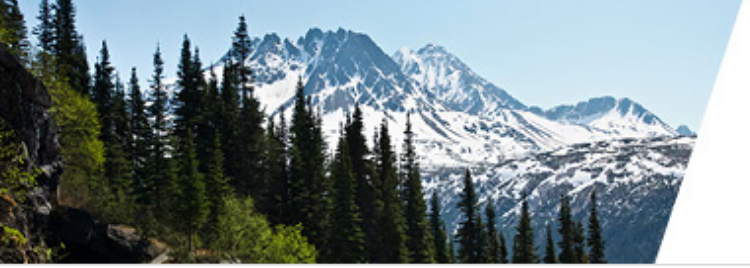

Northwest (HHS Region 10)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Northwest, Northeast &Caribbean, and Great Lakes ATTC present:

Integration Series: Enhancing Program Structure and Environment

- **Got questions?** Type them into the chat box at any time and they will be answered at the end of the presentation.
- An ADA-compliant recording of this presentation will be made available on our website at: http://attcnetwork.org/northwest

SAMHSA
Substance Abuse and Mental Health Services Administration

Great Lakes (HHS Region 5)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Northeast & Caribbean (HHS Region 2)
ATTC Addiction Technology Transfer Center Network
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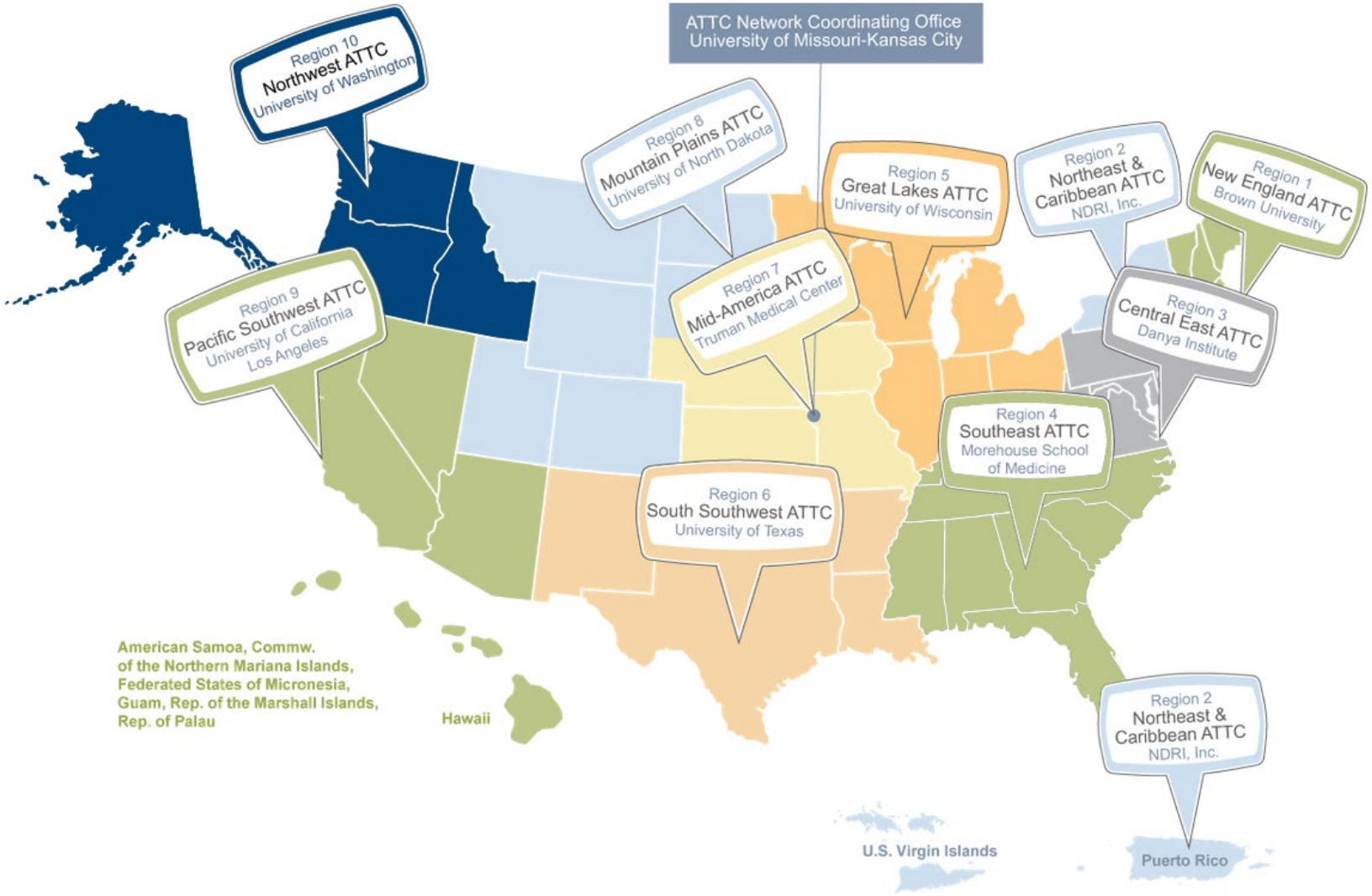
ATTC Network



