


# THE PITFALLS AND POSSIBILITIES OF MERGING MULTIPLE MODALITIES OF TREATMENT

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Historically correctional systems have operated under individual silos. This includes security, medical, classification, mental health, addiction services and more

Each silo has its own set of standards, supervisors, policies and practices, offices and work areas and especially their own ideas of the best way to do business

This is in no way any different than how we operate outside of corrections. It has been often noted that a state correctional system is like a fragment of the larger society. . . with its own set of norms, mores, sub-cultures and values



Silos aren't inherently bad. They are often needed to provide structure and reduce chaos. However as our needs change sometimes the structure needs to be changed as well.

Silos can obstruct or appropriately modulate change

# What we'll talk about today

- Identify both potential and required systemic changes to integrate care (curriculum, staffing, supervision, etc.)
- Understand both direct care and administrative dynamics when systemic changes occur (employee dynamics)
- Know and understand how this type of change can impact national outcome measures
- The challenges of integrating multiple programs, staff, agencies, and supervisors into one program for a client / patient
- Discuss how some components did and did not go as expected and the learning curve we are still going through
- Opening the doors to further discussion among various disciplines that need to work together in treatment /correctional settings

# What **ARE** you talking about?

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# New Technologies change our needs

E mail has created shifts, obstacles and possibilities

E mail alone has an integrative function or potential, it can influence process

# Pitfalls

Most definitions and rules are implied, self imposed or have unknown origins.

**shoulds**

Like culture, language, and computer software it is difficult to traverse this terrain without a shared language or common ground

Not knowing where the silos are connected



## STRUCTURE

Even our overriding federal structure SAMHSA and the Connecticut state structure DMHAS looks like two separate entities

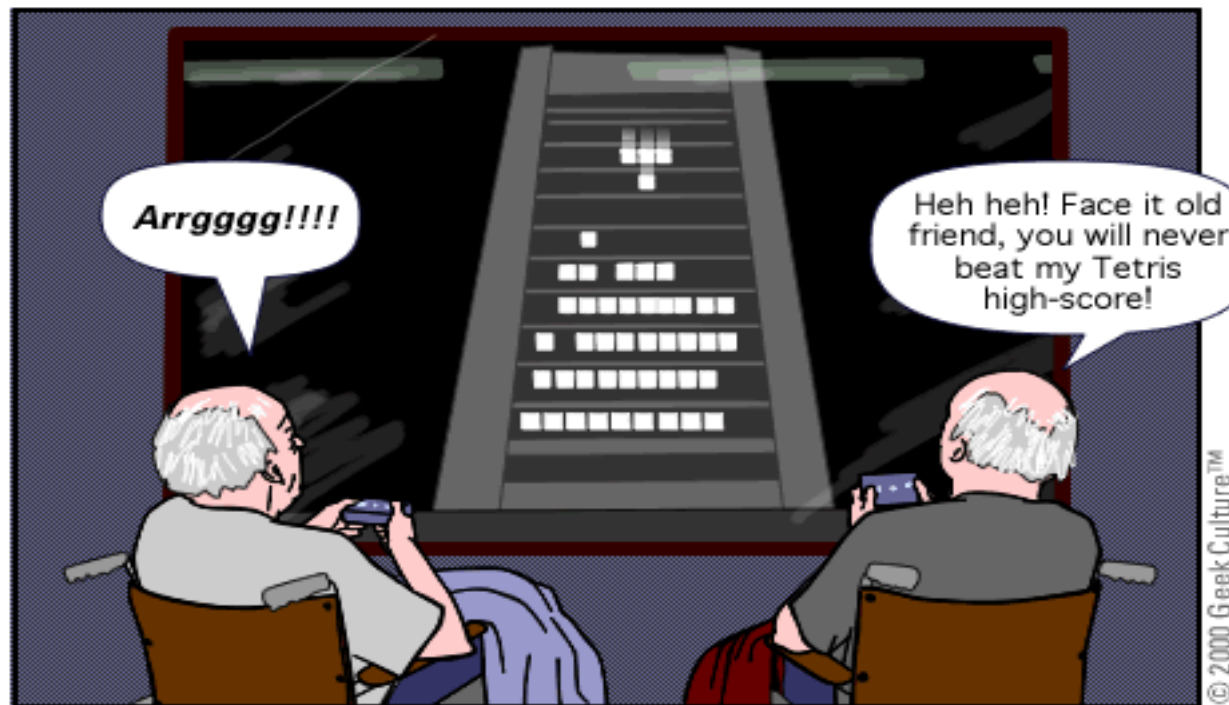
*“America and England are two nations divided by a common language”  
Oscar Wilde*

