Northwest ATTC presents:

Defining and Assessing Integrated Behavioral Health Capacity

Thank you for joining us!
The webinar will begin shortly.

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ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Northeast & Caribbean (HHS Region 2)
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Great Lakes (HHS Region 5)
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MHTTC Mental Health Technology Transfer Center Network
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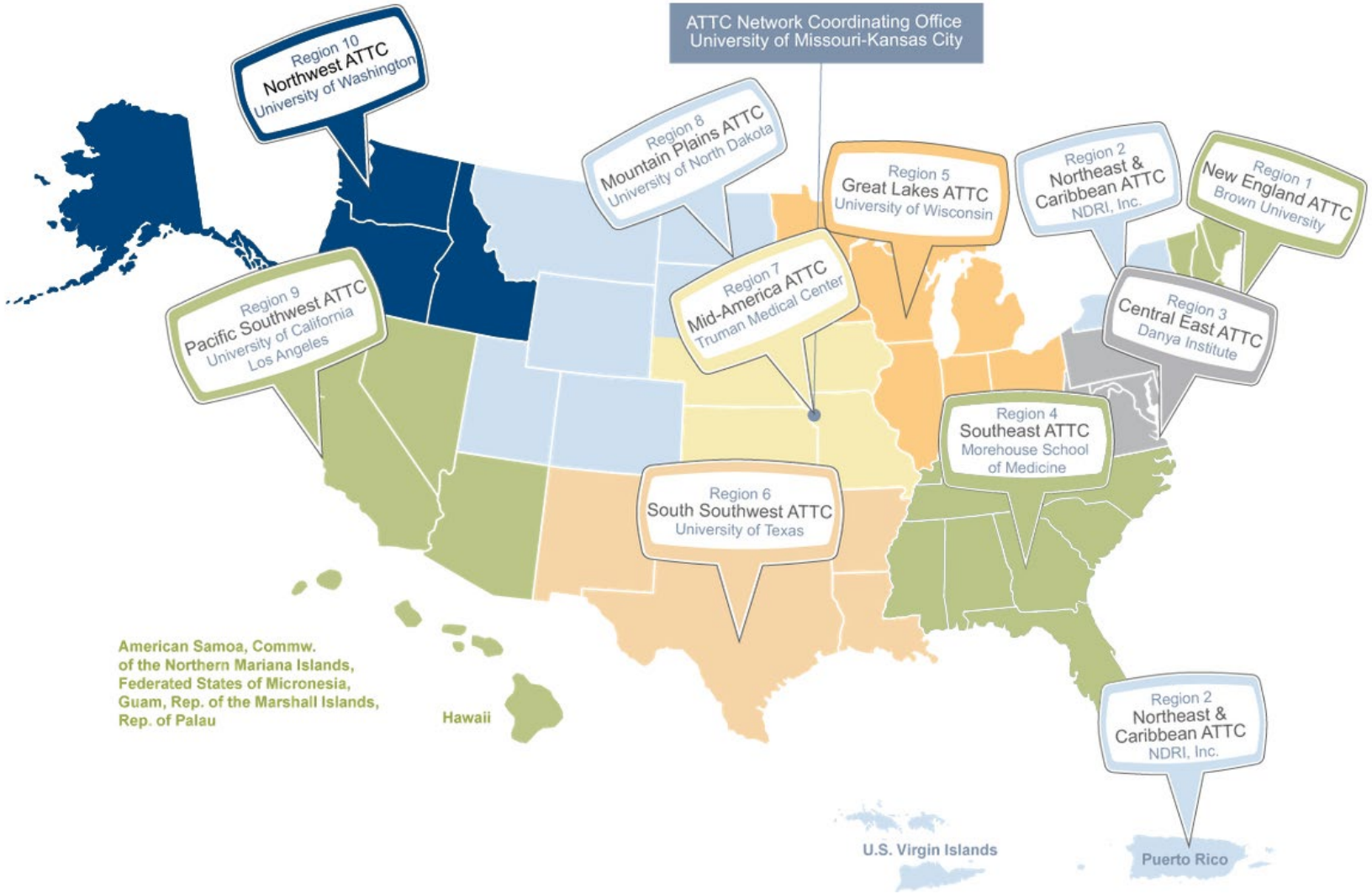
- **Got questions?** Type them into the chat box at any time and they will be answered at the end of the presentation.
- An ADA-compliant recording of this presentation will be made available on our website at: http://attcnetwork.org/northwest

SAMHSA
Substance Abuse and Mental Health Services Administration

ATTC Network



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Q&A

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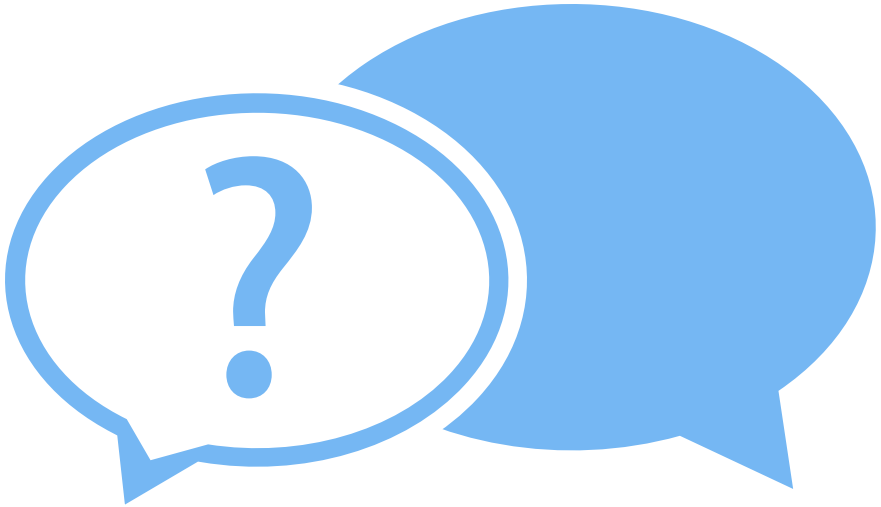


Today's Presenters

Mark McGovern, PhD is a Professor of Psychiatry & Behavioral Sciences at Stanford University School of Medicine and PI of the MHTTC Network Coordinating Office.

Heather Gotham, PhD is a Licensed Clinical Psychologist and Clinical Associate Professor at Stanford University School of Medicine. She is also the Director of the MHTTC Network Coordinating Office.

Jennifer Harrison, PhD, LMSW, CAADC is a social worker, chemical addictions counselor, associate professor, and the interim director for the School of Social Work at Western Michigan University.