ATTC Addiction Technology Transfer Center Network

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Integration Webinar Series

Part II: Enhancing Program Structure and Environment

Presented by:

Denna Vandersloot, M.Ed, Northwest ATTC, University of Washington
Michael Chaple, PhD, Northeast & Caribbean ATTC, Columbia University

Welcome: Webinar Facilitators & Speakers

Michael Chaple, PhD
Northeast & Caribbean ATTC Director

Denna Vandersloot, M.Ed.
Northwest ATTC, Co-director

Travis Swieringa
InterAct of Michigan, CEO

DDCAT/DDCMHT Overview ("Reminder")

Domain	Description
Program Structure	Certification, licensure, coordination and collaboration with other providers
Program Milieu	Extent to which programs/staff expect and welcome clients with dual diagnosis
Assessment	Screening and assessment procedures for dual diagnosis
Treatment	Treatment planning and services delivery for clients with dual diagnosis
Continuity of Care	Assesses discharge planning for clients with dual diagnosis
Staffing	Availability of licensed staff to provide dual diagnosis services
Training	Amount of training staff receives in dual diagnosis

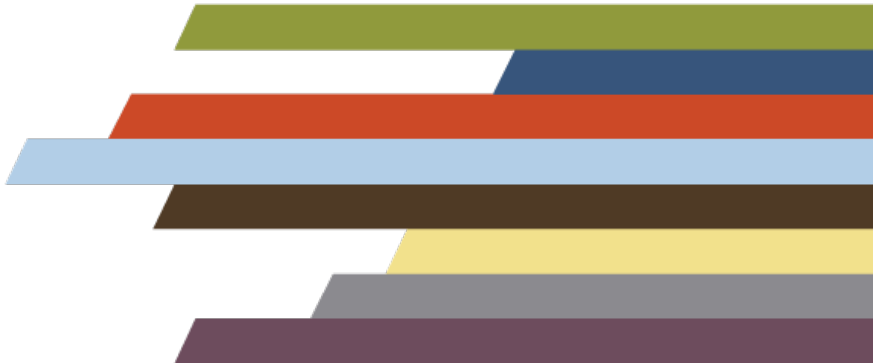
Today's Focus!!!

Goal

This webinar will explore a variety of strategies for:

(1) establishing an organizational culture that communicates support for persons with co-occurring substance use and mental health disorders;

(2) promoting effective coordination and collaboration between mental health and substance use treatment service providers.



Today's "Agenda"

This webinar will incorporate the following elements throughout:

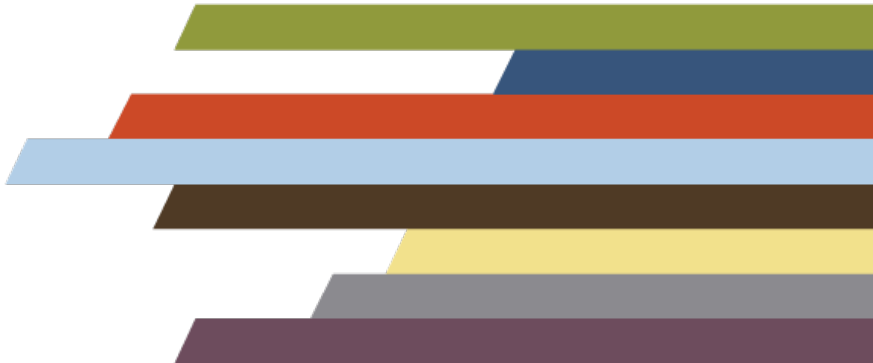
(1) Brief overview of DDCAT constructs that address opportunities for enhancing various aspects of program culture and structure;

(2) Brief review of recommended strategies for enhancing capability;