“Our unit as a whole combined Medical, MH, and Addiction but our system is a functional system organized by functions as if these functions live in a vacuum

# Nothing lives in a vacuum

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## What is a silo?

Silos include certification, licensure, funding sources, historic tasks and functions, education, curricula, policies and procedures, confidentiality laws, professional organizations, location of offices, org charts, record keeping, supervision chains of command



## OUR SILOS

- **Custody**
- **MH**
- **ASU**
- **Medical**

Our Co-occurring team

There is a consensus in the field that the integration of mental health and addiction services is a pre-requisite for meeting the needs of an increasing number of individuals with co-occurring disorders. The Connecticut Department of Correction takes this one step further and designed a pilot to expand the system to a truly integrated approach that includes Addiction, Mental Health, Medical staff and custody.



## OUR SILOS

### **Custody:**

- Includes classification, correctional officers, program staff, etc.
- They act interdependently
- CO's have the least health services training but spend the most time observing, interacting and referring
- Safety and security - discipline and structure  
“making trains run on time”

## OUR SILOS

- **Mental Health:** screening intakes with tools of assessment that are inclusive of AS information.
  - Residential treatment and programming in specialized housing
  - Referral to Addiction Services on individual treatment plans
    - » ASU does not treat MH level 4's ( those in special housing)
  - Little if any contact with Addiction Services
  - Referral to medical (only on paper)



## OUR SILOS

- **Medical:**
  - Intake screening of all inmate
  - Handle all inmates with HIV
  - Order and administer psychotropic medications
  - Little if any contact with MH except by policy on missed meds
  - No contact with Addiction Services
  - are separate parts of charts from MH and separate charts from ASU



## OUR SILOS

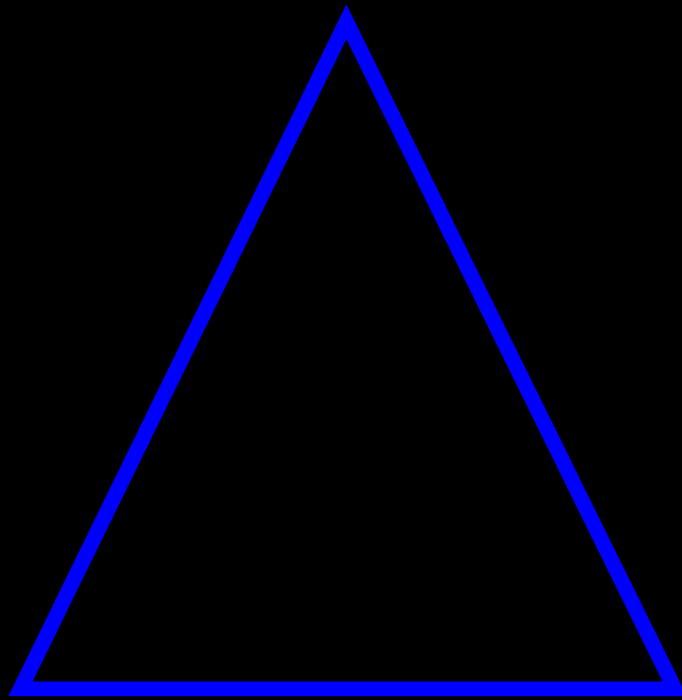
- **Addiction Services:**
  - Screen all inmates with T CUDS
  - Assess all inmates going to prison with ASI
  - Tier III and IV residential treatment program
    - » exclusive of MH 4's
  - No formal contact with health services
  - Addiction Services attend roll call daily

