Northwest ATTC & Oregon Council for Behavioral Health

Integrating Mental Health & Substance Use Disorder Treatment Project

FINAL SUMMARY REPORT

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

OCBH
OREGON COUNCIL FOR BEHAVIORAL HEALTH

December 2021

TABLE OF CONTENTS

PARTNERS

The Substance Use Disorder (SUD) programs participating in this project demonstrated significant commitment and dedication to enhancing services for individuals with co-occurring disorders. We want to thank them for their participation in this project and the important work they do.

Program	Change Leader
Family Recovery Nonprofit, YES House	Tanya Pritt
Transformation Wellness	Dawn Merigan
BestCare Treatment Services - Redmond	Monika Castañeda
BestCare Treatment Services – Klamath Falls	Joseph Allred
ORTC, LLC – Grants Pass Treatment Center	Megan Marx-Varela
Northwest Treatment Center	Jessica Macklin
Volunteers of America: Start Court	Laurie Ellet
Willamette Family Women's Residential Program	Trina Renfrow
Phoenix Counseling Center	Jackie Lien
Emergence	Chris Wig

The success of this project was also due to the high-quality work of the consultants and staff working on this project. Thank you to:

David Jefferson, MSW, SUDP, DDCAT Reviewer & Project Coordinator
Troy Montserrat-Gonzales, MA, LPC, DDCAT Reviewer & Project Coordinator
Jennifer Harrison, PhD, DDCAT Reviewer; Paul Hunziker, MFT, DDCAT Reviewer
Ann Marie Roepke, PhD, DDCAT Reviewer; Mat Roosa, LCSW-R, NIATx Coach

CONTRIBUTING AUTHORS

Denna Vandersloot, MEd
Co-Director, Northwest ATTC
Addictions, Drug & Alcohol Institute
Department of Psychiatry & Behavioral Sciences

Troy Montserrat-Gonzales, MA, LPC
Northwest ATTC Consultant

David Jefferson, MSW, SUDP
Northwest ATTC Consultant

Susan Stoner, PhD
Evaluator, Northwest ATTC
Addictions, Drug & Alcohol Institute
Department of Psychiatry & Behavioral Sciences
University of Washington

Mathew Roosa LCSW-R
Northwest ATTC Consultant
Roosa Consulting, LLC

Bryan Hartzler, PhD
Director, Northwest ATTC
Addictions, Drug & Alcohol Institute
Department of Psychiatry & Behavioral Sciences
University of Washington

Graphic Designer
Erinn McGraw, BFA
Public Info Specialist
Addictions, Drug & Alcohol Institute (ADAI)
Department of Psychiatry & Behavioral Sciences
University of Washington

Citation: Vandersloot D, Montserrat-Gonzales T, Jefferson D, Stoner S, Roosa M, Hartzler B. Integrating Mental Health & Substance Use Disorder Treatment Project: Final Summary Report. Seattle, WA: Northwest Addiction Technology Transfer Center, December 2021.

This work was supported by SAMHSA H79TI080201, Northwest Addiction Technology Transfer Center. The contents are those of the authors and do not necessarily represent official views of, nor endorsement by, HHS, SAMHSA, or the U.S. Government.

BACKGROUND

Providing quality integrated services for individuals with co-occurring disorders (CODs) is a prioritized yet elusive goal. An estimated 17 million adults in the United States live with co-occurring mental health and substance use disorders, yet only 5.7% of these individuals receive treatment for both disorders.[1] The Northwest Addiction Technology Transfer Center identified enhancement of COD services as a high priority workforce development area during interviews with key stakeholders in Oregon. In response to this need, the Northwest ATTC partnered with the Oregon Council for Behavioral Health (OCBH) to develop a comprehensive intensive technical assistance (ITA) project with the primary aim of assisting substance use disorder programs to assess and enhance their co-occurring disorder treatment services in order to become more COD capable.

The goal was to design a project to help participants:

- Assess program capability to deliver integrated MH and SUD treatment services through the use of the Dual Diagnosis Capability in Addiction Treatment Index (DDCAT) Index.
- Develop a strategic plan to enhance co-occurring disorder treatment services.
- Apply a change model to implement effective improvements.
- Access resources to support change within the seven integrated treatment dimensions of the DDCAT.