Stanford MEDICINE | Department of Psychiatry and Behavioral Sciences

Co-Occurring Disorders

Defining and Assessing Integrated Behavioral Health Capacity

Mark McGovern, PhD & Heather Gotham, PhD
Center for Behavioral Health Services and Implementation Research (CBHSIR)

June 10, 2020

Network Coordinating Office
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

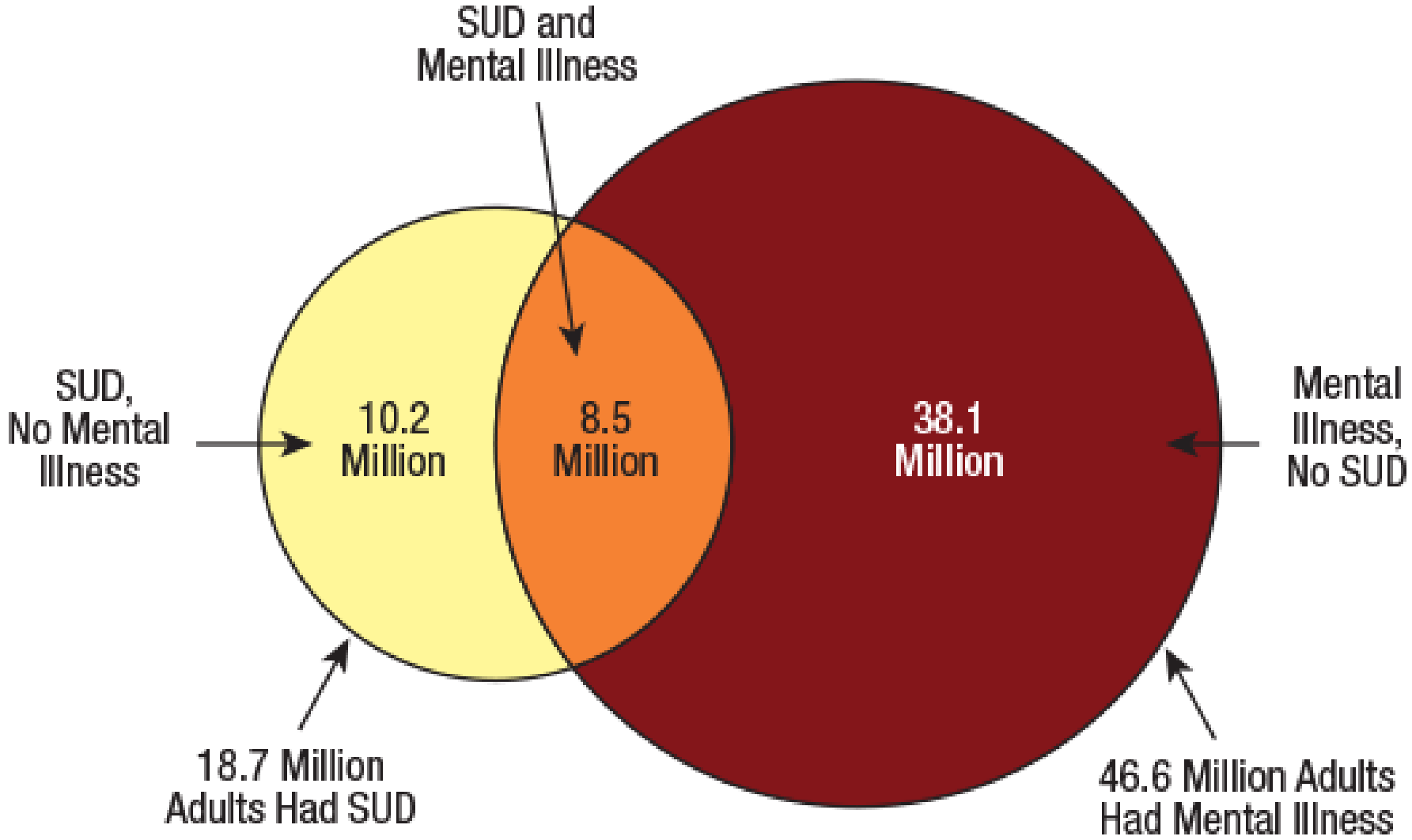
Outline

- Co-Occurring disorders (COD)
- Treatment options & access to integrated services
- Measuring organizational COD capability

Co-Occurring Disorders (COD)

- Coexistence of both a substance use and mental health disorder
- The combination of any mental health disorder and any substance use disorder may be present at the same time
- Co-occurring disorders are:
  - Highly prevalent
  - Often begin in youth
- If untreated, patients with COD can face problems not only related to health, but also other aspects of their lives:
  - Impact school/work, relationships, housing, economics, and incarceration
  - Increased risk for suicide

Co-Occurring Mental Illness and Substance Use Disorder in Adults



SAMHSA, The 2017 NSDUH Report

Treatment Options & Access

Treatment Options

- COD are common in general medical settings and community samples, but are “endemic” in specialty behavioral health care settings, criminal justice systems, and among the homeless[1]
- Treatment for COD is offered in diverse settings and varies in activities and resources[2]
- Depending on where patients seek treatment (e.g., mental health or substance use treatment providers), they may experience different treatment approaches[2-3]

[1]O’Brien et al, 2004;
[2]Sacks et al, 2008;
[3]McGovern et al, 2006;

Integrated Treatment Services

- Integrated treatment services address:
  - **Both problems** (substance use & mental health) at the **same time** during the **same treatment episode**, and by the **same providers**
- COD patients have poorer outcomes in single disorder treatment or non-integrated systems of care[1-2]
- Integrated care is more effective and economically viable versus targeting one or the other disorder independently [3-6]
- National policy statements, expert consensus guidelines & systematic reviews underscore the benefits of integrated treatment[7-12]

[1]Drake et al, 2001
[2]Nunes et al, 2004;
[3]Drake et al, 1998;
[4]Drake et al, 2004a;
[5]Drake et al, 2004b;
[6]Weiss et al, 2000;
[7]SAMHSA, 2002;
[8]SAMHSA, 2003;
[9]New Freedom Commission on Mental Health, 2003;
[10]Mee-Lee et al, 2001;
[11]Institute of Medicine, 2006;
[12]Center for Substance Abuse

Current State of Access to Integrated Treatment

Common Barriers to Integrated Services

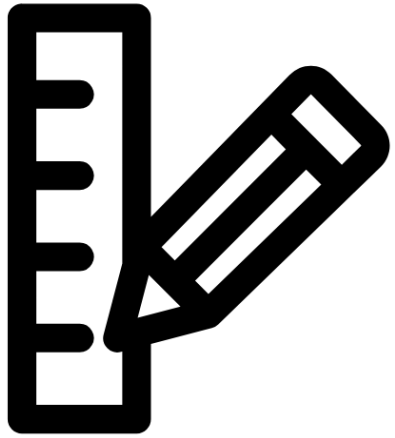
Policy Barriers
- Organizational structure
- Financing
- Regulations
- Licensing

Clinical Barriers
- Clinician knowledge & beliefs
- Clinician self-efficacy
- Career opportunities

Program Barriers
- Service models
- Administrative guidelines
- Contractual incentives
- Quality assurance procedures
- Outcome measures
- Personnel & other resources

Consumer & Family Barriers
- Consumer & family knowledge & beliefs
- Family support
- Denial/minimization of substance use/mental health
- Consumer self-efficacy

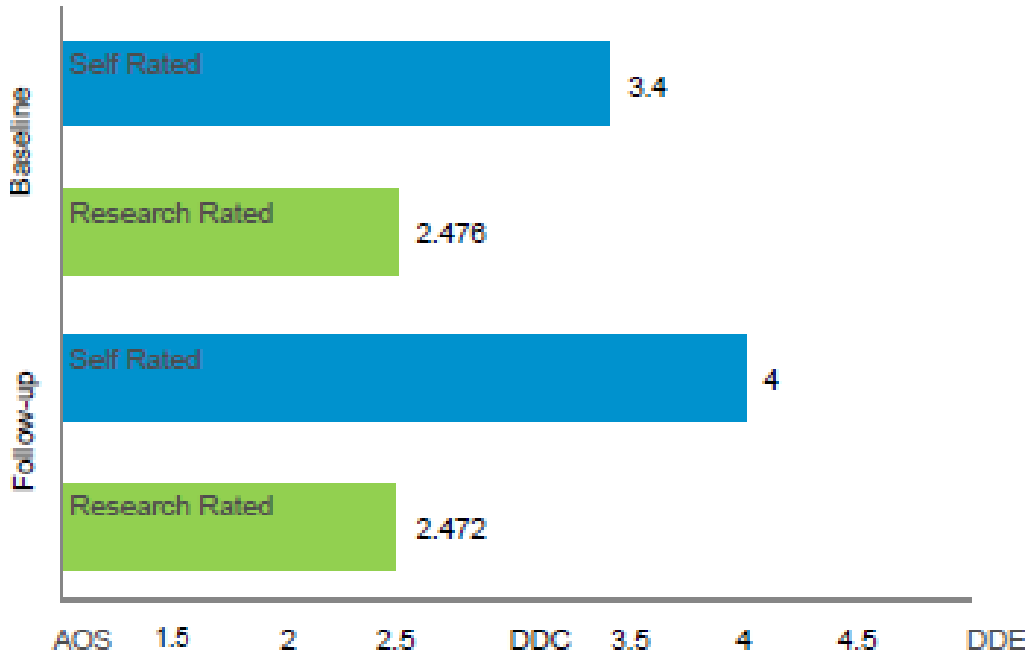
Measuring COD Organizational Capability



Are Your Services Integrated?

