The Connecticut Department of Mental Health and Addiction Services (DMHAS) is requesting proposals from experienced individual or organization applicants to assist DMHAS in the Development of Web-Based Training Material on Co-Occurring Disorders and Integrated Treatment, as detailed in this Request for Proposals.

Responses must be received no later than 3:00 PM Local Time, Friday, April 27, 2007. Any response(s) received after that date and time, will be returned, unopened to the applicant.

For questions on issues relating to this Request for Proposals, contact:

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The full RFP is available on DMHAS’ Web Site at: http://www.dmhas.state.ct.us/rfp.htm

EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER  
MINORITIES AND WOMEN ARE ENCOURAGED TO RESPOND
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I. PROGRAM INTRODUCTION
Co-occurring disorders are defined as the coexistence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one which is a mental health disorder. National studies and DMHAS data report a high prevalence of co-occurring disorders and poor outcomes for people with co-occurring disorders in the absence of integrated care. In recent years, there have been advances in research and practice related to co-occurring disorders and DMHAS is working to close the science to service gap. In September 2005 Connecticut was awarded a Co-Occurring State Incentive Grant (COSIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). COSIG is supporting the Department’s ongoing efforts to further improve services for people with co-occurring disorders.

II. BACKGROUND
A key component in the process of integrating mental health and addiction treatment services is workforce development. Training staff on integrated treatment principles and models is a core element of this systems change initiative. DMHAS’ Education and Training Division initiated the Co-Occurring Academy in 2006 in its biannual catalogue of course offerings. These didactic workshops cover introductory and specific courses on co-occurring disorders, and on developing integrated treatment programs.

There has been a dramatic expansion in many fields in the use of web-based learning to provide training and education. The relatively low cost and broad access that this approach affords makes it an attractive method for potentially reaching large numbers of individuals and organizations. In addition to the didactic trainings offered through the Co-Occurring Academy, the Department would like to implement a high quality, interactive, web-based training product on co-occurring disorders and integrated treatment, for staff throughout our system of care.

III. PROJECT DESCRIPTION
Following submission of responses to this RFP, DMHAS will identify an individual or entity by May 11, 2007 to create web-based training material on co-occurring disorders and integrated treatment. It is anticipated that this web-based training product will have eight, one-hour modules. The materials to be developed by the selected vendor will include the following items for each of the eight modules:

- PowerPoint slides
- Identification of graphics and audio/video segments to be included in the slides
- Scripts for the narrator or voiceover to accompany most of the slides
- Post-test for the participant to complete

It is anticipated that this web-based training product will include two tracks (i.e., basic and advanced). The modules to be created will include information on attitudes and stigma, outreach and engagement, screening and assessment, treatment planning, treatment, medications (both psychiatric and addiction pharmacotherapy), family psychoeducation/support, continuing care, and implementing integrated treatment programs. It is anticipated that the selected vendor will use a variety of resources to create these materials (e.g., Substance Abuse and Mental Health Services Administration’s (SAMHSA) Treatment Improvement Protocol (TIP) #42, Integrated Dual Disorders Treatment (IDDT) toolkit, Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index).
The contract period is expected to be effective May 15, 2007 through August 31, 2007. The contract award amount will be $24,000.00.

**IV. INSTRUCTIONS FOR COMPLETION OF PROPOSAL**

Responses to this Request for Proposals should consist of the following components IN THE ORDER SPECIFIED BELOW. A description of each of these components is provided below. The narrative must be clear, concise, paginated, and must not exceed three (3) pages in length, exclusive of the budget and appendix. The proposal shall be presented with sections labeled and numbered as follows:

1. Name and address of author(s) with phone, fax, email.

2. **Experience & Training (25 Points):** Please describe the author’s knowledge and experience with co-occurring disorders, integrated treatment, training, and development of online training materials.

3. **Applicant’s Availability (25 Points):** Please describe the author’s availability to complete the tasks described above.

4. **Project Management (50 Points):** Please attest to the author’s ability and willingness to:
   a. Develop a written work plan for each module, including components, resources to be used for content, and timelines.
   b. Participate in biweekly meetings or conference calls with staff from the Initiative to discuss progress, questions, and next steps.
   c. Collaborate in person and by phone with the vendor who will be uploading the content developed to the internet.