PROJECT DESCRIPTION

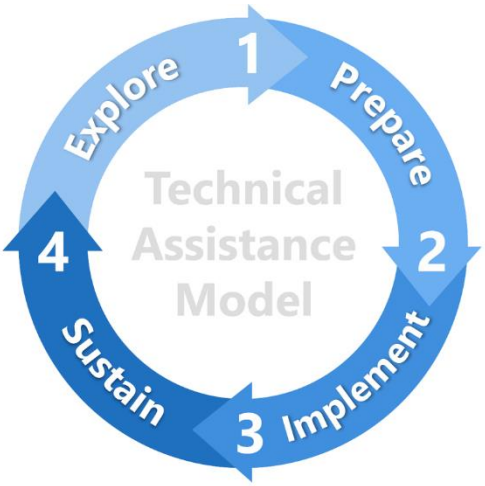
The OCBH leadership presented this project opportunity to OCBH providers at their board and full membership meetings in early 2020 to assess interest and secure leadership buy-in. Provider members expressed significant interest in the opportunity and an informational session was held in June of 2020 to outline the project to interested providers.

Programs interested in this year-long ITA project were invited to apply through the OCBH membership communication channels. All interested program leaders were asked to complete a brief application outlining their program's goals and objectives for participating in this project. Ten Oregon substance use disorder (SUD) programs applied to participate, all of which were accepted into the project.

It is important to note that this project took place during the COVID pandemic with all the challenges that posed, and the participating programs did not receive any financial incentives for participating in the project. The improvement projects were undertaken using the programs' existing personnel and financial resources.

[1] SAMHSA, 2020 National Survey on Drug Use and Health Releases. Rockville, MD. Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services. Available at 2020 National Survey of Drug Use and Health (NSDUH) Releases | CBHSQ Data (samhsa.gov)

The project was divided into phases aligning with Aaron and colleagues' EPIS model for implementing innovative practices.[2] The initial exploration phase involved securing leadership buy-in, assessing the programs' baseline co-occurring disorder services capacity, and providing a detailed summary report with recommendations for enhancing the level of integration. During subsequent preparation and implementation phases, program leadership participated in a NIATx Change Leader Academy, involving learning sessions and monthly coaching calls with an experienced NIATx coach. The eventual sustainment phase involved a final DDCAT virtual site review to evaluate progress and document sustainability efforts. This report is organized around these phases, and describes the project design and resulting findings concurrently.



PHASE I: EXPLORATION AND NEEDS ASSESSMENT

An **orientation webinar** was offered in July of 2020 to kick off the project. The DDCAT Index was used as the baseline assessment measurement to guide the overall change process. This Index provides a quantitative measure of addiction treatment programs' capacity for integrated services for persons with co-occurring disorders. The DDCAT evaluates 35 program elements that are divided into seven dimensions: 1) Program Structure; 2) Program Milieu; 3) Screening & Assessment; 4) Treatment; 5) Continuity of Care; 6) Staffing; and 7) Training. Each element is rated on a Likert scale ranging from 1 to 5 with scoring anchors of 1 (Addiction Only Services, AOS), 3 (Dual Diagnosis Capable, DDC), and 5 (Dual Diagnosis Enhanced, DDE). Based on the sum of the 35 elements, the program assessed can be categorized as AOS, DDC, or DDC. Psychometric studies have supported the reliability and validity of the DDCAT Index measure. [3]

Participating programs all received a **baseline DDCAT assessment site visit** during the months of August through October of 2020. Historically, DDCAT site visits are conducted by two expert DDCAT reviewers via an on-site program visit. However, given the COVID pandemic, a plan was developed to conduct the DDCAT site visits virtually. Site visits were conducted over Zoom and took place over the course of a full day. These site visits included interviews with agency leadership, clinical and support staff, and clients; environmental and milieu scans conducted via video site tours; and review of program documents (e.g. policies and procedures, treatment schedules, training plans) and client records.

Each program then received a written DDCAT summary report with summary and graphical illustration of DDCAT dimension and total scores, a narrative describing current program strengths supporting COD services, and recommendations and resources for improvements. A strategic leadership session was set up two weeks post site visit to review the results and discuss priority areas for enhancing COD services.

---

[2] Aarons, G.A., Hurlburt, M. & Horwitz, S.M. Advancing a Conceptual Model of Evidence-Based Practice Implementation in Public Service Sectors. *Adm Policy Ment Health* 38**,** 4–23 (2011). https://doi.org/10.1007/s10488-010-0327-7.

