

**DEPARTMENT OF MENTAL HEALTH AND ADDICTION  
SERVICES**

**STATEWIDE REQUEST FOR QUALIFICATIONS**

**TELEPHONE PEER SUPPORT SERVICES**

The Department of Mental Health and Addiction Services (DMHAS) is requesting proposals from qualified nonprofit community-based organizations capable of providing person-centered, recovery-oriented Telephone Peer Support Services on a statewide basis. This non-clinical recovery support service will be offered to individuals receiving outpatient treatment at a licensed clinical treatment provider and/or other designated services. Telephone Peer Support Services are designed to assist individuals in the community with their recovery process. Further, the qualifying agency will collaborate with DMHAS, DMHAS-funded treatment service providers, and other community-based organizations to assist persons in sustaining their recovery.

Responses from submitting organizations must be received by DMHAS at 410 Capitol Avenue, 4<sup>th</sup> floor, Hartford, CT no later than **3:00 PM, Friday, May 11, 2007**. Any response(s) received after that date and time shall be returned, unopened to the applicant. Postmarks will not be considered.

Agencies responding to this Request for Qualifications are to submit proposals to:

William Halsey, Project Manager  
Department of Mental Health and Addiction Services  
410 Capitol Avenue - 4<sup>th</sup> Floor  
P.O. Box 341431  
Hartford, Connecticut 06134

**Re: Telephone Peer Support Service RFQ (must appear on  
outside of envelope)**

**EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER  
MINORITIES AND WOMEN ARE ENCOURAGED TO RESPOND**

## **A. PURPOSE**

This Request for Qualifications (RFQ) is designed to establish a non-clinical recovery support service whereby individuals in recovery from substance use disorders receive telephone calls from trained volunteers who may themselves be in recovery. The purpose of this service is to provide continuing care supports to persons in early recovery in order to sustain their recovery in the community. Telephone Peer Services will be offered on a voluntary basis to individuals who are engaged in outpatient treatment and other services with the expectation that the Telephone Support Service will continue after discharge from the outpatient treatment facility.

Individuals who remain engaged in the recovery process after treatment are more likely to sustain long-term recovery; therefore DMHAS plans to extend support services beyond discharge from outpatient treatment. Telephone Peer Support Services are intended to provide a “check-in” with the person in recovery from a trained volunteer who can assist the individual in their recovery and help the individual to access community supports that further support the person’s recovery. Additionally, the trained volunteer can intervene with the individual in recovery if there is a relapse. Early intervention and action after a relapse can often times prevent medical complications and decrease acute care services.

## **B. GOALS**

1. To provide a culturally competent, gender responsive, and respectful service that supports individuals in their recovery who are in the community.
2. To prevent persons with substance use disorders from relapsing and/or requiring admission to acute or inpatient levels of care.
3. To incorporate a continuing care approach within the existing substance abuse treatment service system in order to support individuals in their recovery in the community.
4. To support a person-centered, strengths-based approach for individuals in recovery.

### **C. VALUE STATEMENT**

1. The belief that individuals are unique and have special needs, goals, resources, health, attitudes and expectations for recovery that may require different pathways.
2. The importance of hope and empowerment in changing the course of individuals' lives.
3. The belief that recovery is attainable.
4. The value of cultural competence and gender responsiveness in designing and delivering services.
5. The importance of eliminating stigma and promoting recovery awareness, understanding and sensitivity.
6. The priority of an individual's choices in determining the pathway to recovery and stability.

### **D. FUNDING**

The qualified provider should submit a budget that reflects statewide services of Telephone Peer Support to approximately 2,500 unduplicated individuals per year. The specific funding mechanism has not been determined and is based on available dollars in the DMHAS 2008 budget. Potential funding mechanisms include, but are not limited to a flat grant, fee-for-service or a mix of grant dollars and fee-for-service reimbursement.

### **E. PROJECT OVERVIEW**

The selected applicant is expected to provide a statewide service of Telephone Peer Support. This service will be offered to individuals in substance abuse treatment and other recovery support services. The selected applicant will do extensive and ongoing outreach to treatment and other providers throughout the state in order to solidify successful relationships that promote referrals to this service. Treatment providers will offer Telephone Peer Support to individuals while they are in outpatient treatment. Individuals that choose to participate in this service will receive telephone calls from the selected applicant to support the individual in recovery. The volunteer callers will contact individuals for a minimum of 12-16 weeks. Frequency of calls will be determined on an individualized basis. Individuals may choose to continue the telephone support services beyond the 12-16 weeks.