- "Integrated" lacks specificity and meaning without **objective criteria**
- Like other EBPs, integrated treatment for COD can be **assessed by a fidelity-type scale**

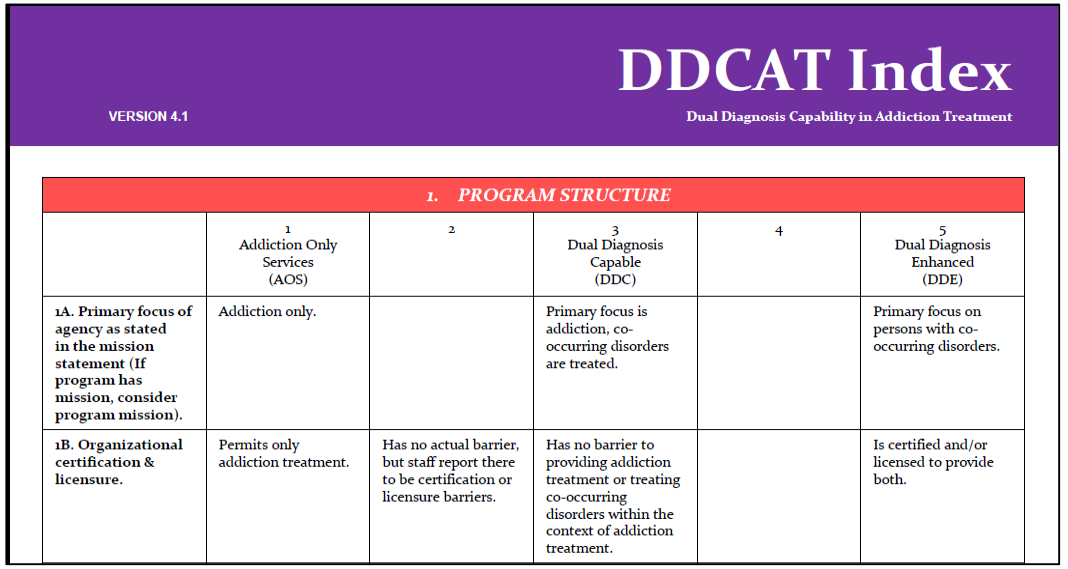
Self vs independent ratings of COD capability (DDCAT Index)[1]



[1]Lee and Cameron, 2009

Measuring COD Capability

- Organizational capability to treat patients with COD can be measured
- These measures include:
  - Dual Diagnosis Capability in Addiction Treatment (DDCAT)[1]
  - Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)[2]
  - Behavioral Health Integration in Medical Care (BHIMC)[3*]

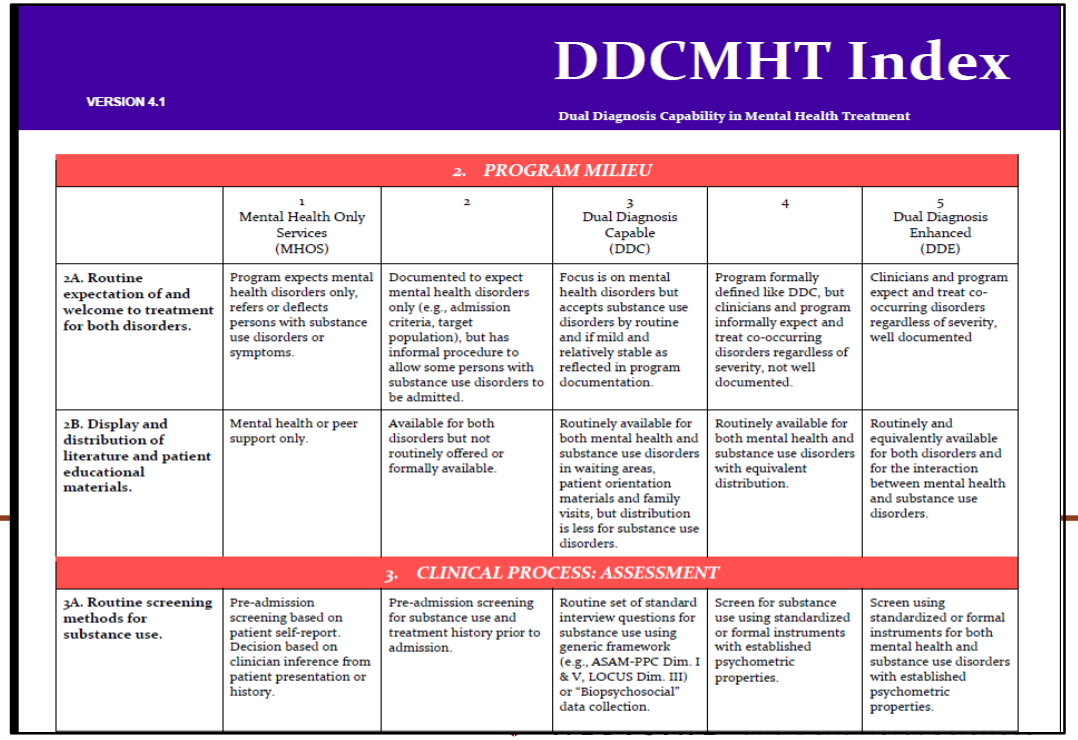


VERSION 4.1

DDCAT Index

Dual Diagnosis Capability in Addiction Treatment

1. PROGRAM STRUCTURE					
	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
1A. Primary focus of agency as stated in the mission statement (If program has mission, consider program mission).	Addiction only.		Primary focus is addiction, co-occurring disorders are treated.		Primary focus on persons with co-occurring disorders.
1B. Organizational certification & licensure.	Permits only addiction treatment.	Has no actual barrier, but staff report there to be certification or licensure barriers.	Has no barrier to providing addiction treatment or treating co-occurring disorders within the context of addiction treatment.		Is certified and/or licensed to provide both.