[3] Giard J, Kincaid R, Gotham HJ, Claus RE, Lambert-Harris C, McGovern MP, et al. The dual diagnosis capability in addiction treatment (DDCAT) toolkit, version 4.0. Substance Abuse and Mental Health Administration: Rockville, 2011.

At baseline, the mean DDCAT total score across the ten programs was 3.21 (SD = .50), with the DDCAT total score for seven programs suggestive of Addiction Only Services and the DDCAT total score for the remaining three programs suggestive of Dual Diagnosis Capability. Figure 1 shows means across the seven dimensions, in addition to this mean DDCAT total score (at far right). Notably, the mean DDCAT dimension scores for this sample of programs were slightly elevated (+.50-.75 SD) relative to published norms and with similar distribution, as might be expected of SUD organizations voluntarily participating in a project focused on organizational capacity to provide integrated COD services.[4]

Figure 1: Mean DDCAT Scores of the Ten SUD Programs at Baseline

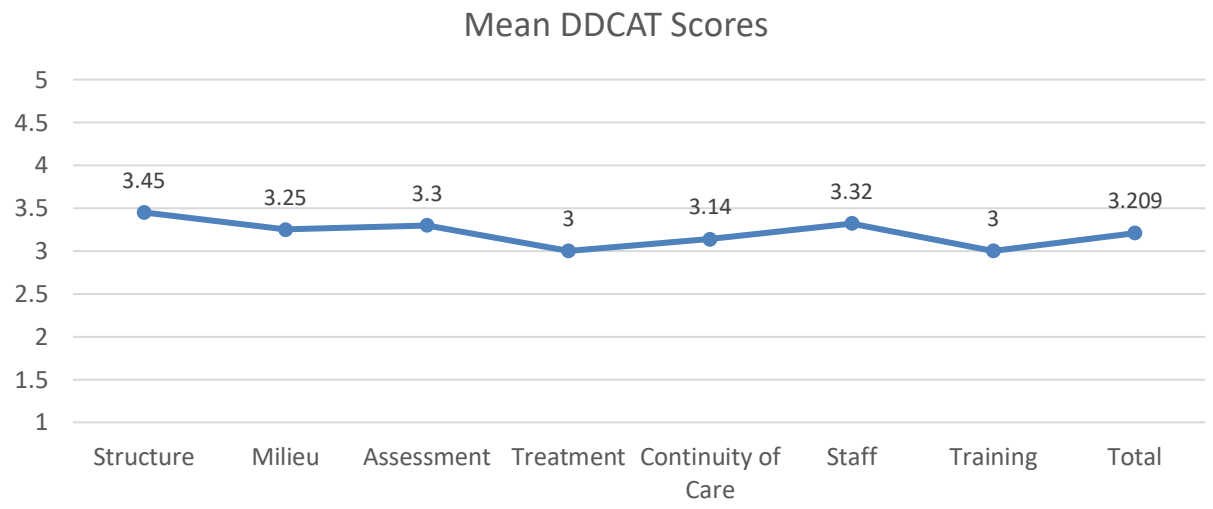


Figure Notes: DDCAT scale anchors include 1=Addiction Only Services, 3=Dual Diagnosis Capable, 5=Dual Diagnosis Enhanced

Follow-up evaluation surveys were conducted with participants to assess the usefulness of the baseline DDCAT review and feedback process. All respondents (n=18) reported the DDCAT baseline assessment as benefitting their professional development and noted they were using information gained to change their practice. They also reported sharing information gained with others.

As part of the initial DDCAT site visit and needs assessment interviews, evaluators also documented barriers limiting providers' ability to serve clients with co-occurring substance use and mental health disorders. Additionally, a survey was administered to program leadership in order to quantify the barriers identified during the interviews.

Program leadership identified barriers related to behavioral health workforce issues, funding and financial limitations, limited access to mental health and prescribing services, and lack of coordination of care across MH and SUD systems. These barriers are detailed below.