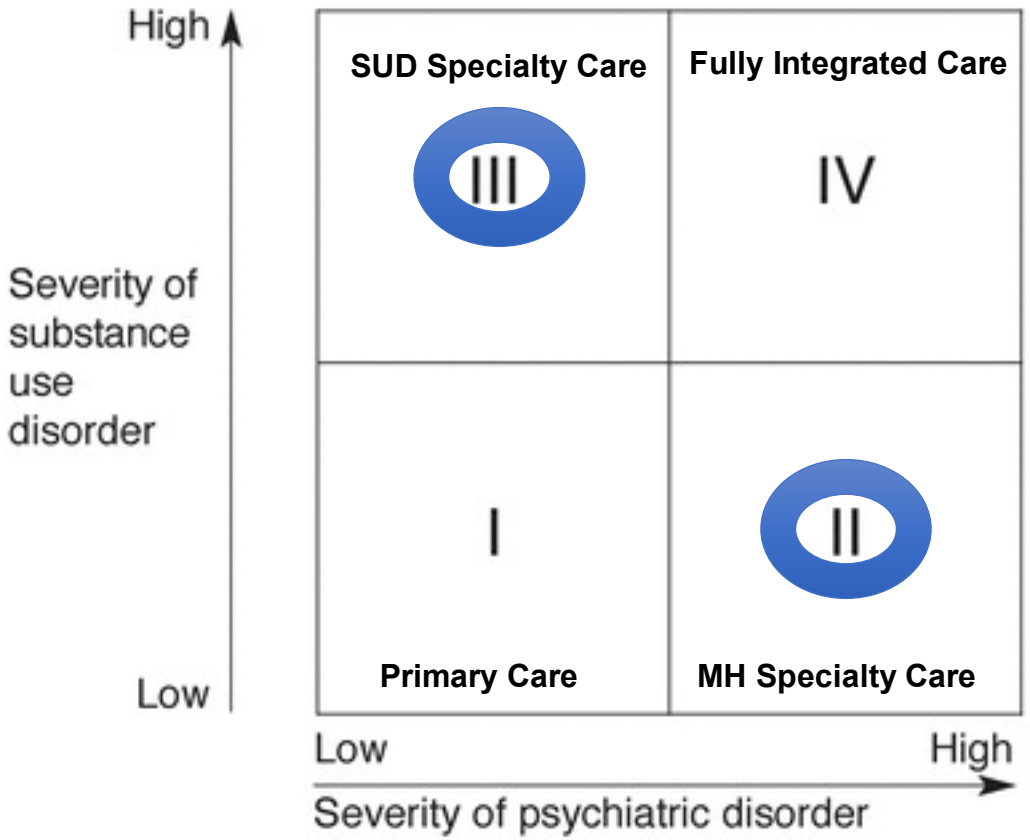
(3) "Interview" with provider(s) illustrating implementation of "in-service" strategies;

(4) Ask the Experts and Innovators: Q&A Session for participants

(5) Summary of recommendations for enhancing capacity



Conceptual Framework for Integrated Care



Quadrant I. Low psychiatric severity: anxiety, mood, personality, and behavioral disorders; low substance severity: (low to moderate substance use disorders).

Quadrant II. High psychiatric severity: schizophrenia, bipolar, schizoaffective, and major affective disorders; low substance severity: (low to moderate substance use disorders).

Quadrant III. Low psychiatric severity: anxiety, mood, personality, and behavioral disorders; high substance severity: (severe substance use disorders).

Quadrant IV: High psychiatric severity: schizophrenia, bipolar, schizoaffective, and major affective disorders; high substance severity: (sever substance use disorders).

First things First: Organizational Culture

Prior to instituting any programmatic changes it is critical that organizational culture be assessed and addressed to ensure alignment with programmatic goals/objectives for integration:

(1) Assess staff receptivity re: treatment of dual diagnosis clients;

(2) Address existing ambivalence to create “buy-in!”

(3) Review admission criteria (formal and informal) to ensure that persons who present with dual diagnosis are not rejected from the program because of the presence of either disorder.

Culture: Assessing Staff Receptivity

Goal: To develop a comprehensive understanding of staff perceptions regarding roles and responsibilities pertaining to dual diagnosis treatment.

❑Identify facilitators/barriers to integrated care; meet staff where they are at!