# The Impact of Silos

- 35,000 intakes = 1/2 million pieces of paper
- Office Space
- Programming - Anger Management x4
- Administrative Layers

# Influences on Change

- **Readiness-** Systems and people works in similar ways. “sometimes quickly sometimes slowly”
- **External forces-** Lawsuits, consent decrees, funding sources, political landscape, memes
- **Champions** - change agents with broad bases
- **Structure** - is there a structure in place that has to change and is there one to support the new outcome
- **Support** - regardless of any of the above, like people, systems need supports to keep the momentum



# Where are we with integrated treatment?

- Pre-contemplative: pre 1998
- Contemplative: 1998 - 2008
- Preparation: 2002-2008
- Action: 2007 -2008
- Maintenance:
- **Relapse:** *Recycling through stages. Each action bring about an opportunity for a pre-contemplative state for another level of change*

# Serendipity

## A time line of fortuitous events

**1998 :** CT State legislature passed a law requiring substance abuse counselors to be licensed or certified. CT State agencies were exempt from this law.

**1998-1999:** model attempted , training and meetings were happening together. ASU / MH met for training but disintegrated without infrastructure, oversight and supervision to support it.

**2002:** DOC removed from state agency exemption, giving DOC 5 years to achieve certification for its 100 counselors and supervisors.

### **2003: Champions and positions created**

Consolidation -staff eliminated from GCI where MH housing was to be concentrated. The expectation would be for co-occurring support from MH.

# Serendipity

## A time line of fortuitous events

**2004:** National Policy Academy on Mental and Substance Abuse Disorders - developed co-sig-

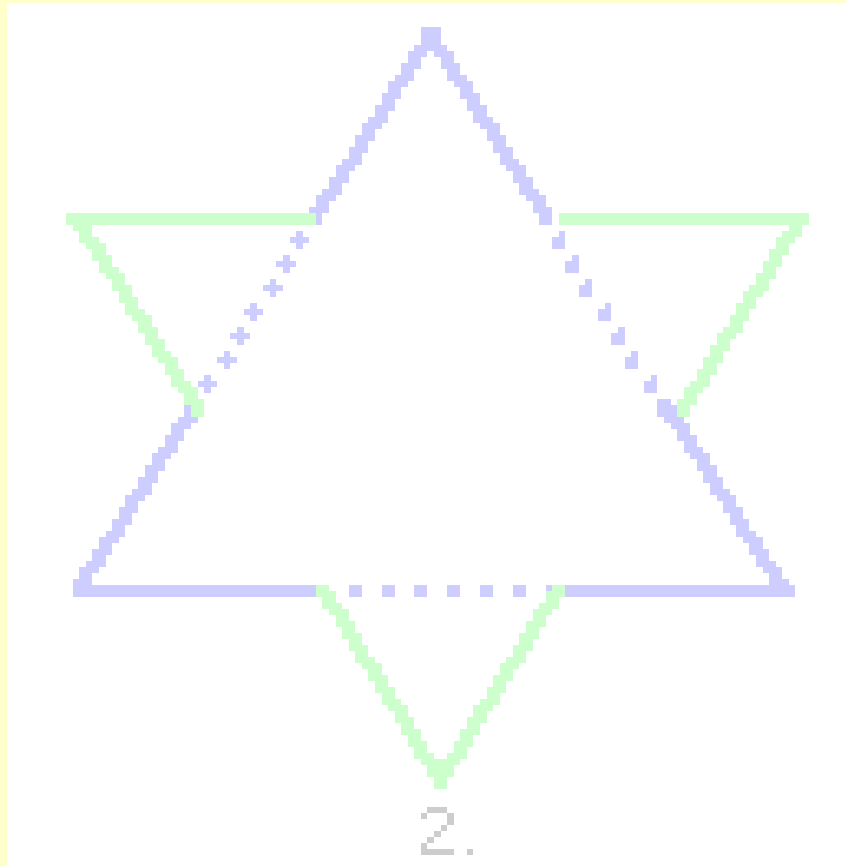
Orientation units created opportunity at intake centers to agree to the placement and immediate needs of an individuals ( first stab at integrated treatment)

