State of New Jersey
DEPARTMENT OF HUMAN SERVICES
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September 27, 2010

Dear Mental Health and Addictions Community,

On behalf of the Co-Occurring Mental Illness and Substance Use Disorders Task Force (COTF), the New Jersey Division of Mental Health Services (DMHS) and the New Jersey Division of Addiction Services (DAS) are pleased to release the task force's final report. We wish to express our gratitude to members of the Task Force who dedicated their time and valuable knowledge to this process.

The COTF was established by and operated under the authority of the Department of Human Services' (DHS) Division of Addiction Services (DAS) and Division of Mental Health Services (DMHS) and met from February, 2009 through April 2010. The COTF was charged with the responsibility of conducting a thorough analysis of the systems that provide co-occurring services in New Jersey.

The enclosed report represents the efforts of the broad range of stakeholders who participated in the COTF, including representatives of state agencies, non-profit mental health provider organizations, non-profit substance use disorder provider organizations, consumers, and professional trade associations. The recommendations proposed by the COTF and its subcommittees will guide the development of a more competent system of treatment for clients with co-occurring disorders in New Jersey. The processes and recommendations discussed in this report are an integral component of the Department's commitment to improve the services offered to the individuals and families affected by COD. Work is already underway to implement some of these recommendations, including the establishment of a stakeholder merger advisory committee for the new Division of Mental Health and Addiction Services (DMHAS), a review of client information systems and opportunities for collaboration, and the initiation of efforts to coordinate consumer advocacy activities.

It is important to note that the initial work and recommendations of the COTF were completed prior to the announcement of the official merging of DMHS and DAS into DMHAS as reflected in the State Fiscal Year 2011 budget. Subsequent to the merger announcement, the COTF members requested that the subcommittees reconvene and revisit their recommendations in light of the merger announcement. The subcommittees

revised some of their recommendations and these changes were compiled into the COTF's final report submitted to DMHS and DAS. Although the time for this additional effort delayed the release of the final report, the COTF and the divisions thought it essential that the published report give consideration to the merger. The Department of Human Services and DMHAS will consider all of the COTF recommendations and implement them to the extent feasible.

Sincerely,

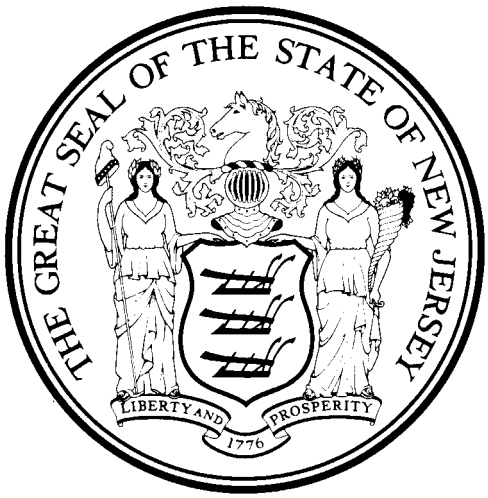
Valerie L. Larosiliere
Acting Assistant Commissioner
Division of Mental Health Services

Raquel Mazon Jeffers
Director
Division of Addiction Services

Enclosure

NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Report of the New Jersey Co-Occurring Mental Illness and Substance Use Disorders Task Force



September 2010

Introduction

The following is a synthesis of the findings and recommendations of the New Jersey Co-Occurring Mental Illness and Substance Use Disorders Task Force (COTF). The COTF was established by and operated under the authority of the Department of Human Services' (DHS) Division of Addiction Services (DAS) and Division of Mental Health Services (DMHS) and met from February, 2009 through March 2010. The COTF was charged with the responsibility of conducting a thorough analysis of the systems that provide co-occurring services in New Jersey. The goal of the COTF was to produce a three to five year strategic plan that, when implemented, will articulate the vision of a co-occurring competent system of care for New Jersey.

It is important to note that the COTF conducted its work prior to the State Fiscal Year 2011 Budget that merges the two divisions into the Division of Mental Health and Addiction Services (DMHAS). As DMHAS works on the merger over the course of SFY 2011 and beyond, it will incorporate, to the extent possible, recommendations detailed by the Task Force. Virtually all of the analyses and recommendations discussed in this report continue to be highly relevant in the context of this interdepartmental merger, as well as implementation of the Patient Protection Affordable Care Act (PPACA). Since a substantial (and possibly a majority) proportion of individuals who will be treated by DMHAS will have co-occurring disorders (COD), the information contained in this report, therefore, can be of invaluable assistance to the planning and conduct of this interdivisional integration.