5. Budget Detail/Justification

6. Please include the appendices specified below in the application.
   - Appendix 1: Documentation of Experience and References. A resume should be provided for each proposed author(s).

**V. FUNDING REQUIREMENTS**

**A. ELIGIBLE APPLICANTS**

Proposals may be submitted from individuals or organizations. Application eligibility is restricted to applicants who have the infrastructure and expertise to provide services requested through this RFP.

**B. FUNDING**

It is anticipated that funding for this project, covering the period May 15, 2007 - August 31, 2007 will be available and the final award amount will be in the amount of $24,000.00.
C. SCHEDULE

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*Note: All times are Eastern Time.*

D. EX PARTE CONTACT PROHIBITED
Any form of ex parte contact regarding this RFP or any proposal being prepared or being considered under this RFP, whether directly or indirectly, is hereby strictly prohibited. This includes, but is not limited to, any contact with elected officials or other state employees asking them for advice, information, or support at any time when actual notification of results is made. Violations will result in outright rejection of any and all proposals submitted under this RFP by the respondent. Any inquiries or requests regarding the RFP must be submitted to the Program Contact (Reference RFP Cover).

E. EVALUATION AND SELECTION
It is the intent of DMHAS to conduct a comprehensive, fair and impartial evaluation of proposals received in response to this procurement. Only proposals found to be responsive to the RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP. The original and four exact, legible copies (total of 5) of the proposal must be submitted in a properly addressed package by the deadline.

F. CONTRACT EXECUTION
The pursuant contract developed, as a result of this RFP, is subject to Department contracting procedures, which includes approval by the Office of the Attorney General. Please note that contracts are executory and that no financial commitments can be made until, and unless, the contracts are approved by the Office of the Attorney General.

G. APPLICANT DEBRIEFING
The Department will notify all applicants of any award issued by it as a result of this RFP. Unsuccessful applicants may, within thirty (30) days of the signing of the resultant contract, request a meeting for debriefing and discussion of their proposal by contacting the DMHAS contact person noted in Section VI-d in writing at the address previously given. Debriefing will not include any comparisons of unsuccessful proposals with other proposals.
VI. GENERAL PROPOSAL REQUIREMENTS

A. DISPOSITION OF PROPOSALS
DMHAS reserves the right to reject any and all proposals, or portions thereof, received as a result of this request or to negotiate separately any service in any manner necessary to serve the best interest of DMHAS. DMHAS reserves the right to contract for all or any portion of the scope of work contained within this RFP if it is determined that contracting for a portion of the work will best meet the needs of DMHAS.

B. CONDITIONS
Any prospective applicants must be willing to adhere to the following conditions and must positively state them in the proposals:

1. Conformance with Statutes. Any contract awarded as a result of this RFP must be in full conformance with statutory requirements of State of Connecticut and the Federal Government.

2. Ownership of Subsequent Products. Any product, whether acceptable or unacceptable, developed under a contract awarded, as a result of this RFP is to be sole property of the Department unless stated otherwise in the RFP or contract.

3. Timing and Sequence. Timing and sequence of events resulting from this RFP will ultimately be determined by DMHAS.

4. Oral Agreement. Any alleged oral agreement or arrangement made by an applicant with any agency or employee will be superseded by a written agreement.

5. Amending or Canceling Requests. DMHAS reserves the right to amend or cancel this RFP, prior to the due date and time, if it is in the best interest of DMHAS and the State.

6. Rejection for Default or Misrepresentation. DMHAS reserves the right to reject the proposal of any applicant that is in the default of any prior contract or for misrepresentation.

7. Department's Clerical Errors in Awards. DMHAS reserves the right to correct inaccurate awards resulting from its clerical errors.

8. Rejection of Qualified Proposals. Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.

9. Applicant Presentation of Supporting Evidence. An applicant, if requested, must be prepared to present evidence of experience, ability, service facilities, and financial standing necessary to satisfactorily meet the requirements set forth or implied in the proposal.

10. Changes to Proposal. No additions or changes to the original proposal will be allowed after submittal. While changes are not permitted, clarification at the request of the agency may be required at the applicant's expense.