Potential strategies for assessing staff receptivity:

- Distribute an anonymous/confidential survey to all staff
- In-depth individual interviews with key clinical staff
- Focus Groups with staff teams
- Roundtable discussions

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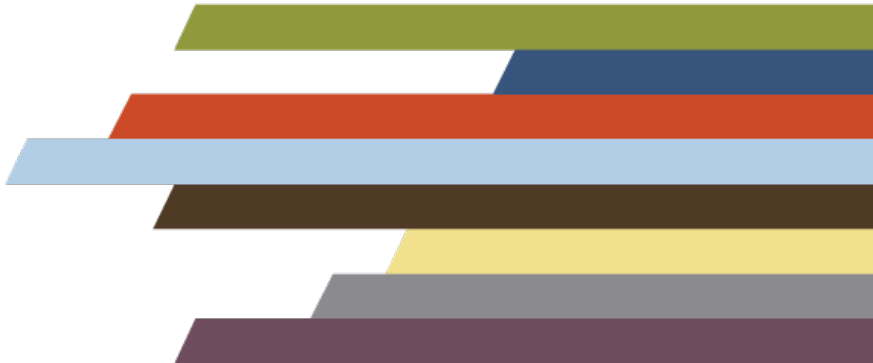

Culture: Addressing Staff Ambivalence

Goal: To facilitate consensus and “buy-in” among staff regarding the importance of dual diagnosis treatment for program clients.

❑Staff are more likely to embrace change that they helped to inform

Potential strategies for addressing staff ambivalence:

- Basic education about dual diagnosis (it’s an expectation, not the exception)
- Advanced staff training to address perceived gaps
- Collaborate on a program vision for integration

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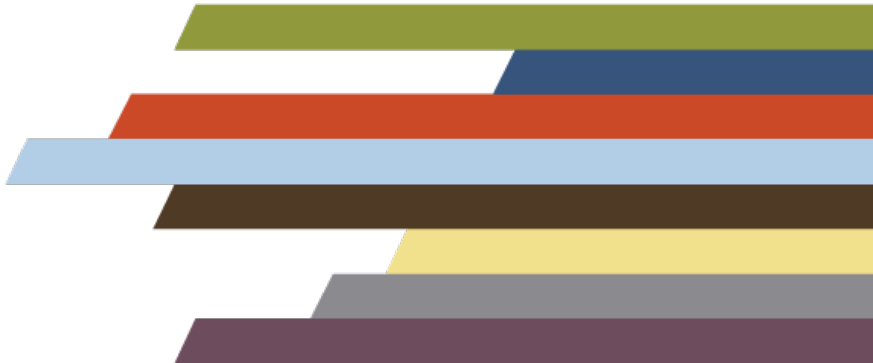

Culture: Review Admission Criteria

Goal: Dual diagnosis clients are welcomed by the program and staff; they are not rejected because of the presence of the “other” disorder.

❑Which dually diagnosed clients are typically excluded?

Potential strategies for addressing admission criteria:

- Review formal policies and procedures to ensure that the program does not endorse specific criteria that excludes certain clients from treatment.
- Identify and address informal practices among staff that have resulted in the exclusion of clients from treatment based on common interpretations.

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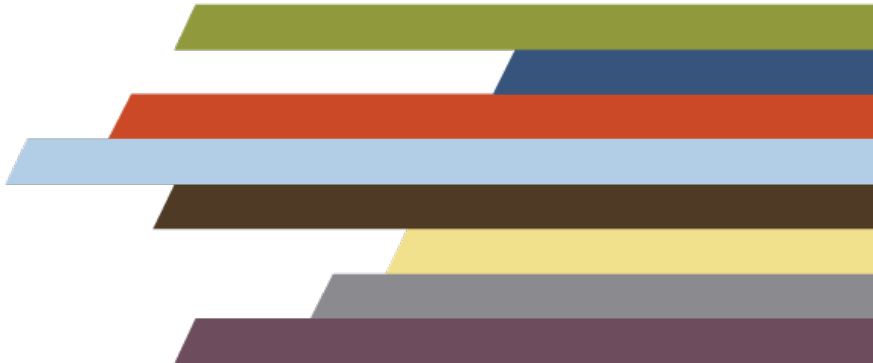


Provider “Interview”: Fostering Cultural Change

Provider review of “in-service” strategies implemented to:

- Assess staff receptivity to dual diagnosis treatment
- Address staff ambivalence toward dual diagnosis treatment
- Ensure admission criteria aligns with goals/objectives for integration

Follow-up Q&A from Participants

The Physical Environment

Subtle additions to the physical environment provide non-verbal cues to clients as to program/staff receptivity toward the dually diagnosed:

(1) Display and distribute literature, educational materials, and other resources that address mental health and substance use disorders;

(2) Amend the program's mission statement to reflect a dual diagnosis focus; should also be posted and distributed for visibility.