The recommendations proposed by the Co-Occurring Task Force and its subcommittees will guide the development of a more competent system of treatment for clients with co-occurring disorders in New Jersey. The processes and recommendations discussed in this report are an integral component of the Department's commitment to substantially improve the services offered to the individuals and families affected by COD. Specific measures to identify, understand, address and overcome existing and other emerging barriers must be developed. The complexity and arduousness of this vitally important work necessitates that the entire process is continually evaluated by the new DMHAS. The Task Force stressed the importance of flexibility and adaptability as guiding principles for state, local, hospital and community based agencies in the evolution toward a more integrated treatment system.

Though the divisions are merging this fiscal year, they continue to operate as two functional divisions at this time and are described as such for purposes of this report.

Process

The COTF membership was selected through a public process and consisted of 33 individuals who were highly qualified and experienced in addressing the issue of co-occurring mental health and substance abuse disorders (COD). Members of the COTF

represented a variety of professional disciplines, services, and work settings. Consumers of co-occurring services were also represented on the Task Force, as were all geographical regions of the state. The COTF was organized into three subcommittees: Systems Integration, Services Integration, and Workforce Development.

Each subcommittee addressed five basic issues and questions which served to guide the groups' discussions. Those discussions were focused upon the specific concerns applicable to each subcommittee and were stimulated by the following:

1. Describe how the system currently exists (and functions) in relation to the areas outlined for each subcommittee.
2. What are the specific strengths and weaknesses?
3. What are the gaps in the system?
4. What are the groups' specific, actionable recommendations for improvement, and movement towards a co-occurring competent system?
5. What barriers exist (or that may arise), that need to be addressed in order for the recommendations to be successfully implemented?

Presentation of the Recommendations has been organized into four Domains: **Services; Administrative; Workforce Development; and Fiscal/Funding.** The **Fiscal/Funding** area was an issue, in some form, for each subcommittee, and appeared of enough concern to warrant its establishment as a separate Domain.

It should be noted that there were multiple areas in which the subcommittees made the same or similar recommendations or action steps. Where possible and appropriate, the material produced by the subcommittees has been synthesized in this report.

Analyses and Recommendations of the COTF Subcommittees

Analysis of the Current COD Treatment System:

Strengths:

- Recent significant improvements in communication and cooperation between DMHS and DAS.
- Direct service personnel in both divisions are dedicated and wish to enhance their professional skills.
- Many supervisory personnel have skills and credentials in both mental health (MH) and substance abuse (SA) related fields.
- Clients are becoming better educated consumers of treatment services.
- DAS and DMHS have substantial evidence of the effectiveness of COD treatment services when those services are competently delivered.
- The DAS Co-Occurring Network has been implemented and is available to qualifying agencies.
- Integrated Dual Diagnosis Treatment (IDDT), an evidence-based practice, has been integrated into much of the DMHS system of services. A notable exception is the state hospital system, which has not incorporated IDDT.
- New Jersey has a number of colleges and universities with degree, and/or certification, programs in various mental health and addictions-related fields.
- Implementation of the merger of DMHS and DAS offers opportunities to improve Co-Occurring Disorder (COD) treatment services.

Weaknesses and Gaps:

I. Services Integration Gaps

- Lack of standardization of data collection for all relevant State agencies.
- Lack of affordable housing for co-occurring clients.
- Inadequate case management, care coordination, and peer support to match client's level of need.
- Lack of standardized screening and assessment.
- Lack of electronic records with client identifier across systems.
- Inconsistent use of evidence-based practices specific to COD.
- Even when both MH and SA treatments are provided at the same location, those treatments are generally separate and parallel, rather than integrated.
- Gap in access to medical care for co-occurring clients.
- Lack of access to smoking cessation diagnosis and treatment at the community level.
- Limited number of self-help groups and drop-in centers for co-occurring clients.
- Inconsistent application of trauma-informed treatment.