11. Collusion. By responding, the applicant implicitly states that the submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud. It is further implied that the applicant did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to its issuance, and that no employee of the agency participated directly or indirectly in the applicant's proposal preparation.
C. **PROPOSAL PREPARATION EXPENSE**
   The State of Connecticut and DMHAS assume no liability for payment of expenses incurred by applicants in preparing and submitting proposals in response to this solicitation.

D. **RESPONSE DATE AND TIME**
   In order to be considered for selection, the Department must receive proposals by **3:00 P.M. Local Time, on April 27, 2007.** Postmark date will **not** be considered the basis for meeting any submission deadline. Any applicant's response, which is received after the deadline, will not be accepted. Receipt of a proposal after the closing date and time as stated herein shall **not** be construed as acceptance of the proposal. If delivery of the proposal is not made by courier or in person, the use of Certified or Registered mail is suggested. **All RFP communications, including proposals, should be addressed to the RFP Program Contact (Reference RFP page 1). Please confirm receipt of your submission by email or phone with the RFP Program Contact.**

E. **INCURRING COSTS**
   DMHAS is not liable for any costs incurred by the applicant prior to the effective date of a contract.

F. **FREEDOM OF INFORMATION**
   Due regard will be given to the protection of proprietary information contained in all proposals received. However, applicants should be aware that all materials associated with this RFP are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations and interpretations resulting therefrom. It will not be sufficient for applicants to merely state generally that the proposal is proprietary in nature and not therefore subject to release to third parties. Those particular pages or sections, which an applicant believes to be proprietary, must be specifically identified as such. Convincing explanation and rationale sufficient to justify each exception from release consistent with Section 1-210 of the Connecticut General Statues must accompany the proposal. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the Applicant that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above-cited Statute. In any case, the narrative portion of the proposal may not be exempt from release. Between the applicant and DMHAS, the final administrative authority to release or exempt any or all material so identified rests with DMHAS.
H. CONFIDENTIALITY
The successful bidder shall comply with all applicable state and federal laws and regulations pertaining to the confidentiality of proprietary information, data and other confidential or personal information concerning the medical, personal or business affairs of patients acquired in the course of providing services under this RFP. The successful bidder shall keep confidential all financial, operating, proprietary or business information of DMHAS relating to the provision of services under this RFP which is not otherwise public information, along with all information, not described above, but specified in writing by DMHAS as confidential information. The successful bidder shall also cause each of its agents, employees, or subcontractors and other persons and organizations involved in doing business with or controlled by it from disclosing or transmitting to any person or legal entity any of the described information. The successful bidder shall ensure that the appropriate qualified service organization agreements are in place pursuant to federal confidentiality regulations.

I. AFFIRMATIVE ACTION
Regulations of Connecticut State Agencies Section 46a68j-3(10) requires agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements:
  i. the applicant's success in implementing an affirmative action plan;
  ii. the applicant's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;
  iii. the applicant's promise to develop and implement a successful affirmative action plan;
  iv. the applicant's submission of EEO-1 data indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and
  v. the applicant's promise to set aside a portion of the contract for legitimate small contractors and minority business enterprises. (See CGS 4a-60).

VII. PROPOSAL EVALUATION
The Department will conduct a comprehensive, fair and impartial evaluation of proposals received in response to this Request for Proposals. There will be two levels of review:

Level 1 - Evaluation of Minimum Requirements
The purpose of this phase is to determine if each proposal is sufficiently responsive to the minimum RFP requirements to permit a complete evaluation of the Proposal. Proposals must comply with the instructions to applicants contained throughout this RFP. Failure to comply with the instructions may deem the proposal non-responsive and subject to rejection without further consideration. The Department reserves the right to waive minor irregularities. The minimum requirements for a proposal to be given consideration are:

Closing Date: The proposal must have been received before the closing of acceptance of proposals in the number of copies specified.
Compliance: The proposal must comply with all of the requirements outlined in this RFP.

Level 2 - Evaluation of the Proposal
Only those proposals passing the minimum requirements will be considered in Phase 2. The Department reserves the right to reject any and all proposals. An Evaluation Team including, but not limited to DMHAS designated staff, will be established to assist in the selection of applicants. The Department reserves the right to alter the composition of this team. The Evaluation Team will be responsible for the review and scoring of all proposals in the following domains, as fully detailed in this RFP.