The selected applicant will use a comprehensive training manual to train volunteer callers. The volunteers who make the calls may be in recovery themselves. The selected applicant will describe the process they use to screen, train (including the manual) and supervise the volunteers. The selected applicant will have a data tracking system to monitor successful and unsuccessful contacts with service recipients, track outcomes related to employment, social support including self-help and abstinence from drugs and alcohol.

Services implemented through this RFQ must meet DMHAS' Cultural Competency Standards and focus on a Recovery-Oriented System of Care to assure that all services are responsive to the culturally diverse needs of populations served and that those services are appropriate for individuals with co-occurring mental health and substance use disorders. (See Appendix 1: Commissioner's Policy Statement on Cultural Competency, Appendix 2: Commissioner's Policy Statement on a Recovery-Oriented System of Care and Appendix 3: Commissioner's Policy Statement on Serving Individuals with Co-Occurring Mental Health and Substance Use Disorders). Additionally proposed services must be consistent with Recovery Practice Guidelines: [www.dmhas.state.ct.us/documents/practiceguidelines.pdf](http://www.dmhas.state.ct.us/documents/practiceguidelines.pdf)

#### **F. OUTCOME MEASURES:**

The Department will work with the selected provider to establish outcome measures.

#### **G. REQUIRED COMPONENTS:**

**The following are mandatory components of the Telephone Peer Support:**

1. A staffing/volunteer pattern that reflects an understanding of addiction culture and is responsive to the ethnic, racial, gender, and linguistic composition of the population requiring services, including a detailed cultural competence orientation plan for volunteers.
2. Knowledge of community self-help recovery support group(s) throughout the state.

3. Knowledge of substance abuse treatment and recovery support programs, such as the General Assistance Behavioral Health and Basic Needs Programs and other local support systems.
4. The capacity to collect, track and report on data regarding call activity and outcomes.
5. Description of procedures for collaborating in the development and implementation of this service with the treatment system on a statewide basis.
6. A policy of accepting individuals who may be actively receiving medication assisted treatment (including methadone maintenance).
7. Telephone Peer Support is to be operational by July 1, 2007.

#### **H. ACCEPTANCE REQUIREMENTS**

##### **IN ORDER TO BE ELIGIBLE AN INDIVIDUAL IS REQUIRED TO:**

1. Be in a substance abuse Intensive Outpatient Treatment level of care or other designated service.
2. Be in a DMHAS-funded Sober House.
3. Be 18 years of age or older.
4. Be willing to receive support calls from the selected applicant.

**The Department requests that responding agencies submit concise bids that do not exceed five (5) pages and include:**

Responses to this Request for Qualifications 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 five (5) pages in length, exclusive of the budget and appendices. The proposal shall be presented with sections labeled and numbered as follows:

1. **Applicant Description and Experience (20 Points):** Please describe applicant's experience with Telephone Peer Support Services.

2. **Program Design (20 Points):** Please describe applicant's proposed approach in delivering services requested through this RFQ.
3. **Project Management/Workplan (40 Points):** Please detail agency's ability and willingness to meet Required Components outlined above in Section F.
4. **Budget Detail/Justification (20 Points)**
5. Please include the appendices specified below in the application.
  - Appendix 1: Documentation of Experience of Key Staff. A resume/job description should be provided for each proposed key staff.
  - Appendix 2: Training manual/curriculum used to train volunteers who make the calls

## **GENERAL PROPOSAL REQUIREMENTS**

### **A. Disposition of Proposals**

The Department 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 the Department. The Department reserves the right to contract for all or any portion of the scope of work contained within this RFQ if it is determined that contracting for a portion of the work will best meet the needs of the Department.

### **B. Conditions**

Any prospective respondents must be willing to adhere to the following conditions and must positively state them in the proposals:

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

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

**Timing and Sequence.** The Department will ultimately determine timing and sequence of events resulting from this RFQ.

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

**Amending or Canceling Requests.** The Department reserves the right to amend or cancel this RFQ, prior to the due date and time, if it is in the best interest of the Department and the State.

**Rejection for Default or Misrepresentation.** The Department reserves the right to reject the proposal of any respondent that is in the default of any prior contract or for misrepresentation.

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

**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 RFQ.

**Respondent Presentation of Supporting Evidence.** A respondent, 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.

**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 respondent's expense.

**Collusion.** By responding, the respondent implicitly states that the submitting a separate response to the RFQ, and is in all respects fair and without collusion or fraud. It is further implied that the respondent did not participate in the RFQ development process, had no knowledge of the specific contents of the RFQ prior to its issuance, and that no employee of the agency participated directly or indirectly in the respondent's proposal preparation.