VERSION 4.1

DDCMHT Index

Dual Diagnosis Capability in Mental Health Treatment

2. PROGRAM MILIEU					
	1 Mental Health Only Services (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
2A. Routine expectation of and welcome to treatment for both disorders.	Program expects mental health disorders only, refers or deflects persons with substance use disorders or symptoms.	Documented to expect mental health disorders only (e.g., admission criteria, target population), but has informal procedure to allow some persons with substance use disorders to be admitted.	Focus is on mental health disorders but accepts substance use disorders by routine and if mild and relatively stable as reflected in program documentation.	Program formally defined like DDC, but clinicians and program informally expect and treat co-occurring disorders regardless of severity, not well documented.	Clinicians and program expect and treat co-occurring disorders regardless of severity, well documented
2B. Display and distribution of literature and patient educational materials.	Mental health or peer support only.	Available for both disorders but not routinely offered or formally available.	Routinely available for both mental health and substance use disorders in waiting areas, patient orientation materials and family visits, but distribution is less for substance use disorders.	Routinely available for both mental health and substance use disorders with equivalent distribution.	Routinely and equivalently available for both disorders and for the interaction between mental health and substance use disorders.
3. CLINICAL PROCESS: ASSESSMENT					
3A. Routine screening methods for substance use.	Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or history.	Pre-admission screening for substance use and treatment history prior to admission.	Routine set of standard interview questions for substance use using generic framework (e.g., ASAM-PPC Dim. I & V, LOCUS Dim. III) or "Biopsychosocial" data collection.	Screen for substance use using standardized or formal instruments with established psychometric properties.	Screen using standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.

[1]McGovern et al 2007;
[2]Gotham et al, 2013;
[3]McGovern et al, 2012;
*Formerly Dual Diagnosis Capability in Healthcare Settings (DDCHCS)

DDCAT/DDCMHT: 7 Dimensions, 35 Items

Dimension	Content of Items
Program Structure	Program mission, structure and financing, format for delivery of substance abuse services.
Program Milieu	Physical, social and cultural environment for persons with co-occurring disorders.
Clinical Process: Assessment	Processes for access and entry into services, screening, assessment & diagnosis.
Clinical Process: Treatment	Processes for treatment including pharmacological and psychosocial evidence-based formats.
Continuity of Care	Discharge and continuity for both addiction and psychiatric services, peer recovery supports.
Staffing	Presence, role and integration of staff with addiction treatment expertise, supervision process
Training	Proportion of staff trained and program's training strategy for co-occurring disorder issues.

DDCAT/DDCMHT Scoring: Range: 1 - 5

1. AOS / MHOS	3. DDC	5. DDE
• Addiction or Mental Health Only Services • Serve clients with no or minimal COD	• Dual Diagnosis Capable • Serve clients with low severity COD	• Dual Diagnosis Enhanced • Serve clients with more severe, unstable COD

Methodology

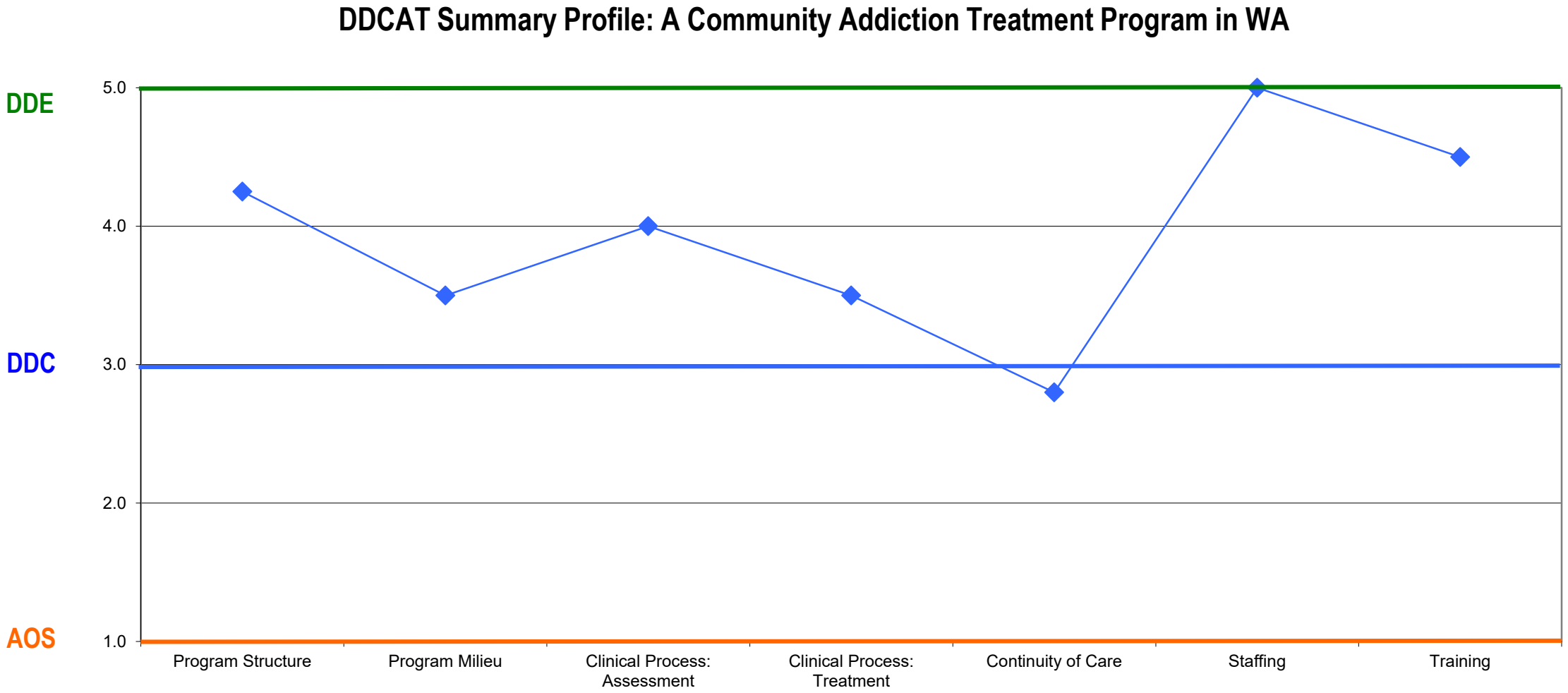
- Data obtained during independent site visits conducted by external raters

- Collected during half day site visits and from a variety of sources:
  - Ethnographic observations of milieu and physical settings
  - Focused, but open-ended key informant interviews with agency directors, clinical supervisors, clinicians, prescribers, support personnel, and clients
  - Review of documentation such as medical records, program policy and procedure manuals, brochures, daily patient schedules, telephone intake screening forms, etc.

- Unit of analysis: program

- “Triangulation” of data

Example Results



Assefa, McGovern, et al, 2019

DDCAT & DDCMHT Toolkits (2011)

- Applications for different purposes (e.g., system and regulatory agencies, treatment providers, health services researchers, families and individuals seeking services)
- Methodology & Training
- Scoring & Profile Interpretation
- Examples of Enhancements - moving from AOS/MHOS to DDC, or DDC to DDE
- Site Visit FAQs
- Sample Forms, Screening & Motivation Tools