A. EXPERIENCE & TRAINING (25 Points)
B. AVAILABILITY (25 Points)
C. PROJECT MANAGEMENT (50 Points)
COMMISSIONER’S POLICY STATEMENT ON SERVING PERSONS WITH CO-OCCURRING DISORDERS

Commissioner’s Policy Statement No. 84
Effective Date: January 11, 2007

Purpose
The single overarching goal of the Department of Mental Health and Addiction Services (DMHAS), as a healthcare service agency, is promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care. The full attainment of this goal is not possible if the service system design, delivery, and evaluation are not fully responsive to people with co-occurring mental health and substance use disorders. Given the high prevalence of co-occurring disorders, the high number of critical incidents involving individuals with co-occurring disorders, and the often poor outcomes associated with co-occurring disorders in the absence of integrated care, it is extremely important that we collectively improve our system in this area. There have been advances in research and practice related to co-occurring disorders and it is important that the system close the science to service gap. Through these and other related improvements, the citizens of the state can expect better processes of care and better outcomes for people with co-occurring disorders.

Policy Statement
The publicly funded healthcare system in Connecticut will be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care).

Definitions
- Co-occurring disorders are defined as the coexistence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder.
- Integrated treatment is a means of coordinating both substance use and mental health interventions; it is preferable if this can be done by one clinician, but it can be accomplished by two or more clinicians working together within one program or a network of services. Integrated services must appear seamless to the individual participating in services.

Guiding Principles
- People with co-occurring disorders are the expectation in our healthcare system, and not the exception.
- There is “no wrong door” for people with co-occurring disorders entering into the healthcare system.
- Mental health and substance use disorders are both “primary”.
- The system of care is committed to integrated treatment with one plan for one person.
- The system will offer evidence-based techniques and protocols, and evaluate how these relate to outcomes.
- The system will strive to identify, develop, evaluate, and document new emerging or promising practices.
- Improvements will be made to program structures and milieu, staffing, and workforce development relative to co-occurring disorders.
- Recovery support (including self-help, mutual support, peer-delivered and peer-run services) and family education and support are important components of a co-occurring enhanced system of care.
- Integrated care must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.

Background
Connecticut has taken significant and important steps over the last several years to increase the system’s capacity to provide accessible, effective, comprehensive, integrated, and evidence-based services for adults with co-occurring disorders. In this respect, Connecticut is fortunate to have combined separate agencies into a single state authority that has responsibility for both mental health and addiction services. Subsequent to this merger,
DMHAS has undertaken both an Integrated Dual Disorders Treatment (IDDT) initiative and a Dual Diagnosis Capability in Addiction Treatment (DDCAT) initiative. DMHAS has also established strong academic partnerships related to co-occurring disorders with Dartmouth Medical School, the University of Connecticut, and Yale University. Finally, Connecticut was one of several states to participate in the National Policy Academy on Co-occurring Disorders and to receive a SAMHSA award for a Co-Occurring State Incentive Grant (COSIG) in 2005. This policy is yet an additional important step forward in achieving a fully integrated and co-occurring disorders enhanced system of care for all of the state’s citizens receiving publicly funded behavioral health services.

There has been significant national attention in recent years to the issues associated with co-occurring disorders. The Surgeon General’s Report on Mental Health in 1999, the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2002 Report to Congress on co-occurring disorders, the President’s New Freedom Commission Report on Achieving the Promise in 2003, and SAMHSA’s Treatment Improvement Protocol (TIP) #42 on co-occurring disorders issued in 2005 all note the high prevalence of co-occurring disorders, the lack of integrated care available in our healthcare system, and the poor outcomes experienced in the absence of integrated care. In addition, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) jointly developed a “four quadrant” model describing different groups of people with co-occurring disorders; the American Society of Addiction Medicine (ASAM) developed the vocabulary of “addiction only,” “dual diagnosis capable,” and “dual diagnosis enhanced” for program assessments; and SAMHSA began awarding Co-Occurring State Incentive Grants (COSIG) in 2002. As is evident throughout these developments and initiatives, there is a clear 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.