#### **C. Proposal Preparation Expense**

The State of Connecticut and the Department assume no liability for payment of expenses incurred by respondents 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 Friday, May 12, 2007**. Postmark date will **not** be considered the basis for meeting any submission deadline. Any respondent'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, as the actual receipt of the document is a clerical function. If delivery of the proposal is not made by courier or in person, the use of Certified or Registered mail is suggested. **All** RFQ communications should be addressed to the RFQ Program Contact (Reference RFQ Cover).

#### **E. Incurring Costs**

The Department is not liable for any costs incurred by the respondent 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, respondents should be aware that all materials associated with this RFQ are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations and interpretations resulting there from. It will not be sufficient for respondents 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 a respondent 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 Statutes must accompany the proposal. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the respondent 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 respondent and the Department, the final administrative authority to release or exempt any or all material so identified rests with the Department.

#### **G. Offer of Gratuities**

By submission of a proposal, the respondent certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the Department if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the respondent, the respondent's agent or the respondent's employee(s).

#### **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 RFQ. The successful bidder shall keep confidential all financial, operating, proprietary or business information of the Department relating to the provision of services under this RFQ which is not otherwise public information, along with all information, not described above, but specified in writing by the Department 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 46a-68j-3(10) require agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements:

The respondent's success in implementing an affirmative action plan;

The respondent's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;

The respondent's promise to develop and implement a successful affirmative action plan;

The respondent'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,

The respondent's promise to set aside a portion of the contract for legitimate small contractors and minority business enterprises. (See CGS 4a-60).

#### **J. Evaluation and Selection**

It is the intent of the Department to conduct a comprehensive, fair and impartial evaluation of proposals received in response to this procurement. Only proposals found to be responsive to the RFQ will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFQ.

The original and four (4) exact, legible copies of the proposal must be submitted in a properly addressed package by the deadline.

#### **K. Respondent Debriefing**

The Department will notify all respondents of any award issued by it as a result of this RFQ. Unsuccessful respondents 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 the RFP cover page in writing at the address previously given. Debriefing will not include any comparisons of unsuccessful proposals with other proposals.

## ATTACHMENT 1:

# 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". *Source: Muir Gray JA. (1997) Evidence-based Healthcare: How to Make Health Policy and Management Decisions. London: Churchill Livingstone.*
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

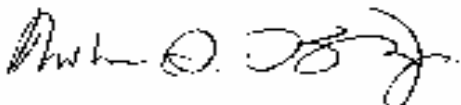
as instruments to permeate cultural competence throughout the DMHAS public/private network of services.

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 2:**

# **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:

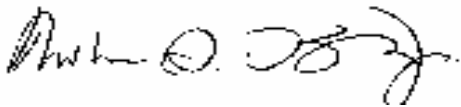
Returning to a healthy state evidenced by improving one's mood and outlook on life following an episode of depression;

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**

## ATTACHMENT 3:

# Commissioner's Policy Statement No. 84 Serving People with Co-Occurring Mental Health and Substance Use Disorders

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**

The DMHAS Co-Occurring Disorders Initiative website - <http://www.dmhas.state.ct.us/cosig.htm> - includes the following resources to help implement integrated mental health and addiction treatment:

- ☐ 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>
- ☐ Commissioner’s Policy Statement #83: Promoting a Recovery-Oriented Service System: <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 4:**

**GIFT AFFIDAVIT**

**Gift Affidavit to Accompany Bid or Proposal [on] for Large State Contracts,  
as defined in Section 2 of Public Act 04-245**

[Instructions: The following form is an affidavit that may be used by bidders or proposers on all large state contracts to comply with Public Act 04-245.]

I, \_\_\_\_\_, hereby swear that during the two-year period preceding the submission of this bid or proposal that neither myself nor any principals or key personnel of the submitting firm or corporation who participated directly, extensively and substantially in the preparation of this bid or proposal nor any agent of the above gave a gift as defined in Conn. Gen. Stat. § 1-79(e), including a life event gift as defined in Conn. Gen. Stat. § 1-79(e)(12), except the gifts listed below:

<u>Name of Recipient of Gift</u>	<u>Value of Gift</u>	<u>Date of Gift</u>	<u>Gift Description</u>
1. _____			
2. _____			
3. _____			

to (1) any public official or state employee of the state agency or quasi-public agency soliciting the bids or proposals who participated directly, extensively, and substantially in the preparation of the bid solicitation or preparation of request for proposal or (2) to any public official or state employee who has supervisory or appointing authority over the state agency or quasi-public agency soliciting the bid or proposal [whose name(s) has been provided to me by the state agency or quasi-public agency.] Further, neither I nor any principals or key personnel of the submitting firm or corporation who participated directly, extensively and substantially in the preparation of this bid or proposal know of any action to circumvent this gift affidavit disclosure.