Display and Distribution of Resources

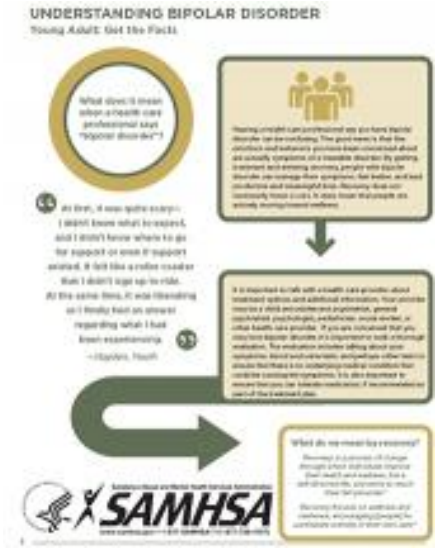
Goal: Make information on dual diagnosis readily available to clients

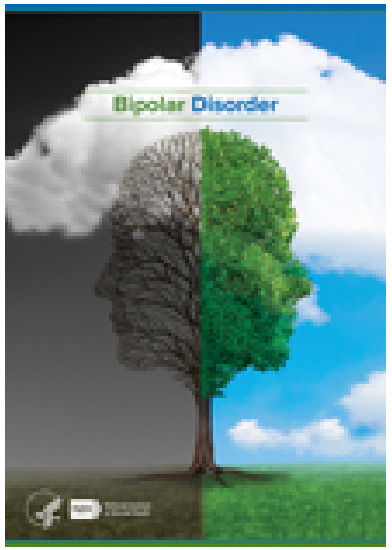
❑Communicates program receptivity and raises client awareness

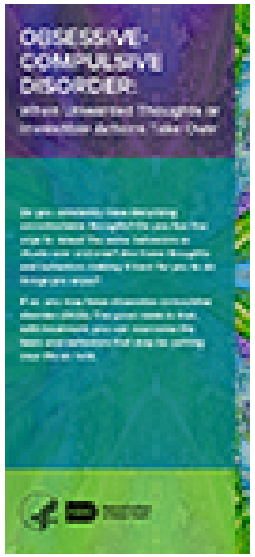
Potential strategies for dissemination of information:

- Display (in waiting room and other common areas) and have clinicians distribute educational materials about MH and/or SA disorders/symptoms (e.g., pamphlets, posters, brochures, fact sheets, and/or infographics).
- Display and distribute resources for community-based support (e.g., peer supports, crisis centers and hotlines, ancillary services, etc.)
- Play educational videos in waiting room and advertise community events

Literature & Patient Education







National Institute on Mental Health
https://www.nimh.nih.gov/health/topics/index.shtml

SAMHSA Clearinghouse for Co-occurring Disorders

https://www.store.samhsa.gov/issues-conditions-disorders/co-occurring-disorders

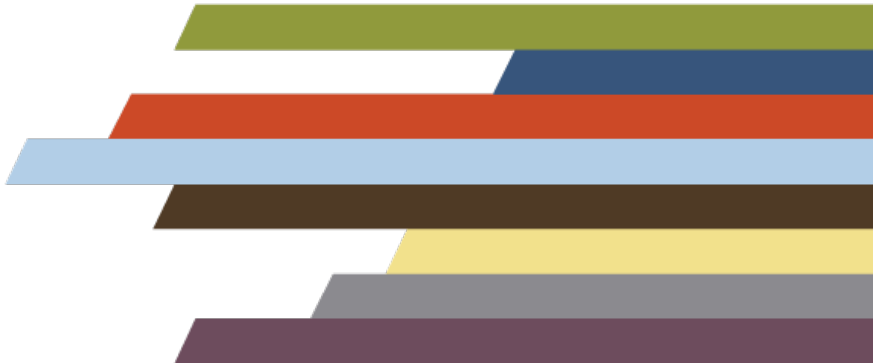
The Mission Statement

Goal: Communicate dual diagnosis focus of treatment services

- Revising a mission statement is emblematic of a “sea change” in leadership philosophy, culture and commitment

Potential strategies for revision of mission statement:

- Revise mission statement to reflect an emphasis on both disorders
- If mission statement cannot be revised, develop a unique program statement
- Post revised mission statement in common program areas for visibility



Revising SUD Focused Mission Statement

Traditional Mission Statement for a SUD Treatment Provider

"The North Side Drug Treatment Center is dedicated to assisting persons with alcohol and drug problems regain control over their lives."