**2005:** SAMHSA MH transformation grant created , workforce development emphasis Co-Sig grant awarded to DMHAS - training of staff throughout DMHAS for co-occurring

- MOA with UCONN amended to create co-occurring capable workforce

- Statewide language shift to one of recovery orientation instead of treatment

**2006:** Treatment at GCI was not going as planned. Four competing plans for facility programming.



# Pitfalls Become Possibilities

- Office space for the Health and Addiction Services Unit
- Premature release of ASU staff from MH facility
- Understaffed MH unit and an under staffed AS unit
- ADA issues - MH4 not having access to Addiction services
- Antiquated technology

# “ JUST DO IT ”

April 2007 Champion says “make it happen”.

Co-chairs appointed

Committee is created

Mission Decisions

# Pilot Process

- Use simple pilot to identify custody/facility obstacles - Garner CI selected
- Committee membership - administrative and staff representatives
- Get integration “buy-in” - respect silo(s)
- AS staff is a member of the treatment team
- Do we really want to do this? Possible impacts for all. (Restrain change intervention)

# Pilot Process (Round 2)

- Focus on facility needs and facility changes/supports required
- Identify target group - who and how many?
- Use tasks to increase co-occurring staff interaction - curriculum and ASI
- Adjust staff schedules/responsibilities
- Homework for all committee members

# Uh Oh

## “Silo” issues come to the forefront

- Individual counseling - Who is doing the “real” clinical work? Who is doing “just” case management?
- Liability - What if someone is suicidal?
- Though all AS staff go through ASI administration training MH Social worker really doesn’t need to. Implies that Social Work staff as more “expert”
- Committee absenteeism
- Lack of certified staff at UCHC/CMHC to get staff co-occurring certification at GCI. Additional resources (\$) will be needed to develop co occurring capable health services workforce at other facilities
- Identified MH staff goes to second shift for personal reasons
- Custody pushing to have 2 “problem” inmates included in pilot group
- No line Medical staff identified for committee. HSA only

# Good News / Bad News

- There is something new happening
- Resistance is more overt
- Problems are better defined
- Problem solvers are identified

Lets go back to the old way

“The sky is falling”

This is too much trouble

Hope-disappointment cycle

# Process to Product

- AS staff will chart in Health Record chronologically with MH and Medical notes
- Goal to have one integrated treatment plan per inmate per year (format of Individual Treatment Plan to be determined by Co-occurring Committee)
- New Curriculum to be developed by committee.
- Let's ask the inmates - Client Evaluation of Self and Treatment
- Decision approved to put Addiction Services tab in Health Record for TCUDS and ASI's

# The “Tab”

- Seemingly inconsequential but significant in potential impact
- Involves every inmate (35,000 intakes per year)
- Health Record Management - location, filing, accountability
- Stepping stone toward integrated screening and assessment