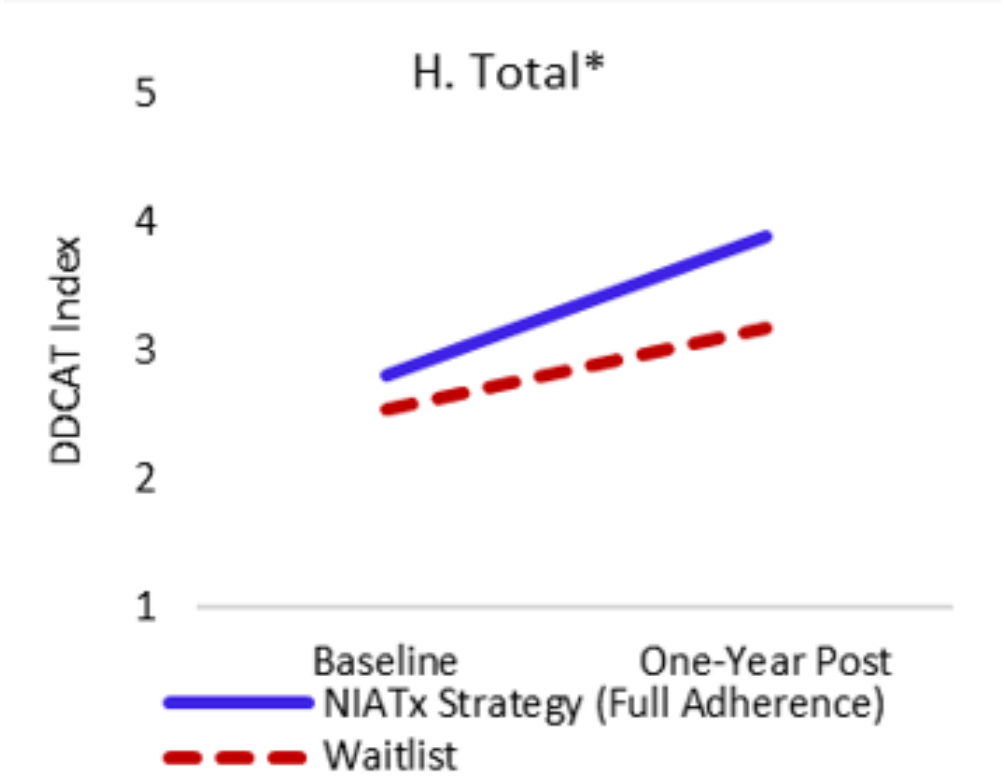
  - https://www.centerforebp.case.edu/resources/tools/ddcat-toolkit
  - https://www.centerforebp.case.edu/client-files/pdf/ddcmhttoolkit.pdf

Using Measures of COD Capability

- Use of the DDCAT/DDCMHT/BHIMC as assessment method at baseline and as a measure of change over time
- Single agency quality improvement process
- Formal implementation and change plan development
- Large scale state system change
- Formal implementation science/health services research

DDCAT: Increasing Integrated COD Capability in Addiction Settings with NIATx

- Rigorous implementation research experiment, RCT and standardized measures
  - From a study of 49 addiction treatment programs in Washington State
- NIATx
  - Process improvement strategies
  - Individual coaching
  - Peer sharing with other agencies
- Agencies with full adherence to NIATx protocol had significantly higher COD capability at one-year follow-up than waitlist agencies



Assefa, McGovern, et al. 2019

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Co-Occurring Fidelity Implementation Project

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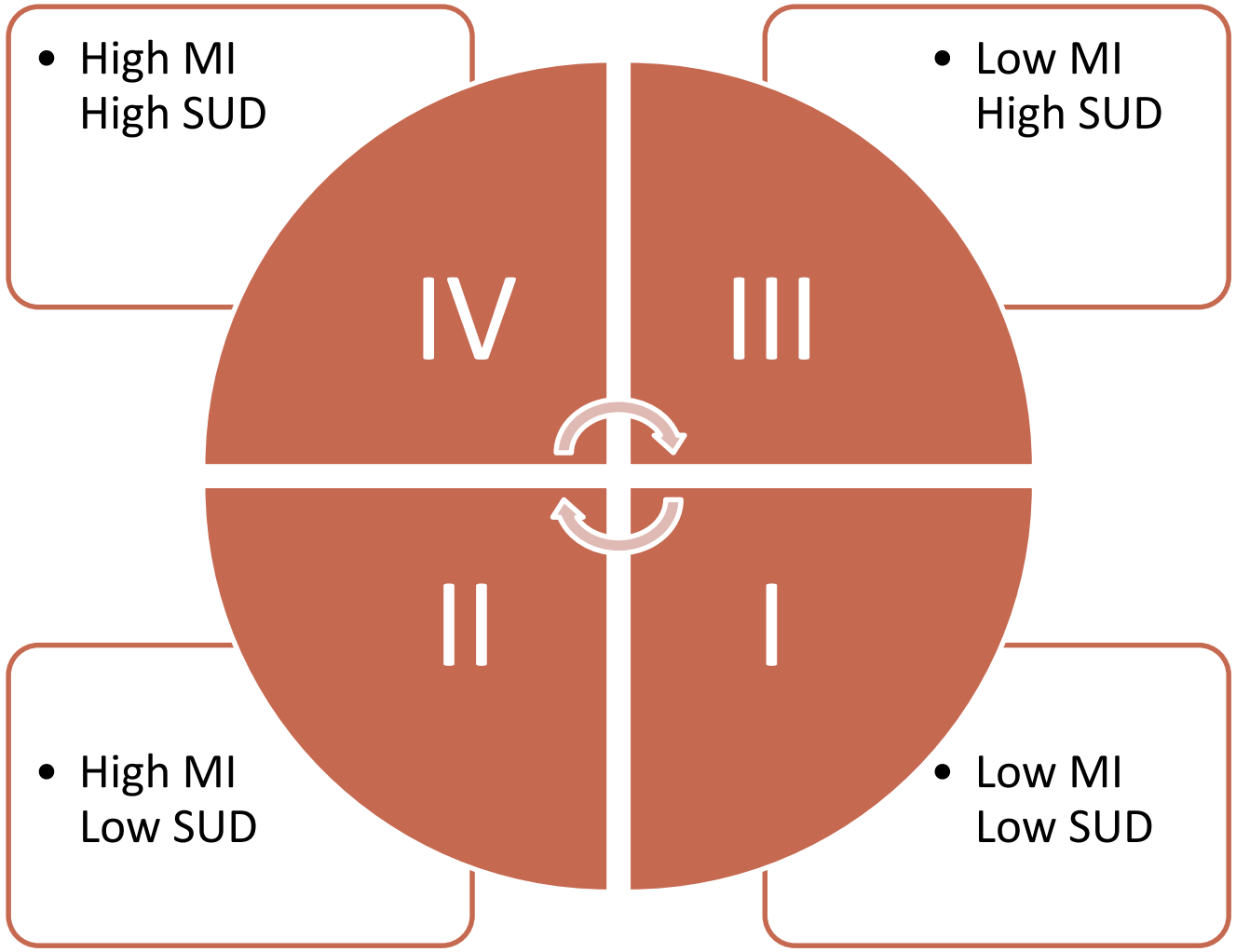
College of Health and Human Services
Western Michigan University