Revised Mission Statement Reflecting an Integrated Approach

"The North Side Drug Treatment Center is dedicated to assisting persons initiate a process of recovery from substance use and its associated problems."

Revising MH Focused Mission Statement

Traditional Mission Statement for a MH Treatment Provider

“The Mental Health Community Board is dedicated to assisting persons with mental health problems regain control over their lives.”

Revised Mission Statement Reflecting an Integrated Approach

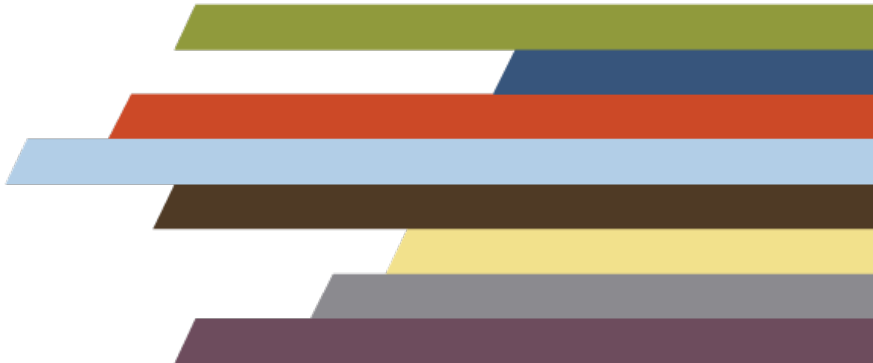
“The Mental Health Community Board is committed to offering a full range of behavioral health services to promote well-being and lifelong recovery.”

Provider “Interview”: Physical Enhancements

Provider review of “in-service” strategies implemented to:

- Make educational resources available
- Address revisions to the mission statement

Follow-up Q&A from Participants



Organizational Certification & Licensing

Goal: Provide unrestricted services for individuals with COD

- ❑ Allows for the highest level of integration
- ❑ Actual barriers versus perceived barriers

Potential strategies for enhancing certification/licensing & financial incentives:

- Secure MH or SUD Program Certification
- Partner with a program or individual who can provide the MH or SUD services within your program; but bill and operate under their own license.
- Review state and funder policies around treating individuals with co-occurring disorders and educate staff on the actual restrictions (this is also relevant to scope of practice)