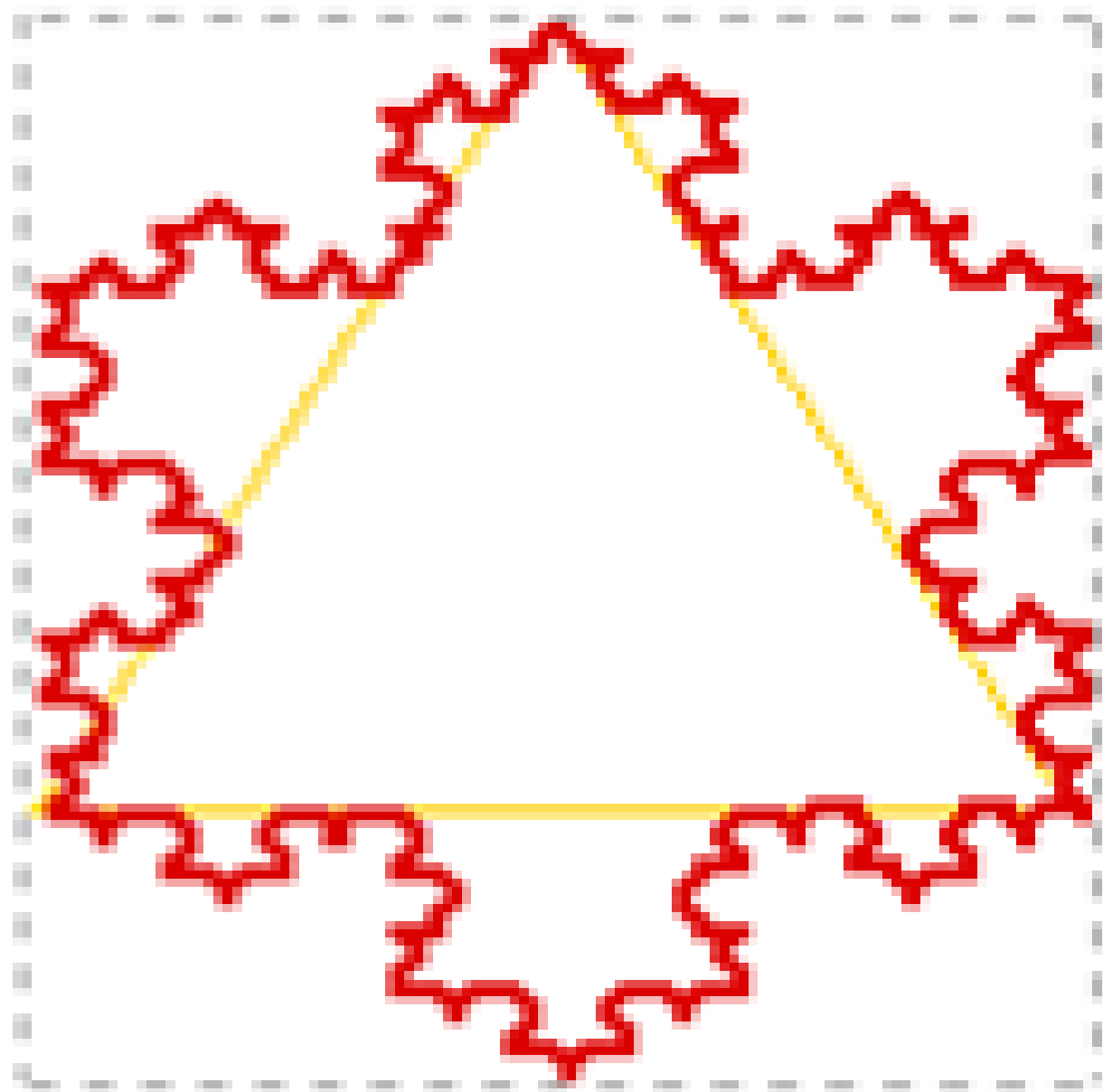
# Structural Changes

- Health records changes -Tipping point
- Supervision and case loads
- Creating dynamic tension - “new dance”
- Enhances sustainability



There are those who will eagerly embrace change and those who'll stand rigid holding on to conventional habits





4.

## The Coney Island Polar Bear Club



We're all in this together