Objectives

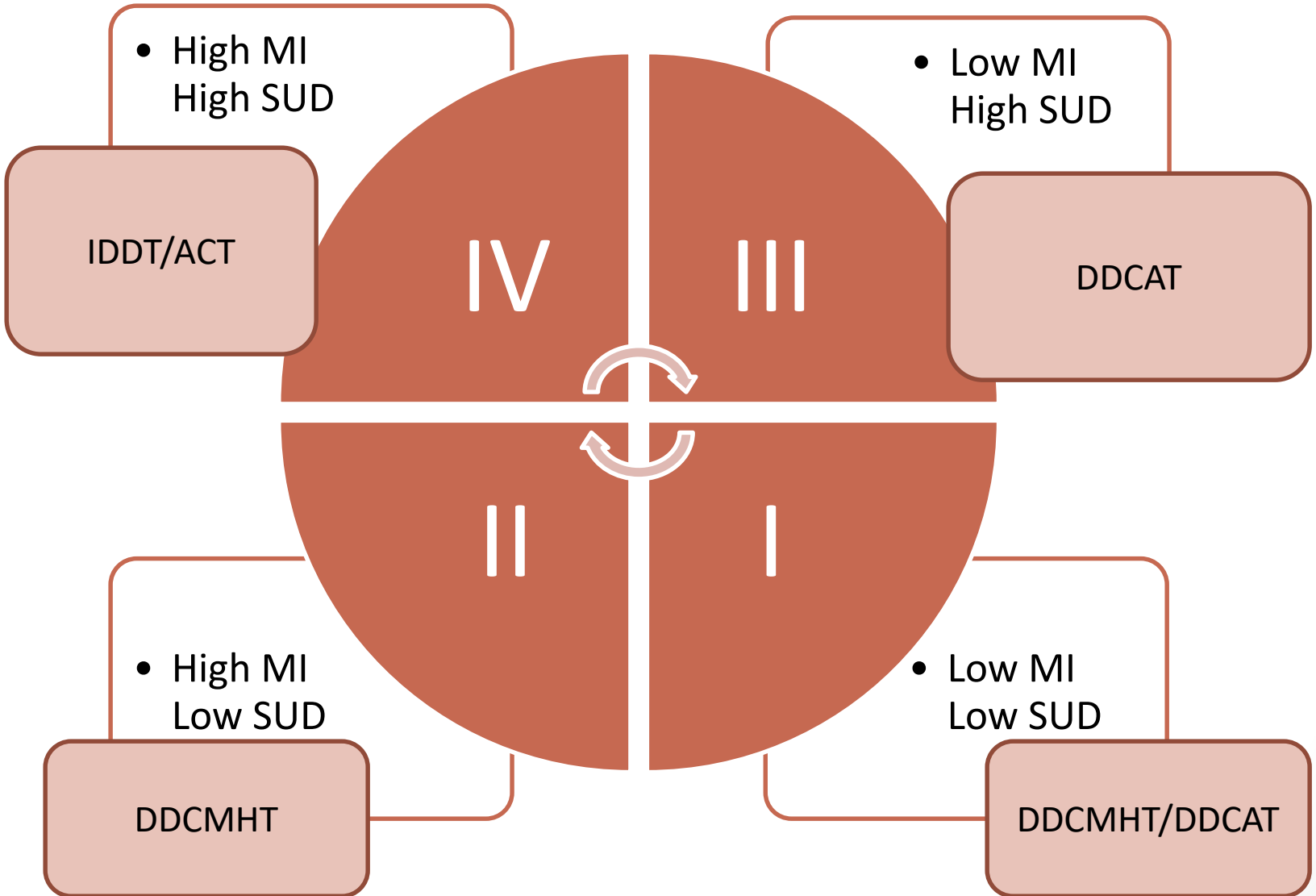
- Become aware of the importance of treating co-occurring mental health and substance use disorders in an integrated method
- Learn the components and measurement strategies for co-occurring fidelity assessment
- Understand how the state of Michigan implemented co-occurring treatment programs and fidelity assessment, and how this methodology is being used to improve care over time

Translational research

Four quadrant model for co-occurring disorders: Mental illness (MI) and substance use disorder (SUD)



Four quadrant model for co-occurring disorders: Mental illness (MI) and substance use disorder (SUD)



Why implement evidence-based practices?

Providers can address mental and substance use disorders at the same time to hopefully:

- Lower costs
- Create better outcomes

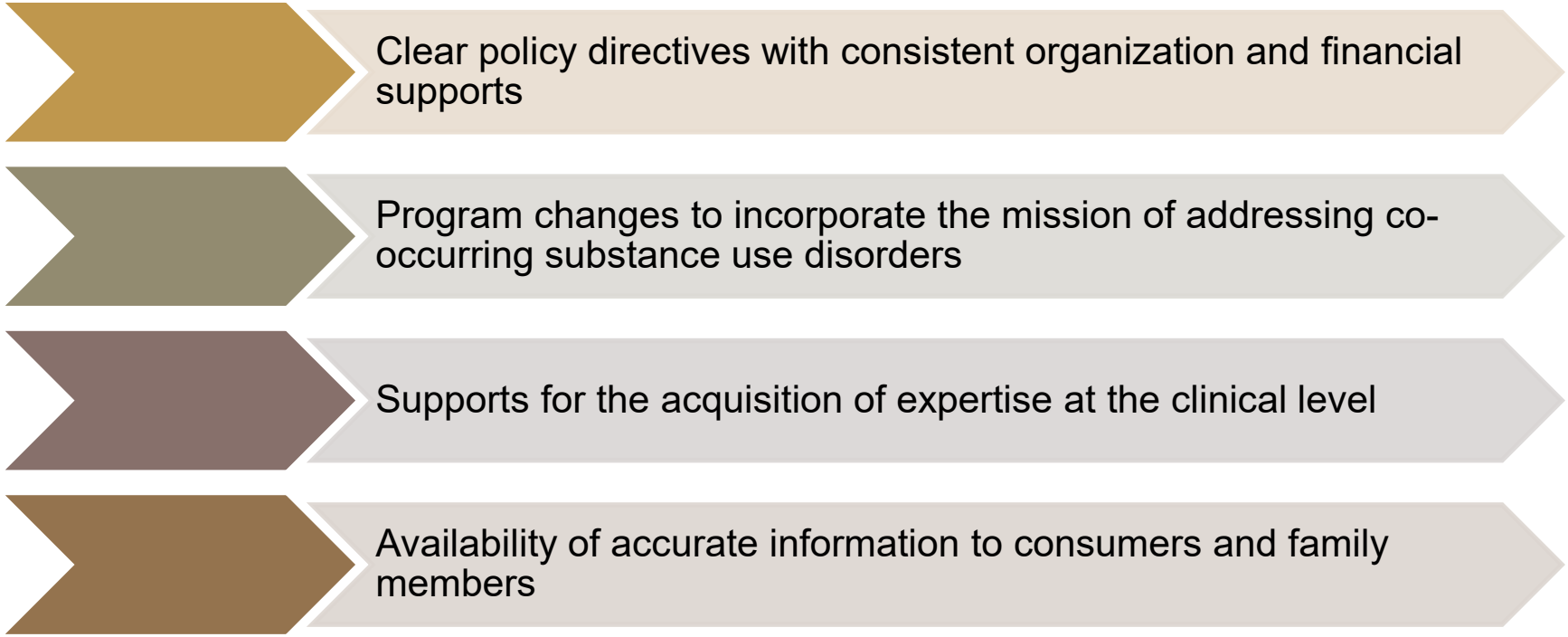
Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders

Early detection and treatment may improve outcomes and quality of life for people with co-occurring disorders