Sworn as true to the best of knowledge and belief subject to the penalties of false statement.

\_\_\_\_\_  
Signature Date \_\_\_\_\_

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_

\_\_\_\_\_  
Commissioner of the Superior Court

Notary Public

**GIFT” IS DEFINED UNDER Conn. Gen. Stat. §1-79(e), excluding subdivision (12) as follows:**

- (e) "Gift" means anything of value, which is directly and personally received, unless consideration of equal or greater value is given in return. "Gift" shall not include:
- (1) A political contribution otherwise reported as required by law or a donation or payment as described in subdivision (9) or (10) of subsection (b) of section 9-333b;
  - (2) Services provided by persons volunteering their time;
  - (3) A commercially reasonable loan made on terms not more favorable than loans made in the ordinary course of business;
  - (4) A gift received from (A) an individual's spouse, fiancé or fiancée, (B) the parent, brother or sister of such spouse or such individual, or (C) the child of such individual or the spouse of such child;
  - (5) Goods or services (A) which are provided to the state (i) for use on state property, or (ii) to support an event or the participation by a public official or state employee at an event, and (B) which facilitate state action or functions. As used in this subdivision, "state property" means (i) property owned by the state, or (ii) property leased to an agency in the Executive or Judicial Department of the state;
  - (6) A certificate, plaque or other ceremonial award costing less than one hundred dollars;
  - (7) A rebate, discount or promotional item available to the general public;
  - (8) Printed or recorded informational material germane to state action or functions;
  - (9) Food or beverage or both, costing less than fifty dollars in the aggregate per recipient in a calendar year, and consumed on an occasion or occasions at which the person paying, directly or indirectly, for the food or beverage, or his representative, is in attendance;
  - (10) Food or beverage or both, costing less than fifty dollars per person and consumed at a publicly noticed legislative reception to which all members of the General Assembly are invited and which is hosted not more than once in any calendar year by a lobbyist or business organization. For the purposes of such limit, (A) a reception hosted by a lobbyist who is an individual shall be deemed to have also been hosted by the business organization which he owns or is employed by and (B) a reception hosted by a business organization shall be deemed to have also been hosted by all owners and employees of the business organization who are lobbyists. In making the calculation for the purposes of such fifty-dollar limit, the donor shall divide the amount spent on food and beverage by the number of persons whom the donor reasonably expects to attend the reception;
  - (11) Food or beverage or both, costing less than fifty dollars per person and consumed at a publicly noticed reception to which all members of the General Assembly from a region of the state are invited and which is hosted not more than once in any calendar year by a lobbyist or business organization. For the purposes of such limit, (A) a reception hosted by a lobbyist who is an individual shall be deemed to have also been hosted by the business organization which he owns or is employed by, and (B) a reception hosted by a business organization shall be deemed to have also been hosted by all owners and employees of the business organization who are lobbyists. In making the calculation for the purposes of such fifty-dollar limit, the donor shall divide the

amount spent on food and beverage by the number of persons whom the donor reasonably expects to attend the reception. As used in this subdivision, "region of the state" means the established geographic service area of the organization hosting the reception;

(12) A gift, including but not limited to, food or beverage or both, provided by an individual for the celebration of a major life event;

(13) Gifts costing less than one hundred dollars in the aggregate or food or beverage provided at a hospitality suite at a meeting or conference of an interstate legislative association, by a person who is not a registrant or is not doing business with the state of Connecticut;

(14) Admission to a charitable or civic event, including food and beverage provided at such event, but excluding lodging or travel expenses, at which a public official or state employee participates in his official capacity, provided such admission is provided by the primary sponsoring entity;

(15) Anything of value provided by an employer of (A) a public official, (B) a state employee, or (C) a spouse of a public official or state employee, to such official, employee or spouse, provided such benefits are customarily and ordinarily provided to others in similar circumstances;

(16) Anything having a value of not more than ten dollars, provided the aggregate value of all things provided by a donor to a recipient under this subdivision in any calendar year shall not exceed fifty dollars.