
  • Trazodone/Doxepin, Gabapentin, Hydroxyzine
• Brain Stabilization – based on ability to remain abstinent from other substances
  • Methadone
  • Bupenorphine – OBOT Clinics
• Psychotropic Medication
  • Avoid Quetiapine, Bupropion, Anticholinergics and Benzodiazepines
• Receptor Blockade
  • Alcohol and Opiates
  • Oral or LTI Naltrexone
DATA DRIVEN DECISION MAKING

• Screening
  • ASSIST/AUDIT/ CAGE/PHQ 9
  • BAM – Brief Addiction Monitor
    • Pattern of Use
    • Risk Factors
    • Protective Factors
• UDS - frequent and unannounced
• Monitoring – are your services making a difference
  • Craving Tools
  • ORAS – CJ Tool
  • DLA 20
STAFF SKILL SET – IT’S A PARTNERSHIP

- Respectful Engagement – can they ask the questions without judging
- Tolerance for patient “failure” and “dishonesty”
- “Investigative Reporter”
  - Healthy skepticism
  - Identify Discrepancies
  - Research – PDMP, Arrest History
- Set positive – and firm – boundaries
- Self Awareness
  - Humility – expert but not the driver of recovery
  - Dissonance and countertransference
PROGRAM STRUCTURE

• EBP Models are plentiful – implementation with fidelity is the problem
  • Training and education
  • Monitor implementation especially as staff turns over
• Clear and consistent structure, expectations and consequences combat the specific brain deficits of Co-occurring conditions
  • Doing the right thing even when it is met with anger and denial
  • Your expertise is what you bring to the partnership
• Continuity and warm handoffs are essential for success within your system and your community
  • Establish partnerships and learning opportunities
  • Build in clear crosswalks as individuals progresses through treatment
WHERE DO YOU BEGIN

• Collective Impact Model – Structured Community Collaboration
• Involves commitment and engagement
• Five Essential Premises
  • Common Agenda
  • Shared Measurement
  • Mutually Reinforcing Activities
  • Continuous Communication
  • Backbone Support
• What local committees or forums would allow you to enter into a collaborative effort with stakeholders? Who can take the lead?
CREATING A PARTNERSHIP WITH THE CJ/COURT SYSTEM

• Find common ground and areas of mutual interest
  • Episodic Treatment Systems
  • Goal is to implement Value Based Care
  • Successful Transition between systems/levels of care is critical
• Establish committees and work on joint projects
  • MHSATF
  • Reentry committee
  • Problem solving courts and outpatient commitment laws
  • CIT Training
• Consultant and Service provider – become boundary spanners!
STRATEGIC MAPPING

• Sequential Intercept Model – GAINS Center Model to prevent further penetration into the CJ System
  • Local Law Enforcement
  • Initial Court Hearing
  • Jails/Courts
  • Reentry
  • Community Corrections
• Service Gap Analysis (as opposed to financial GAP Analysis)
  • Intra-agency
  • Community
  • Stakeholders
ONE SYSTEMS JOURNEY

• Seminole System of Care – a founding partner of Aspire Health Partners – and SCSO forged a partnership after a significant local tragedy

• Foundational Building Blocks
  • Public Safety and MHSATF
  • CIT Training
  • Co-occurring Competence

• CQI Process – building a continuum
  • Outpatient Commitment
  • Problem solving courts

• The Opiate Taskforce and beyond
THE SEMINOLE SYSTEM FLOW

- Multiple points of entry and treatment paths, one team
THE SEMINOLE EXAMPLE: TEAM COMPETENCE

- Ensuring a Co-Occurring Competent treatment team
  - One leader, equal voices among team members
    - No single guru mentality
  - Empowering members as “experts” in their areas
    - Recognize value in varying program perspectives
  - Encouraging cross communication
    - Successful teams cross credential barriers
  - Maintaining “wrap-around” care
    - Truly a team approach to client care minimizes chances of someone slipping through the cracks
THE SEMINOLE EXAMPLE: CQI IN ACTION

• How CQI has shaped the Seminole System
  • ADC: Internal/external reviews, DATA, ongoing education and commitment to change
    • Past enhancements: Patch, TIC (EMDR)
    • In process: Expanded testing hours, groups, NARCAN for families
  • CJ Partnership: Identified access barriers lead to SPA, homeless outreach partnership, provider symposiums
  • Opioid Council: Peer enhancement, sequential mapping for identifying service gaps
THE SEMINOLE EXAMPLE: VALUE BASED CARE

- Co-Occurring Competence delivers VBC!
  - Track your data so your funders know it too!

- ADC Outcomes:
  - National Institute of Justice 2005 report on recidivism indicates:
    - 67.8% re-arrest rate 3 years out of prison
    - 56.7% of this group re-arrested <1 year out
    - 76.9% of drug offenders were re-arrested at any point
    - [https://www.nij.gov/topics/corrections/recidivism/pages/welcome.aspx](https://www.nij.gov/topics/corrections/recidivism/pages/welcome.aspx)
  - Seminole County ADC results (per 12/28/2018 report by Brooke Research & Consulting, LLC):
    - 242 enrolled from October 2015 – June 2018
    - 109 (45%) successful graduates, 62 still active (26%)
    - Year 1 Cohort Recidivism (after year 2): 25 (10%)! *not specific to program status
THE SEMINOLE EXAMPLE: VBC

Case Example: AOT Treatment Path (Severe SUD + Severe SPMI)

- Pre-AOT services
  - 10+ CSU admissions in 3 years
  - Minimal engagement in Psych Med Clinic, no other engagement
  - High risk for CJ involvement, low motivation

- During AOT services
  - Psych Med Clinic
  - PSR (w/ Co-Occurring group overlay)
  - Short-term residential w/ TCM
  - 3 Acute Care admissions

- Post-AOT services
  - 0 Acute Care admissions
  - Ongoing engagement w/ Psych Med Clinic
  - Guest speaker at PSR
TAKE AWAYS

• Brainstorm your vision internally and with community partners
  • Create Collaborative Work Groups to achieve specific goals
  • Plan implementation based on current strengths and financial resources
  • Establish timelines you can – AND WILL - keep
  • Create pilot projects for proof of concept
• Measure your successful outcomes
  • Person Centered Functionality, HEDIS Measures and Screening/Monitoring Tools
  • Transform successful pilots into cost saving, Value Based Services
  • Use data to support funding and grant requests.
CRISIS CREATES the OPPORTUNITY for
TRANFORMATIVE CHANGE
in your
SYSTEM OF CARE

TALK is CHEAP … ACTION PLANS with TIME FRAMES are a
COMMITMENT to CHANGE
QUESTIONS?