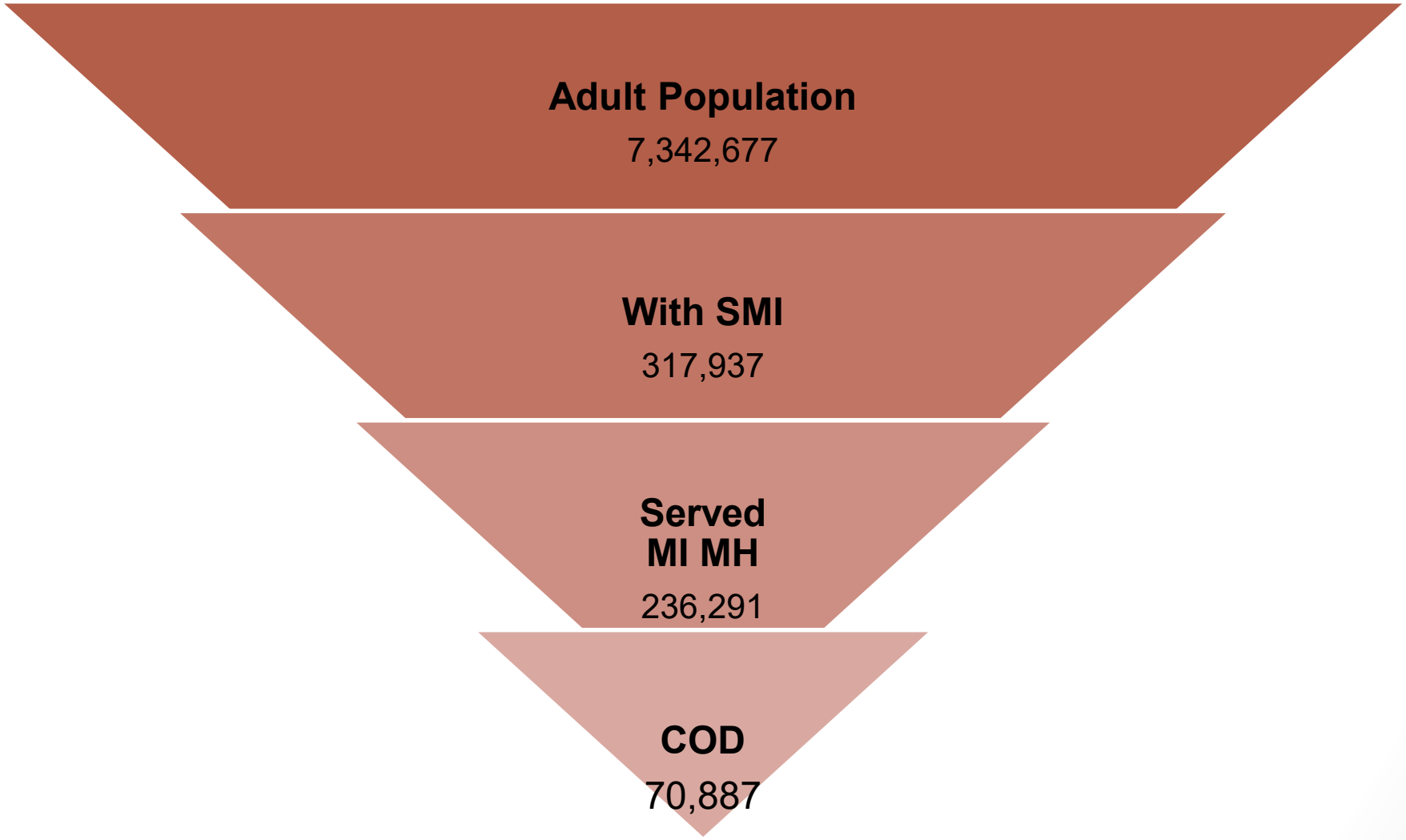
Course of dual disorders

- Treatment emphasizes symptom reduction
  - Duration
  - Intensity
  - Frequency

Successful implementation of dual diagnosis services within health systems will depend on changes at several levels.



Estimate Of Michigan's Adult Population With Co-Occurring Disorders (2016)



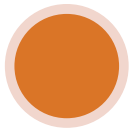
Implementation of COD fidelity review process

2004 - 2007

Recognized the problem of COD; planning

2008 - 2010

Implementation



2010 - present

Continual improvement

Challenges to EBP implementation

Michigan's system had a service gap for individuals with co-occurring disorders

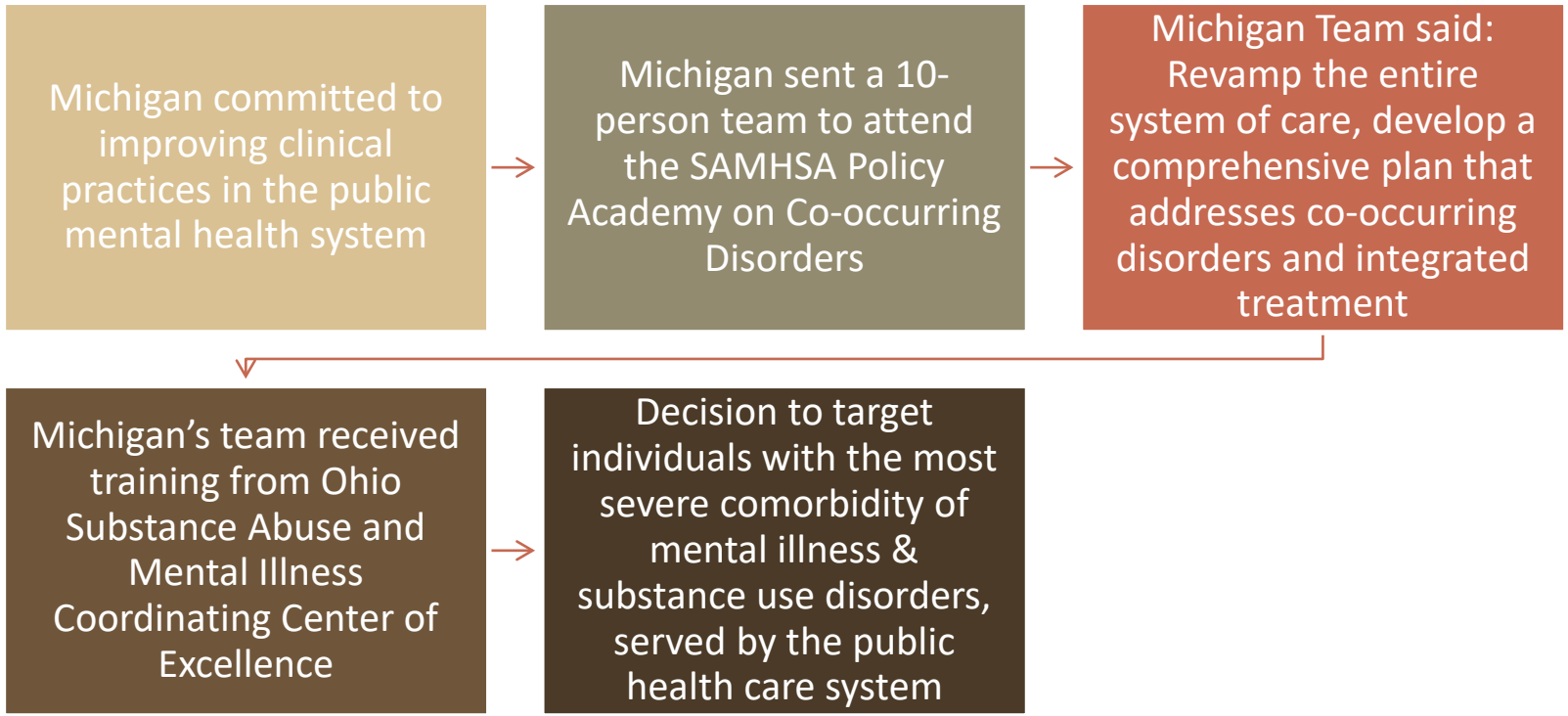
- Services followed and were developed according to separate funding streams
- Eligibility for services was defined by diagnosis
- Individuals with co-occurring disorders could not get all services in one place

Traditional service delivery is not designed to address the complex needs of individuals with co-occurring disorders

- Different funding, rules and regulations, clinician training, and clinical practices[2]
- Sequential or parallel treatments may be incompatible or in conflict with each other

No data existed to demonstrate the scope of co-occurring disorders, or need for supports and services[1]