II. Administrative Integration Gaps

- Regulations are not consistent between divisions.
- Lack of shared funding and shared goals, between divisions for the care of co-occurring clients.
- Lack of standardized funding mechanism for co-occurring services.
- Some of the co-occurring populations, such as compulsive gamblers, are inadequately served within either treatment system.

III. Workforce Development Gaps

- Lack of a dually competent workforce that can be shared across both systems.
- Lack of standardized clinical supervision across systems.
- Medical professionals: Physicians, Advance Practice Nurses (APNs) and psychiatrists are not cross-trained.
- Continuing to persist in both the SA and MH fields is the prevailing misconception that persons with COD constitute a limited subgroup of the client population. This distortion contrasts with the more valid understanding that co-occurring symptomatology is to be expected in the population of persons seeking SA and/or MH services. As a result, each system (i.e. MH and SA) tends to under diagnose or misdiagnose clients in the corresponding category.
- There is a critical need for improved communication and cooperation among the multiple systems, organizations and providers that serve the COD population.
- There is paucity in the amount and availability of specific, COD-related education and training throughout the relevant systems.
- There are not agency level or regulatory requirements, and often, no encouragement for staff in one system (e.g. MH) to pursue training in subjects associated with the other system (e.g. SA).
- There is substantial difficulty in the recruitment, hiring and retention of persons qualified to provide co-occurring services. For example, experienced, well-trained personnel often leave DAS or DMHS treatment programs to work in other systems (e.g. Criminal Justice, the private sector, etc.).
- Clinical supervision is often inconsistent, inadequate, or non-existent in agency/clinical settings.

Problems, Recommendations and Action Steps of the COTF Subcommittees

Below are identified problems, recommendations and action steps that the divisions and partners should engage in. As the divisions begin to work on implementation, Action steps will need to be more specifically defined.

Services:

1. **Problem*:*** There are historical disparities in philosophies and approaches in the Mental Health and Substance Abuse fields on a systematic level. This impacts client care on all levels including but not limited to:

   - Access
   - Service Options
   - Coordination of Care
   - Appropriateness of care
   - Outcomes

   Recommendation: Use the merger of DAS and DMHS as an opportunity to develop a new model for holistic treatment.

   Action Steps:

   A. Develop regulation that supports a mutual philosophy of client centered treatment that also addresses all four quadrants of COD and those clients who are diagnosed exclusively SA or MH.

   B. Develop a unified Client Information System to capture all salient client data.

2. **Problem:** People with COD who seek admission to MH or SA agencies are often inadequately screened or assessed at intake, and consequently, do not receive the appropriate treatment.

   Recommendation: The system should ensure appropriate screening, assessment and treatments and/or referral.

   Action Steps:

   A. All agencies should provide a screening for the presence of a COD symptoms or disorder that can be used as a catalyst for further assessment or referral.

1. MH agencies must screen all applicants for admission for SA disorders (in addition to the expected assessment for MH issues), using one (or more) of the following screening tools:
   i. Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
   ii. Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
   iii. CAGE* AID (CAGE Adapted to Include Drugs)
   iv. TWEAK (Tolerance, Worried, Eye-opener, Amnesia, K/Cut down)—Screening for alcohol abuse/dependence in women.
   v. Drug Screening for all clients.
   vi. Screening for process addictions, i.e. gambling, sexual etc.
   vii. Screening for trauma exposure and PTSD

2. SA agencies should screen all applicants for admission for MH disorders (in addition to the expected assessment for SA issue), using one (or more) of the following screening tools:
   i. Mental Health Screening Form – III (MHSF-III)-(Gambling and Sexual addiction addressed in this tool.)
   ii. Modified Mini Screen (MMS)
   iii. K6 Mental Health Screening Tool
   iv. Screening for process addictions if not otherwise covered
   v. Screening for trauma exposure and PTSD

B. DMHAS should require that all clinical evaluations at both SA and MH agencies would include the same areas of assessment that would be required by licensure and contracting. Those areas of assessment can be found in *Addendum 1.*

C. Screeners in both systems are adequately trained and competent to screen for both MH and SA.

3. **Problem:** Interventions used in the treatment of COD often neither adequately engage the client, nor produce desired outcomes.

Recommendation: Evidence-based and emerging practices should be the foundation of treatment for adults with co-occurring disorders.