**Tools for Implementing the Policy**

Resources available to help implement integrated mental health and addiction treatment:

- The DMHAS Co-Occurring Disorders Initiative website - [http://www.dmhas.state.ct.us/cosig.htm](http://www.dmhas.state.ct.us/cosig.htm) - includes the following resources:
  - Definitions and standards for co-occurring enhanced services
  - Integrated Dual Disorders Treatment (IDDT) Toolkit
  - Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit
  - SAMHSA’s Treatment Improvement Protocol (TIP) #42: Substance Abuse Treatment for Persons with Co-Occurring Disorders
  - DMHAS Co-Occurring Training Academy
  - Access to consultants to assist with organizational and practice changes
  - Specialty credentials for serving people with co-occurring disorders
  - Standardized mental health and substance use screening measures in English and Spanish
  - Outcome reports specific to people with co-occurring disorders
  - Audiovisuals, books, curricula, pamphlets, and posters on co-occurring disorders
  - The national Co-Occurring Center for Excellence: [coce.samhsa.gov/](http://coce.samhsa.gov/)
  - Commissioner’s Policy Statement #76: Policy on Cultural Competence: [http://www.dmhas.state.ct.us/policies/policy76.htm](http://www.dmhas.state.ct.us/policies/policy76.htm)
  - Commissioner’s Policy Statement #83: Promoting a Recovery-Oriented Service System: [http://www.dmhas.state.ct.us/policies/policy83.htm](http://www.dmhas.state.ct.us/policies/policy83.htm)
  - Practice Guidelines for Recovery-Oriented Behavioral Health Care: [www.dmhas.state.ct.us/documents/practiceguidelines.pdf](http://www.dmhas.state.ct.us/documents/practiceguidelines.pdf)
  - Key Principles and Practices of Person-Centered Care: [www.dmhas.state.ct.us/recovery/pcc.pdf](http://www.dmhas.state.ct.us/recovery/pcc.pdf)

Thomas A. Kirk, Jr., Ph.D.
Commissioner
ATTACHMENT 2

COMMISSIONER’S POLICY STATEMENT ON CULTURAL COMPETENCY

Effective Date: August 29, 2003

Purpose: The purpose of this policy is to formally designate cultural competence as an essential characteristic and defining quality that must be embedded in all aspects of the DMHAS healthcare service system. The single overarching goal of the DMHAS, a healthcare service agency, is promoting and achieving a value-driven, recovery oriented system of care. The fullest attainment of that goal is simply not possible if the service design, delivery and evaluation are not culturally competent.

Definition: Cultural competence is a set of congruent practice skills, attitudes, policies and structures which come together in a system, agency or among professionals and enable that system or those professionals to work effectively in cross cultural situations. Cultural competency is the acceptance and respect for difference, continuing self assessment regarding one’s own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations (Cross, Brazron, Dennis, & Isaacs. 1998)

Policy Statement: The DMHAS healthcare service system shall function with cultural competency that responds effectively to the needs and differences of all individuals, based on their race, gender, age, physical or mental status, sexual orientation, and ethnic or cultural heritage. Both the population of Connecticut and the demographic profile of persons served by DMHAS operated or funded agencies reflect significant changes toward greater diversity. Further, findings in the professional literature point to patterns indicating disparities in access and other indices of the quality of healthcare for some racial, cultural and low-income groups in systems of care such as DMHAS. Consequently, there must be a special focus on identifying persons or groups who, while in need of the behavioral healthcare services, are either not well or unserved by the DMHAS system. Once identified, informed and strong steps must then be taken to assure provision of effective quality and parity of healthcare to these persons/groups. Such populations, as must be the case for all persons involved with any aspect of the DMHAS public/private system, must be equitably served and have full access to a culturally competent DMHAS healthcare system. An established system-wide environment of support and education related to cultural competence must exist in order to assist the public/private workforce to be culturally competent.
DMHAS Tools For Implementing the Policy:

A. Behavioral Health Initiatives
To promote effective implementation of this policy as part of the overarching goal and Strategic Action Plan of DMHAS, the agency’s policies shall require all services to be culturally appropriate, and to be supported by the provision of multicultural professional training for all planned services so as to achieve the desired quality outcomes for any of DMHAS’ behavioral health initiatives. The latter may include:

1. **Quality Care**, described as the commitment to a statewide culturally appropriate, quality care management system, designed to achieve defined service outcomes and the continued improvement of the integrated DMHAS healthcare system.

2. **Recovery**, identified as the process in which an individual of any cultural/ethnic/racial heritage served by the DMHAS healthcare system is supported in their effort to restore or develop a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.