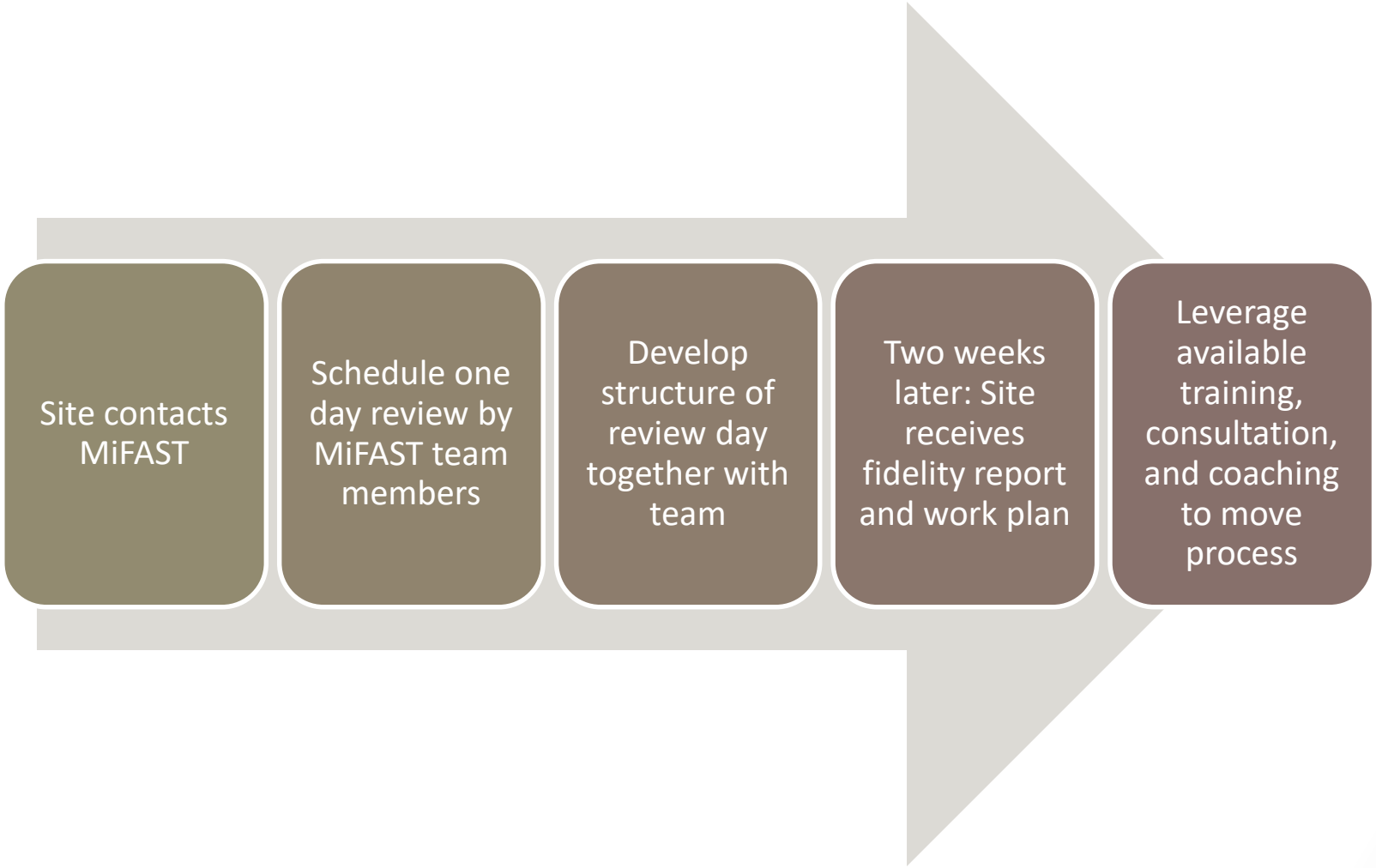
Michigan's early moves in COD fidelity review



Enter….

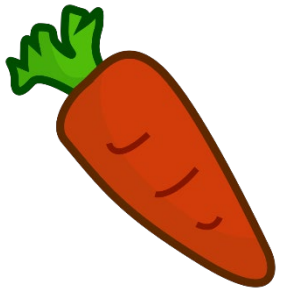
MICHIGAN FIDELITY ASSESSMENT AND SUPPORT TEAM (MIFAST)

How a review with MiFAST works



Structure and approach for MiFAST

ALL



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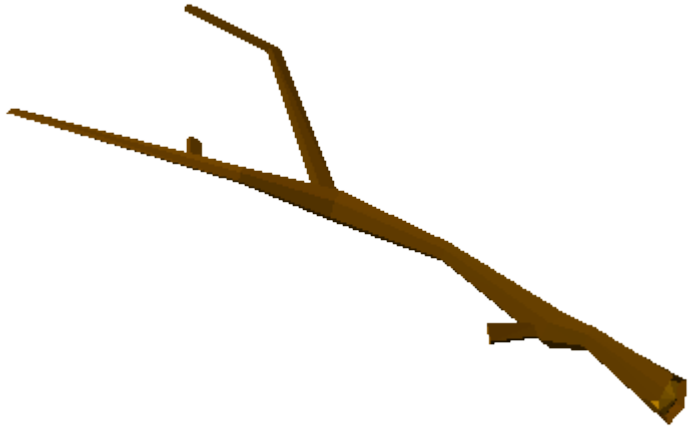


- Available for consultation and fidelity reviews for any team
- Results in fidelity review and full work plan
- Team decides where to focus energy on improvements after review
- Consultation and training available free of charge after review

Results in Michigan

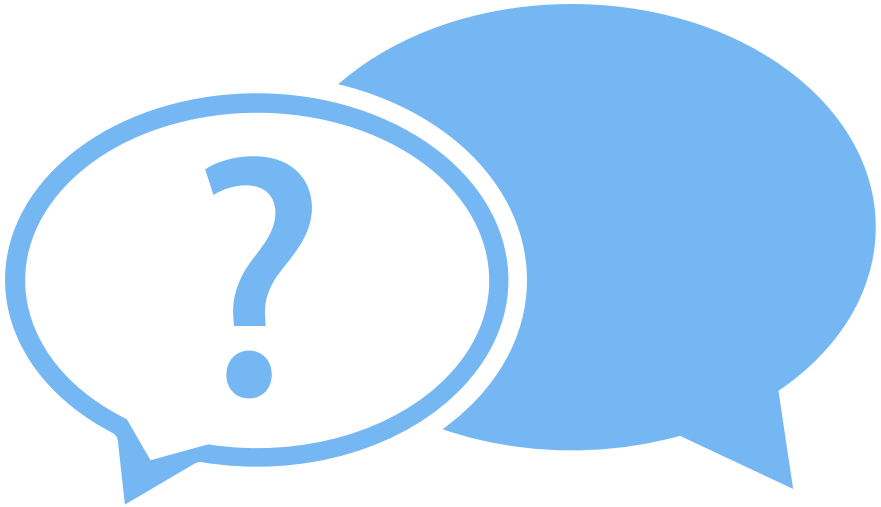
Evidence Based Practice	Michigan (2016)	United States (2016)
Assertive Community Treatment	4.3%	2.1%
Supported Housing	1.3%	3.1%
Supported Employment	3.2%	2.1%
Family Psychoeducation	0.2%	1.9%
Integrated Dual Diagnosis Treatment	1.9%	10.5%

MiFAST reviews available for…

- DDCMHT
- DDCAT
- IDDT
- ACT
- Individual Placement and Support (IPS) Supported Employment
- Motivational Interviewing
- Dialetical Behavioral Therapy (DBT)
- Trauma-Informed Organizations
- Parent Management Training Oregon model (PMTO)

Q&A

Questions? Please type them in the chat box!



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Every survey we receive helps us improve and continue offering our programs.

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Upcoming Webinar

Join us for our next webinar!

Best Practices for Co-occurring Disorder Treatment: Organizational Structure & Service Environment

July 30,2020, 10am-11am PST

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