Action Steps*:*

A. Require and support the implementation of evidence-based, person-centered and emerging practices in DMHS and DAS contracts and licensure. The Subcommittee recommended specific evidence-based and emerging practices that can be found in *Addendum 2.*

4. **Problem:** Housing and related services are often inadequate or nonexistent for consumers with COD.

   Recommendation: DAS and DMHS should collaborate (with each other and with other relevant organizations) in order to facilitate the development of housing that meets the needs of COD consumers.

   Action Steps*:*

   A. DAS and DMHS should collaborate to identify housing resources and gaps appropriate for co-occurring service needs.

   B. The two divisions should examine the housing resources to identify the range of housing available for COD consumers.

   C. Where indicated, DMHS and DAS would collaborate to increase the availability of housing and related services appropriate for persons with COD.

5. **Problem:** There is a need for uniform data collection across DMHS and DAS (See Administrative Domain)

6. **Problem:** There is a need for revisions to current regulations to support integrated treatment of COD disorders (See Administrative Domain)

Administrative:

1. **Problem:** As a result of bureaucratic silos, there are difficult and longstanding systemic barriers to the integration of MH and SA treatment such as separate administrative structures, funding mechanisms, priority populations.

   Recommendation*:* DAS and DMHS should make firm commitments to ensure the development and operation of a jointly managed, comprehensive, integrated system of care for the population of persons with COD being treated by their providers.

   Action Steps*:*

   A. DMHS and DAS should commit to jointly managing the system of care for persons being treated with COD including:
      1. Review DMHS and DAS regulatory standards and develop needed common standards and requirements for treatment programs, in areas such as: Staff qualifications, physical plant, licensure, administrative records, etc.
      2. Establish a common clinical language and compatible clinical processes and tools. Incorporate that common language into RFP and contracting processes

3. Use one data system which will allow for ready access to information that will better coordinate care and manage resources.
4. Integrate separate MH and SA funding mechanisms.
5. DMHS and DAS should collaborate in order to obtain funding from federal or other sources, and apply such funding to COD services.

2. **Problem:** There is inadequate coordination, communication and planning, etc. among the multiple systems, organizations, stakeholders, and other entities that provide services or are otherwise involved with the COD population.

Recommendation*:* Establish mechanisms to ensure effective planning, coordination, data management, etc.

Action Steps*:*

DMHS and DAS should incorporate specific guidance from existing cross system review groups on building more effective COD services. Such groups include the Governor's Council on Alcohol and Drug Abuse (GCADA) and the Mental Health Planning Council. These groups include representatives from Criminal Justice, Homeless and Veterans Services, SA and MH consumers and family members, and other stakeholders that work together to address systemic problems. These groups would have access to relevant data, in order to use that data to guide planning and decision-making re COD services.

Workforce Development:

NOTE: In the interest of budgetary concerns, the Workforce Development Subcommittee identified certain Action Steps and Recommendation that could possibly be implemented at little, or no increased cost. Those items have been marked:***

1. **Problem:** There is, among many practitioners, a misconception that CODs are confined to a limited subgroup of the SA or MH client population. A related misconception is the tendency of some practitioners to categorize clients as having only MH or SA problems, as opposed to a COD. These misconceptions result in fragmented services provided by a workforce that is often unprepared to address the clinical realities.

Recommendation*:* Clinicians (in both SA and MH settings) must have basic knowledge of the signs and symptoms of COD, in order to accurately diagnose that disorder in applicants for treatment. Clinicians must further understand that, within the context of COD, both MH and SA disorders are to be regarded as primary, and therefore, treated in an integrated manner.

Action Steps*:*
Make available ongoing training and clinical supervision in order to develop a workforce that has a thorough understanding of COD. Such training and supervision would be designed to develop and maintain the **core competencies/skills** constituting a necessary standard for all clinicians working with the COD population. Those Core Competencies can be found in *Addendum 3*.

2. **Problem:** There are substantially fewer numbers of programs (and staff with COD expertise) providing competent co-occurring treatment than needed for the existing numbers of persons (probably a majority of clients in both the MH and SA systems) requiring such treatment.

Recommendation*:* DAS and DMHS must jointly plan and initiate multiple strategies designed to substantially increase the availability and quality of COD treatment in N.J.