[4] Mark P. McGovern PhD, Aurora L. Matzkin MA & Julienne Giard MSW (2007) Assessing the Dual Diagnosis Capability of Addiction Treatment Services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, Journal of Dual Diagnosis, 3:2, 111-123, DOI: 10.1300/J374v03n02_13

Barriers to Serving Clients

Workforce Issues Resulting in Limited Access to MH and COD Services

- Lack of licensed mental health practitioners to hire (especially in rural areas).
- Shortage of dually credentialed staff to provide direct COD services and supervision of staff.
- Many SUD providers, such as CADCs are very conscientious about staying within their scope of practice, which can result in co-occurring disorders not being discussed or added to the clients treatment plan.
- Lack of access to telehealth MH and COD services for clients in SUD residential services.
- Clients without established MH therapist or prescriber often wait 4-6 weeks for a MH assessment.
- Clients need access to prescribers who have expertise in addiction medicine and psychiatric medications (many people are receiving their medications from primary care practitioners).
- Several local MH programs closed due to financial difficulties related to COVID, limiting MH service capacity.

Regulatory and Funding Issues

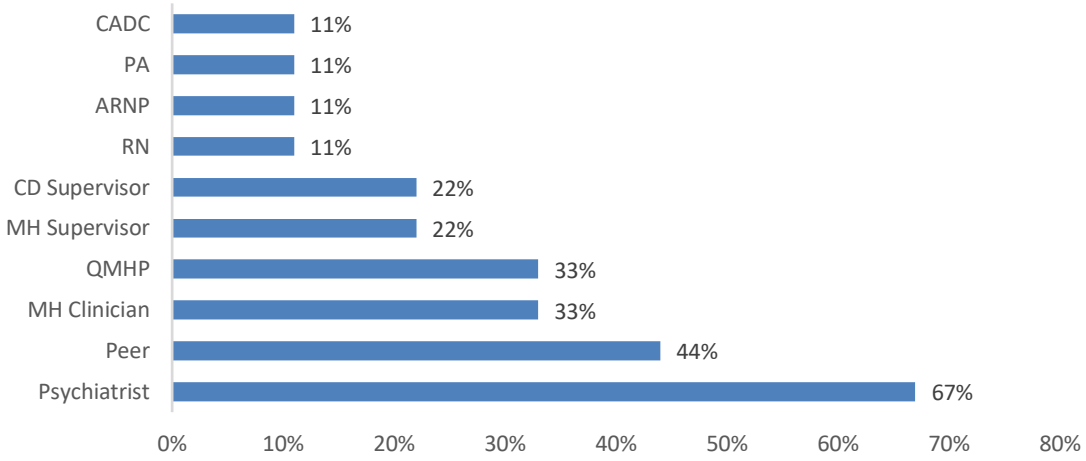
- Coordinated Care Organizations' rules and regulations often interfere with access (e.g. CCOs may require clients to be discharged from MH services when transitioning into SUD residential care), leaving clients without MH services during SUD treatment.
- No billing codes available for COD services; which are more expensive to provide than SUD.
- Payment rates for SUD services make it fiscally difficult to hire MH practitioners and prescribers.
- Funding for service codes is less if offered by CADCs, even if it is the same level of service.
- Funding sources sometimes require separate providers for MH and SUD services.
- Multiple CCOs are hard to navigate; especially for residential programs serving clients from across the state.
- State regulations around separating MH and SUD records make it difficult to integrate services.

Lack of Coordination of Care Across MH and SUD Systems

- Coordination and collaboration across the systems has not been incentivized and programs are often reluctant to share information with each other.
- Forty percent of the survey respondents indicated they were unable to successfully collaborate with CCOs to secure the needed mental health services for clients.