3. **Evidence Based Healthcare**, described as a culturally appropriate clinical practice that is "...an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best". 

4. **Health Disparities**, defined as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

B. The Multicultural Advisory Council (MCAC)
The late Commissioner Albert J. Solnit, M.D. established the DMHAS Multicultural Advisory Council (MCAC) in 1995. The MCAC since that time has served the Department of Mental Health and Addiction Services as a creative resource in the area of multiculturalism that develops and recommends culturally appropriate system change. This specially chosen group of professionals shall continue to take initiatives that promote embedding cultural awareness into the language, spirit and structure of the DMHAS service delivery and management system.

The MCAC shall be comprised of a diverse membership, especially with representation of underserved populations throughout the regions, agencies and consumer/person in recovery populations across Connecticut. It shall help foster best culturally appropriate health practices. It will be supportive of multicultural training of the DMHAS system workforce. It shall identify opportunities to be used as instruments to permeate cultural competence throughout the DMHAS public/private network of services.

The MCAC shall assist in identifying that which is culturally appropriate in programs as well as approaches that produce replicable effective quality outcomes. Such programs/approaches are models that can be validated by research and replicated as standard practice throughout the healthcare system.

The MCAC shall assist DMHAS in identifying underserved groups. This will be accomplished by examining demographics of the DMHAS public/private workforce and of those persons and groups in need of behavioral healthcare services but who are either unserved or underserved by the DMHAS healthcare service system. It shall identify barriers to quality service delivery and recommend how to remove those barriers.
The MCAC shall provide support to the Office of Multicultural Affairs in the search and recognition of individuals qualified for appointment to the MCAC membership and shall decide by vote whether to approve any candidates for referral to the Commissioner for appointment. This process shall emphasize the diversity of membership and be representative of the persons/populations who should entrust their care and recovery to the DMHAS healthcare service system.

The Department of Mental Health and Addiction Services is fully and enthusiastically committed to adhering to the principles and spirit of this Policy Statement. It will be critical in assisting us to improve the health of Connecticut’s citizens and in helping those who develop mental illness or substance use disorders to be treated with respect and to recover their lives.

Thomas A. Kirk, Jr., Ph.D.
Commissioner

This directive replaces Commissioner’s Policy Statement No. 76 dated January 1, 1997.
ATTACHMENT 3

COMMISSIONER’S POLICY STATEMENT NO. 83 PROMOTING A RECOVERY-ORIENTED SERVICE SYSTEM

Effective Date: September 16, 2002

Purpose
The purpose of this policy is to formally designate the concept of “recovery” as the overarching goal of the service system operated and funded by the Department of Mental Health and Addiction Services (“Department”). This action is consistent with the fact that the Department is a healthcare service agency. Thus, it is most appropriate that one should hope and expect that, as a result of active involvement with this healthcare system, they will be better able to manage their illness and improve the quality of their life.

Policy Statement
The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the Department’s healthcare system. Services within this system shall identify and build upon each recovering individual’s strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. As one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery-oriented service system.

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for who selected or indicated prevention strategies are appropriate.

The concept of recovery is embodied in the Recovery Core Values articulated by the addiction and mental health recovery communities in Connecticut. In keeping with this vision, and in partnership with the recovery communities, the Department shall create new and make necessary revisions to existing policies, procedures, programs, and services, and shall ensure that all new initiatives are consistent with a recovery-oriented service system. Finally, the Department shall ensure that future strategic planning and resource development efforts build upon existing strengths and continue to move the Department in the direction of promoting recovery as a core concept. In so doing, we shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.
The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one’s recovery. Whenever possible, services shall be provided within the person’s own community setting, using the person’s natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

**Definition:**

“Recovery” is a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.

Recovery is a person-centered approach and it thus may vary from person to person and within the mental health and addiction communities. Just a few examples of recovery include:

- Returning to a healthy state evidenced by improving one’s mood and outlook on life following an episode of depression;
- Managing one’s illness such that the person can live independently and have meaningful employment and healthy social relationships;
- Reducing the painful effects of trauma through a process of healing;
- Attaining or restoring a desired state such as achieving sustained sobriety;
- Building on personal strengths to offset the adverse effects of a disability.

*Thomas A. Kirk, Jr., Ph.D.*
*Commissioner*