Action Steps*:*

A.*** Allow flexibility at the provider level to utilize funding from various sources in order to establish an increased number of integrated COD services, provided by an appropriately trained workforce.

B.*** Planning processes should include the fiscal departments from DMHS, DAS and the Treasury Department working in concert, in order to identify and pool funding together between the Divisions (see the Drug Court model).

C.*** Additional staff with expertise in COD treatment (thus facilitating the development of more providers of COD services), could be produced by the following: Course work in integrated COD treatment could be required for the recertification of MH and SA professionals. Those courses should encourage staff from MH and SA to train together (i.e. cross training). Funding for such training might be arranged through current contracts or from DAS and DMHS through an RFP process. Increased COD expertise in the workforce would facilitate the development of additional treatment providers.

D. Consider permitting qualified individual clinicians to provide COD services (in addition to services provided by established agencies). This would expand the range of service options, better match client needs (where indicated), and reduce waiting lists.

E.*** Facilitate, encourage and monitor increased and more effective use of:

1. AA/NA, and other appropriate 12-Step and self-help groups
2. Double Trouble

3. Recovery, Inc.

F. Agencies could deliberately focus hiring practices in order to develop staff and treatment teams with complementary expertise in providing COD services.

3. **Problem:** There is paucity in the amount and availability of specific, COD-related education and training throughout the relevant systems.

Recommendation*:* DAS and DMHS could offer the continuing, specific, COD-related education and training, that is essential for developing and sustaining the dually qualified workforce necessary for a COD competent system.

Action Steps*:*

A. Training in specific co-occurring subject matter must be regularly offered in both SA and MH systems, with classes composed of staff from both divisions, as well as personnel from other organizations/systems that serve the COD population (i.e. cross training).

B. DAS and DMHS could consider pooling their training budgets to ensure that co-occurring training experiences are available to personnel from both divisions. Such a pooling of budgets would eliminate cost-inefficient redundancy in the use of limited dollars.

C. Both divisions should provide financial support for staff pursuing relevant training/professional development activities. Additional funding should be secured by DMHS and DAS in order to provide this valuable benefit.

4. **Problem:** There are currently no requirements for staff in one system (e.g. MH) to pursue training in subjects associated with the other system (e.g. SA). ***The training of staff in one system or profession in the subject matter of another system or profession, is referred to as cross- training. This modality of training is invaluable in increasing the expertise, and ability to communicate across boundaries, thereby reducing barriers, increasing understanding, and facilitating integrated treatment services.

Recommendation*:* In order to increase the number and quality of staff with the expertise to provide competent, integrated COD treatment, there must be substantial encouragement and support of staff in DAS and DMHS to pursue cross-training.

Action Steps*:*

A.*** Opportunities for cross training must be increased. Recommendations for training dissemination strategies can be found in *Addendum 4.*

B.*** Staff members in the MH field should be educated on SA subject manner, and encouraged to become licensed or certified in a SA field and vice versa.

C. If partnership with a college/university is not feasible, DMHS and DAS might partner in pursuit of official accreditation/authorization for their own COD credential.

D. Promote dual licensure, wherein individuals pursuing master's level programs in counseling, social work, etc. could take elective coursework (in COD-related subjects) in order to become eligible for the LPC, LCSW, etc., and the LCADC. Agencies could offer incentives for staff members to become dually licensed.

4. **Problem:** There is a lack of standardized clinical supervision across systems.

Recommendation*:* Policies and procedures at every level (i.e. systems, organization, provider, etc.), must promote the provision of consistent, ongoing clinical supervision—which has been identified as the most critical factor in fostering, assessing, monitoring, and sustaining workers' competencies/skills.

Client care is enhanced through the optimal use of multi-disciplinary treatment teams as an important context for clinical supervision and training.

Action Steps*:*

A. Supervision that is supportive and focused on skill acquisition has been shown to improve clinical care and staff morale and to reduce turnover. It must be an integral part of a clinical staff's routine. Supervisory sessions should be conducted on a weekly basis and offered in both individual and group formats, if possible.

B.*** Clinical supervisors must be engaged in continuing training and professional development activities.

C.*** In the interest of achieving fully integrated COD treatment the planning for clinical supervision, training, and other workforce development activities should take into consideration the differing needs of clinicians who have functioned in the MH and SA systems.