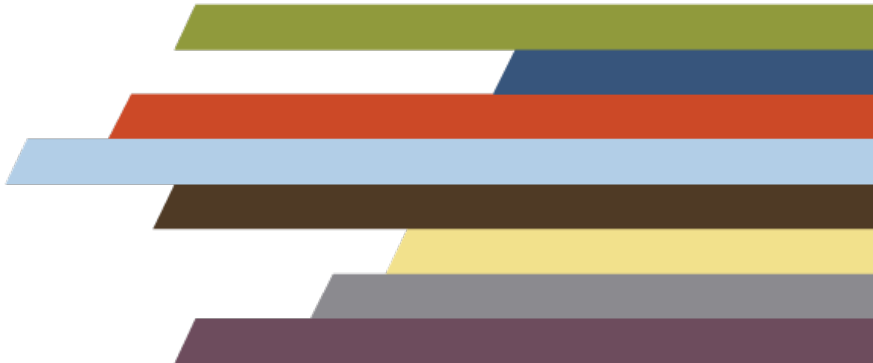
Financial Incentives

Goal: Program can bill for MH and SUD evaluations and services

❑ Allows for the highest level of integration

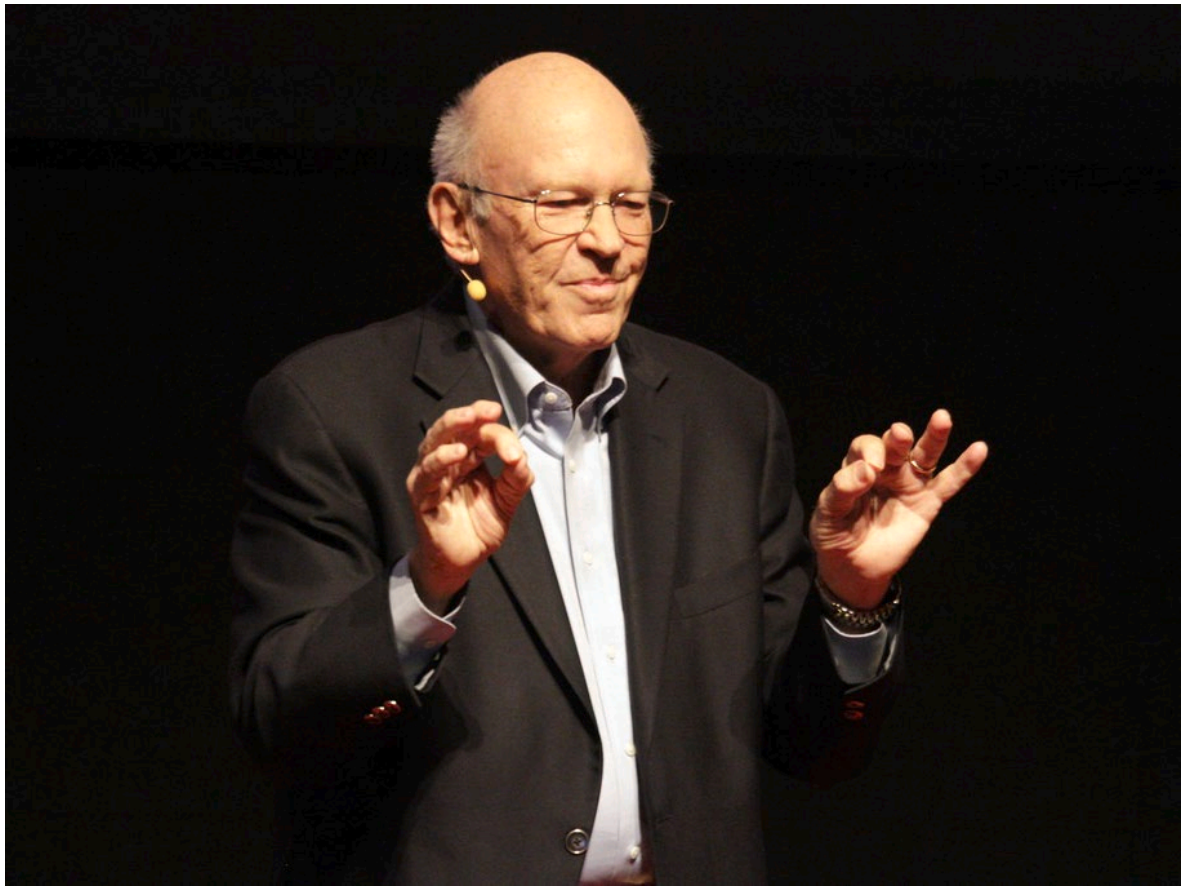
Potential strategies for enhancing :

- Secure the licensing and contracts to provide integrated care
- Partner with a program or individual who can provide the MH or SUD services within your program; but bill under their own license.
- Some states are providing higher rates for programs offering integrated services
- Secure grants to enhance services



Collaboration is key to effective care

Communication is key to coordinated care



Ken Blanchard – TED Talk
Collaboration- Affect/Possibility
https://www.youtube.com/watch?v=HKGkBRk1kSo

There are two key aspects to collaboration:

1) Essence (heart, values, meaning)
2) Form (how are we going to do it)

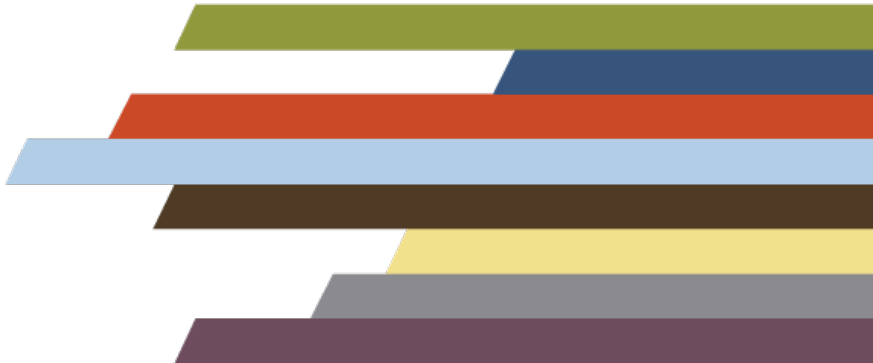
Collaboration and Coordination

Goal: Individual receives services for CODs that are coordinated and align to treat the "whole person" and this is achieved through high levels of communication and a shared sense of responsibility between providers.

