Community Counseling Center's COSII Sustainability Statement

The primary mission of Community Counseling Center is to serve all individuals in need of assistance for mental health (and co-morbid substance use problems) regardless of their ability to pay. Community Counseling Center is a broad-based comprehensive mental health agency serving individuals, couples, veterans and their families, refugees, the deaf population, the elderly, to transgendered and gender-questioning individuals, not to mention individuals seeking assistance for anxiety, depression or a whole host of other psychiatric issues. One area which had previously not been a focus of training and intervention were substance abuse assessment and treatment of co-occurring clientele. Community Counseling Center has prided itself on being very forward thinking, training its clinicians in trauma-informed treatments such as CBT, DBT, EMDR, TF-CBT and MATCH to name a few. However, our participation in the COSII project over the last 18 months has illustrated how much this agency initially was rooted in solely mental health treatment with a cadre of highly trained LCSWs/LCPCs most of whom had no formal training or experience in working with co-occurring clientele. In keeping with Community Counseling Center's desire to stay current with best practice models of care, CCC embarked on changing the norms of the clinical staff and shifting the clinical paradigm to clearly expect all clinicians to have the capacity to see and effectively treat individuals suffering from co-occurring issues.

To this end Community Counseling Center formally trained its entire supervisory staff in concepts of Motivational Interviewing and offered many in-service trainings (on stages of change, SA assessment, treatment interventions including moderation management, etc.) to increase staff competencies in this area. CCC has amended its mission statement, job descriptions, employee evaluations and policies to reflect an expectation of co-occurring competencies and integrated treatment of clients served. As well, we have hired several individuals who possess the dual licensure of LADC and have revamped our phone and intake systems to make them of welcoming and user friendly to clients. Going forward, Community Counseling Center is committed to sustaining and enhancing these gains, as well as continuing to build and support partnerships with other (primarily substance abuse) agencies, such as CAP, Mercy Hospital, YAI crisis, etc. to collaboratively work as a treatment community to help shared clients lessen their emotional distress, improve functioning and expand coping skills and natural supports. Efforts to sustain co-occurring competency include:

- As part of regular standard operating procedures the combined AC-OK/MiniBasis is completed on every new client to screen for co-morbid substance use issues.
- As well, all new employees attend training on co-occurring informed treatment and agency policies around providing a welcoming environment for the clients we serve.
- Within our agency strategic plan is on-going regular staff trainings (at All Staff events) covering areas of substance abuse counseling, from assessment, differential diagnosis, identification of and interplay of SA/MH issues, to treatment modalities and external resources/support groups.
- Agency staff evaluations include a section requiring employees to move towards COD competency as part of each employee's individual annual goals.

- Our agency psychosocial assessment has a large section on stages of readiness, historical and current use patterns, etc. and is now a standard part of all intake assessments.
- CCC has placed on our general access drive a large folder with nearly 90 different handouts covering the array of co-occurring issues which clients could benefit from using these tools which clinicians have access to whenever they desire.
- Supervisory staff have been trained in Motivational Interviewing and will continue to receive supervisory instruction in this modality as well as other best practice models for COD to continue to interweave COD interventions into all conversations with peers and supervisees regarding clinical consultation.
- Continue attending regional meetings and maintain COSII Project Team to continue to study and plan access and retention strategies for COD clientele.
- Continue to market our availability to co-occurring clientele and link with DRA and other support groups/organizations to further referrals in this regard. Possibly move even towards holding a weekly DRA group at CCC.

Lessoned learned:

Important factors to assist with a better flow and quicker integration would be:

- Buy-in and communication from the top, and at each programmatic level. Although our upper management were fully behind the COSII Project, the initial (and secondary) person acting as the COSII Project Coordinator were line staff (or lower management) who were tasked with the responsibility of implementing change towards integrated treatment, but who possessed limited authority to do so as they could not implement changes to agency protocols, initiate trainings, etc. without upper management approval. As a result, we at CCC learned how very important it is to sustain and maintain a visible presence and promotion by senior management throughout the course of the project. And how attendance and participation at trainings seemed to pick up when there was promotion from that level of management, resulting in 31 staff now being dually trained. Thus, our first recommendation is to have the COSII Project Co-coordinator always be someone in the upper circles of management to ensure Rapid Cycle Change projects and culture change are not impeded by levels of bureaucracy or staff feeling the agency is only half-heartedly behind such change.

- It is important to establish a baseline from where to start concerning staff's "comfort level" regarding engagement and effective treatment of co-occurring clientele. When we completed such a pre-COSII survey it was learned that one-third of the agency staff had little to no training or experience in working with substance abusing/dependent clients and did not know how to complete an appropriate SA screening. One-quarter of the staff reported that they were "Very comfortable" in working with such clientele with the majority of staff falling somewhere in between. This helped us shape trainings offered, initially completing basic trainings on substance abuse assessment and differential diagnosis of psychiatric and substance-induced disorders, then moved on to offer trainings on the ASAM Clinical Pathway, harm reduction strategies and a whole series on motivational interviewing. Thus, completing a staff survey helped us

know who our population was that we would be training and their level of need. Therefore, we feel completing a pre-post survey of staff is an important measure of baseline then change over time. We simply sent an e-mail to all staff with a Likhert scale 0-2 "Very Uncomfortable" 3-4 "Uncomfortable", 5-7 "Comfortable" 8-10 "Very comfortable" and asked each staff to identify any training of experience they had in this area.

- Our third recommendation would be to have only one person be responsible for gleaning enrollment follow-up data and dispensing of gift cards for participation. Connected to item 1, Our COSII Project Coordinator had to ask upper management for client gift cards with many times extended lags in receiving the client cards. As well, we found that phone contacts for follow ups were very time consuming with many times "phone tag" events occurring where people had relocated without an active phone number in the database, or repeated messages had to be left before a follow up could be entered. We found that having one staff be responsible to track when follow ups were coming due and have their therapist fill it out with the client at their next session (then give them gift card for immediate reinforcement) created greater success in gleaning follow-up data and clients were happy as they immediately received their reward for completing the follow-up.

- Enacting a study group of supervisory staff trained in Motivational Interviewing and "COSII savvy" would be a great proactive step for new agencies starting the COSII integration process. This was done post hoc at our agency as line staff would regularly go up to the two MI/ COD trained staff and frequently ask for case consultation on an informal basis. Having a study group offered weekly can help support clinicians to become more comfortable with seeing COD clients.

- Familiarizing those responsible for collecting and up-loading data through the COSII database early on in the process. At CCC we initially were going to have each clinician who had one or more co-occurring clients be responsible for gathering and inputting the data into the COSII database. We learned early, however, that such a method held inherent problems and found that it was best to have a single individual responsible to keep abreast of changes/up-grades to the database; as line staff, who infrequently accessed the database, required constant refreshing on how to enter and import data.

- Mental Health agencies, such as CCC, develop over time specialty programs and specialty trained staff. Here at CCC, our intake staff would funnel clients to clinicians "by specialty" (E.g. DBT, CBT, EMDR, TF-CBT) and by programs, such as SAT (child Sexual Assault Trauma team). Thus it was important for Senior Management to articulate a generalized paradigm shift that ALL clinical and case management staff will become not only trauma-informed, but also co-occurring competent. That all staff with be expected to treat COD clients, verses this being seen as yet another sub-specialty where such client are funneled to a handful of dually licensed or trained staff members.