1. Also to be considered are the specific ways in which gaps and barriers to effective COD treatment operate differently across clinical settings. An example would be ways in which problems in attitude and knowledge about 12-step approaches and/or medication management are different in SA and MH settings.

5. **Problem:** There is substantial difficulty in the recruitment, hiring and retention of persons qualified to provide co-occurring services

Recommendation*:* Proactively addressing staff well-being and morale has been found to improve the quality of care, and reduce staff turnover. This strategy will, in turn, facilitate the improved client care. Suggestions for staffing patterns can be found in *Addendum 5.*

Action Steps*:*

A.*** Leadership at every level of COD service provision (i.e. systems, organizational, agency, etc.) must establish and sustain policies and procedures which create and maintain work environments that are supportive, affirming, and that promote workers' morale and professional development.

B.*** Specific attention must be given to avoiding worker burnout (which is a continuing danger in the demanding work of COD treatment). Effective measures include: promoting a team structure, as opposed to working in isolation; use of staff support groups, and other opportunities for workers to discuss their experiences, feelings and reactions, etc.; promotion of morale-building activities; encourage the development of personal stress-management/burnout prevention programs; insuring that supervision that is supportive, focuses on skill acquisition and provides technical and professional guidance.

C. A poorly compensated workforce leads to high staff turnover, and ultimately to fragmented and discontinuous care. Make all efforts to provide optimal funding for workers' salaries and benefits (educational, healthcare, etc.).

Fiscal/Funding:

1. **Problem:** There are numerous service gaps in the systems that provide co-occurring services in New Jersey. Some of these gaps are created by requirements and limitations.

Recommendation*:* DMHS/DAS should explore gaps and develop cost estimates and plans for the development of a co-occurring competent system of care. This planning would involve a reallocation of existing funding and the acquisition of needed additional resources.

Action Steps*:*

A. DAS and DMHS should assess funding gaps and deficiencies and explore funding mechanisms to minimize them.

B.*** DAS and DMHS should develop cost estimates of the processes required to: Increase the availability of COD services; improve the quality of existing services; and to increase outreach to under-served populations.

C.*** The two divisions should work with counties in order to demonstrate how braided or blended funding could facilitate the delivery of co-occurring services in a more integrated, flexible and efficient manner.

D. DMHS and DAS could invite Medicaid, DOC, DDD, and DFD to join in creating blended funding to provide COD services to persons receiving other services from those departments.

E. DAS and DMHS should review the factors required to enhance the reimbursement rate, and to improve staff qualifications through measures such as cross-training.

2. **Problem:** Often there is insufficient funding available to support the delivery of co-occurring services where there is need for such services

Recommendation: DAS and DMHS must actively collaborate in order to identify all possible sources of funding for COD treatment services. This process should include the Treasury Department.

Action Steps*:*

A.*** Give agencies the flexibility to utilize funding from various sources to provide integrated COD services in a single clinical setting.

B.*** Develop capacity for Medicaid reimbursement for targeted case management within treatment programs in order to enhance engagement and coordination of care.

C.*** Coordinate Funding between DAS and DMHS to maximize resources.

D.*** DMHS and DAS apply jointly for Federal Funding.

F. Funding and contracting practices support the primary goal of integrated, client centered care (i.e. will funding fit the needs of the individual and/or will the individual drive the funding).

ADDENDUM 1
Areas of Assessment

DMHS and DAS should require that all contracted agencies provide screening and assessment for co-occurring disorders based upon those agencies competencies. If an agency is not competent to conduct the indicated assessment that organization must coordinate the client's referral to another agency that has all competencies.