❑ Services appear seamless from the customer's perspective

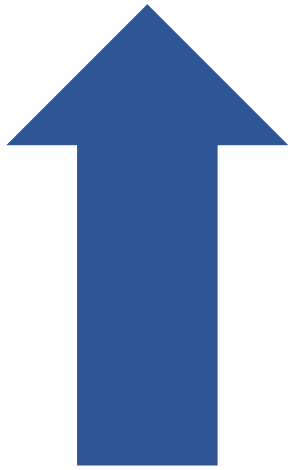
Potential strategies for enhancing collaboration and coordination:

- Multi-disciplinary case staff meetings
- Formalize procedures and protocols for coordination (MOUs, regular check-ins)
- Communicate regularly by phone or email
- Care managers facilitate coordination of care
- Partner with an agency to provide telehealth services
- Co-location of services
- Shared patient records

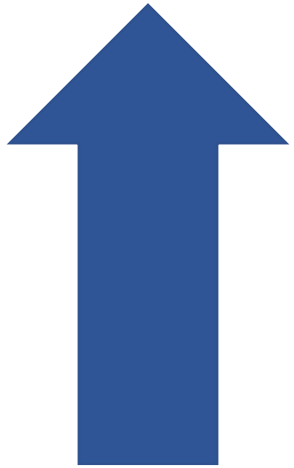


Minimal Coordination	Consultation	Collaboration	Integration
1) Provider aware of a MH or SUD condition; and 2) Referral made with no or minimal follow-up communication	Informal process between two providers treating the same individual. Interaction is : • informal • episodic • limited	Formal process of shared responsibility for treating a person with co-occurring disorders. Involves: • Regular communication • Sharing progress reports • MOU in place	Shared responsibility for the development and implementation of a treatment plan that addresses the co-occurring disorders. Highest level often involves one clinician addressing both SUD and MH issues.
Example: Program A refers Bob to the County MH program after screening positive for MH issues; but does not follow-up on the referral.	*Example: Program B refers Bob to the County MH program and asks for a copy of Bob's MH evaluation.*	*Example: Program C refers Bob to the County MH program and a MOU is in place between these two programs addressing communication, shared patient records, joint treatment planning, etc.*	*Example: Program D has a dually credentialed staff member who addresses MH and SUD issues through the lens of COD treatment. They use the COMBINE manual to guide treatment.*

Collaboration & Coordination



As shared responsibility goes up….



So does the level of needed communication

Provider “Interview”: Collaboration & Coordination

Provider review of strategies implemented to:

- Enhance communication and collaboration between MH and SUD providers
- Develop a team approach to care
- Address financing and licensing issues
- Provide seamless care to the client with CODs

Follow-up Q&A from Participants

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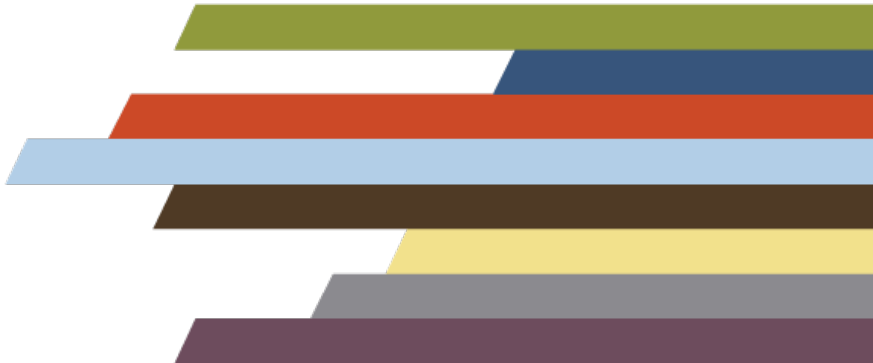

Integrated Treatment Webinar Series

Join us for our next webinar!

Best Practices for Co-occurring Disorder Treatment
Staffing and Training
Facilitated by: Michael Chaple, Ph.D. and Denna Vandersloot, M.Ed.
August 19, 1:00 ET, 12:00 CT, 11:00 MT, 10:00 PT

gracias cảm ơn bạn ধন্যবাদ 고맙습니다

شكرا جزيلا salamat благодарю вас 谢谢

Dziękuję Ci **Thank** ευχαριστώ

quyana tack **you!** አመሰግናለሁ

धन्यवाद danke asante grazie

hík'ʷu? merci תודה obrigado ขอบคุณ

ありがとうございました спасибі mahalo