The subcommittee recommends that all assessments at both Substance Abuse Treatment and Mental Health Treatment agencies include the following:

- Current and past emotional and behavioral functioning and treatment; including previous admissions to psychiatric facilities; history of suicidal/homicidal ideation and attempts; outpatient psychiatric treatment; and psychotropic medications
- Current and past alcohol, tobacco and other drug use and treatment
- Current and past gambling problems
- Medication history, including medication dosage, frequency and side effects
- Current and past physical health problems and observation of physical appearance as it may relate to the client's mental condition.
- Behavioral risk factors for HIV and Hepatitis A, B, and C
- Legal status
- Abuse, neglect, and domestic violence history
- Family situation, including the constellation of the family group; current living situation; and the social, ethnic, cultural, emotional and health factors
- Educational and work history
- Identification of the community resources current utilized by the client
- Psychological assessment, when clinically indicated
- Evaluation of any language, self care and other areas of functioning which relate to the client's mental condition
- Supervised urine drug screen, screening for commonly used drugs in your geographical area

ADDENDUM 2
Recommended Evidence-Based Practices

- Cognitive Behavioral Therapy and Cognitive Behavioral Therapy for late life depression
- Motivational Interviewing
- Dialectical Behavioral Therapy
- 12 Step Facilitation
- Medication Management
- Seeking Safety
- Trauma Recovery and Empowerment Model
- Integrated Dual Diagnosis Treatment
- Anger Management
- Contingency Management
- The Community Reinforcement approach
- Desensitization and Reprocessing (EMDR) (emerging practice)
- Integrating medical care per the Medical Home Model (emerging practice)

ADDENDUM 3
Recommended Core Competencies for the Work Force

The following is a listing of core competencies/skills. This listing is in alignment with TIP 42's classification of basic and intermediate skills.

- The ability to engage the client, in order to initiate the development of an effective working alliance. Engagement of the client includes (but is not limited to) the following skills:
  - Active listening, in order to convey the worker's empathy, sincere interest in, and efforts to understand the client and her/his situation
  - Ability to convey hope
  - Knowledge of motivational interviewing and other motivational strategies
  - An understanding of common client anxieties and accompanying defensive behavior (resistances)
  - Understanding of the increased difficulty that COD clients have in tolerating affective states in treatment/process groups, and in individual sessions.
  - The recognition of barriers to treatment, and the modifications (of treatment approaches, techniques, etc.) needed to deal effectively with such barriers.
  - Basic knowledge of signs and symptoms of mental health and addictive disorder, to include ongoing awareness of current and emerging trends related to those conditions/behaviors.
  - Basic knowledge of signs and symptoms of COD, and the understanding that both disorders are primary.
  - Understanding the concept of integrated treatment for COD, including applicability to both systems (i.e. SA and MH). Also included in this understanding is a commitment to the belief that there must be "no wrong door" for persons with COD who seek healthcare services.
  - Possessing the essential attitudes, beliefs and values necessary for clinicians to work successfully with persons who have COD (TIP 42, p.57)
  - Cultural competence, and linguistic competence or the ability to facilitate linkages with providers that can meet the linguistic needs of consumers.
  - Knowledge of basic methods and techniques of screening and assessment (including use of functional assessments) concomitant with the worker's area of expertise and levels of training, certification and/or licensure. This skill includes an understanding of ASAM PPC-2 and DSM-IV R, as appropriate.
  - The ability to make appropriate referrals and to conduct the ongoing consultation and collaboration associated with such referral.
  - The ability to conduct and/or contribute to treatment/discharge planning, and to do the appropriate documentation associated with all phases of treatment.
  - The ability to coordinate with other workers/organizations, etc., who work with the same client.

- Additional clinical skills:
  - A knowledge of evidence -based treatment methods, general counseling skills and modalities of treatment (individual, group, family, residential/inpatient, outpatient/IOP, half-way house, short/long-term, etc.)
  - An ability to provide Case management
  - Understanding of Basic psychopharmacology and Medication Assisted Treatment
  - Understanding the concept of relevant stages (i.e. of life span development, stages of change, etc.)
  - A working knowledge of the major theoretical approaches to treatment/counseling (e.g. cognitive-behavioral, psychodynamic, dual recovery mutual self–help/12-step fellowships, directive, non-directive, client-centered, etc.)
  - A working knowledge of the treatment needs of special COD populations (women with children, adolescents, the homeless, cultural/racial/ethnic groups, persons with HIV/AIDS, criminal justice, etc.)
  - Understanding of and ability to work with persons in the relevant DSM IV diagnostic categories (e.g. Clinicians need to understand and have the ability to manage the substantial impacts that clients with personality disorder can have upon an agency's staff members.)
  - Clinicians must understand which treatment approaches are most effective for particular diagnostic categories, and which are contraindicated for certain diagnosis.
  - Recognition of and ability to deal with barriers to care (e.g. dementia)

ADDENDUM 4
Workforce Training Dissemination Strategies

- The CEO/President of each organization/agency/provider must be advised of, and make a commitment to actively support the development and sustaining of workforce competencies/skills and ongoing clinical supervision.
- Clinical supervisors must be engaged in continuing training and professional development activities.
- Performance evaluations must reflect the quality and functioning of supervisors' and staff members' required competencies/skills – for example: A staff member's ability to interact with clients humanely and effectively; a clinician's sensitivity to and knowledge of issues related to cultural competence.
- Single event trainings, while effective in communicating knowledge, have been consistently shown by research to be ineffective in creating lasting change at both the individual and institutional levels. Training, especially of core competencies/skills, is more effective when conducted onsite, at the agency level (as opposed to larger, more centralized settings).
- Follow up coaching (in addition to, or in the context of clinical supervision), conducted onsite, is a vital method of promoting long-term skill acquisition. In addition (or as alternatives) to the onsite modality, other forms of follow up coaching can be useful and more cost-effective, such as the use of conference calls or other forms of interactive communication (e.g. teleconferencing, use of e-mail, etc.).
- DAS and DMHS could consider pooling their training budgets to ensure that co-occurring trainings are available, and to eliminate cost-inefficient redundancy in the use of limited training dollars.
- Financial support for staff pursuing training/professional development is desirable.
- Whenever possible, training should include consultation with the targeted agency, in order to assist in the implementation and integration of the training into that agency's structure.
- Training in specific co-occurring subject matter must be regularly offered in both SA and MH systems.
- Specific COD-related training, at the agency level, must be offered to all staff, including non-clinical and support personnel (e.g. cafeteria workers, clerical and escort staff). Such training will promote the ideal that interactions with all staff are therapeutic.
- Executive management curricula must be developed in order to ensure that agency leaders and managers are appropriately trained, and will provide leadership for the implementation of necessary policies and procedures.

ADDENDUM 5
Staffing Patterns for Provider Agencies

The WFD subcommittee's work on Staffing Patterns focused primarily on the issues of licensure and certification for members of the COD workforce. The following recommendations were offered:

- Required training for recertification for CADC, LCADC, LPC, LCSW, and BA level mental health professionals, etc. should include course work in integrated COD treatment. These seminars/courses should enable staff from MH and SA to train together. Funding for such training could possibly be arranged through current contracts or from DAS and DMHS through an RFP process.
- Staff members in the MH field should be educated on, and encouraged to pursue certification in the SA field (i.e. obtaining the CADC or LCADC).
- Propose a joint venture with DMHS wherein employees working in DMHS treatment facilities would become eligible to attend CADC training classes. Perhaps a "special" track for employees from MH treatment providers could be developed. Such training for MH workers might be offered through NJPN.
- Develop a co-occurring curriculum that could be "added-on" to existing masters' level licenses.
- Develop a "certification" in COD treatment, the requirements for which would be endorsed by the Task Force, DAS and DMHS, for present or newly-hired employees. Such a credential might be developed in partnership with a college or university-based addiction studies program (depending upon that institution's funding for such a program). If partnership with a college/university is not feasible, DAS and DMHS might partner in the development of their own authorized credential in co-occurring treatment.
- Establish a body (i.e. committee, team, etc.) to monitor the processes of licensing and certification in those professions that serve persons with MH and/or SA issues (i.e. credentialing in the fields of: counseling, social work, psychology, nursing, medicine, etc.). As requirements for licensure/certification in those fields are scheduled to be reviewed/revised, this monitoring body would advise DAS and DMHS, who would, in turn, recommend that the requirements for credentialing include training in the interrelationships between MH and SA problems (i.e. COD).
- If the provisions in the above are implemented, colleges and universities in NJ and surrounding states, housing the relevant professional schools, departments and programs (e.g. addiction studies, etc.), should be informed of these provisions. These institutions would be further advised to modify their curricula in order to better prepare their students to meet the revised credentialing requirements.
- Organizations should make firm commitments to ensure cultural competence in their operations, policies and workforces. They must be able to adapt to the cultural contexts of the communities they serve, and should recruit from diverse ethnic and cultural groups.