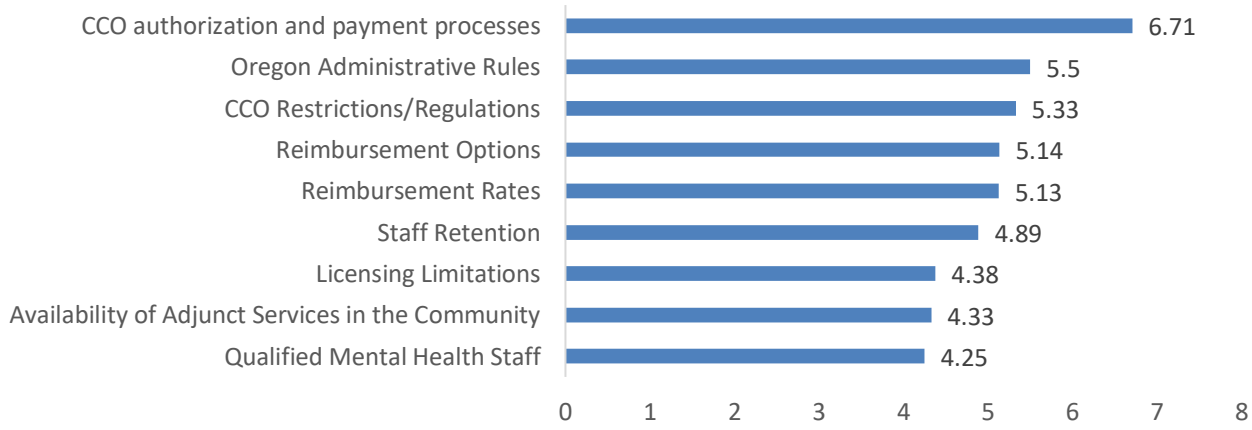
When asked, "*If your program had additional funding or other means to adequately bill for COD services, what would you add to your current array of providers?"* survey respondents identified hiring a psychiatrist as being the top priority (67%). Figure 2 presents the full survey results for this item.

Figure 2: Rates of Endorsement for Prioritized New COD Services



When asked to rank a set of nine barriers from most important (8) to least important (1) for fully serving clients with co-occurring disorders, survey respondents rated CCO authorization and payment process as the barrier of greatest importance. As illustrated in Figure 3, this was followed by Oregon Administrative Rules, CCO regulations and restrictions, reimbursement options, and reimbursement rates.

Figure 3: Ratings of Importance for Barriers to Providing COD Services



The barriers identified during this phase of the project were shared with the Oregon Coordinated Care Organization Behavioral Health Directors and the Oregon Health Authority's Co-occurring Disorder workgroup to enhance bi-directional communication about barriers to COD and discuss potential solutions. These system barriers do impact the level of integration a program is able to achieve on its own and may represent the final barriers to full integration of MH and SUD services.

PHASE II: PLANNING AND IMPLEMENTATION

During the second phase of this project, change leaders and executive sponsors participated in a six-month **NIATx Change Leader Academy**. NIATx is a multi-faceted approach that combines process improvement methodology with engineering principles to guide change efforts[5]. The NIATx model and tools were taught via four (90-minute) learning sessions delivered in the fall of 2020. Following the change leader learning sessions, change leaders and team members met with Mat Roosa, a NIATx coach, for monthly coaching sessions to apply the NIATx tools to their COD improvement efforts. The Change Leader Academy wrapped up in March of 2021, with a final learning session where program leaders shared the results of their improvement efforts.

All ten programs completed the Change Leader Academy and shared the results of their change projects at the final learning session in March, 2021. Agency presentations of essential components of integration improvement efforts included five common themes:

- **Strengths-based**, client-centered supports, including use of feedback and individualized supports.
- **Teamwork** in the development and implementation of projects, including using the PI tools to strengthen the team bond.
- **Culture change** through questioning practice assumptions.
- **Data-driven** change implementation, including thoughtful study of multiple variables involved.
- **Curiosity** at the heart of the work, by showing a willingness to question, try new things, and be guided by the results.

The majority of participants responding to a follow-up survey identified the following NIATx components as being extremely helpful to the change process: change leaders' academy training, holding regular change team meetings, and the monthly coaching calls with the NIATx coach. Seventy-five percent of the respondents also indicated they were highly to extremely likely to use the NIATx process improvement model to guide future change efforts. Several respondents identified using data to guide change, PDSA rapid cycle change, and charting progress, as tools they were likely to use going forward.

NIATx Change Project: Case Examples

ORTC, LLC- Grants Pass Treatment Center

Increased their identification of mental health needs and referral to MH services within the first thirty days of treatment from 14% to 72% through increasing collaboration and coordination with mental health agencies, adding MH screening, and increasing the focus on mental health issues in case consultations.

Volunteers of America: Stop/Start Drug Court

Increased their mental health billable hours from .93 contacts per month to 2.63 through enhancing prescriber involvement and adding several COD specific groups. This additional revenue helped support hiring a full-time prescriber.

[5] NIATx, Center for Health Enhancement Systems Studies, University of Washington, www.niatx.net

PHASE III: EVALUATION AND SUSTAINMENT

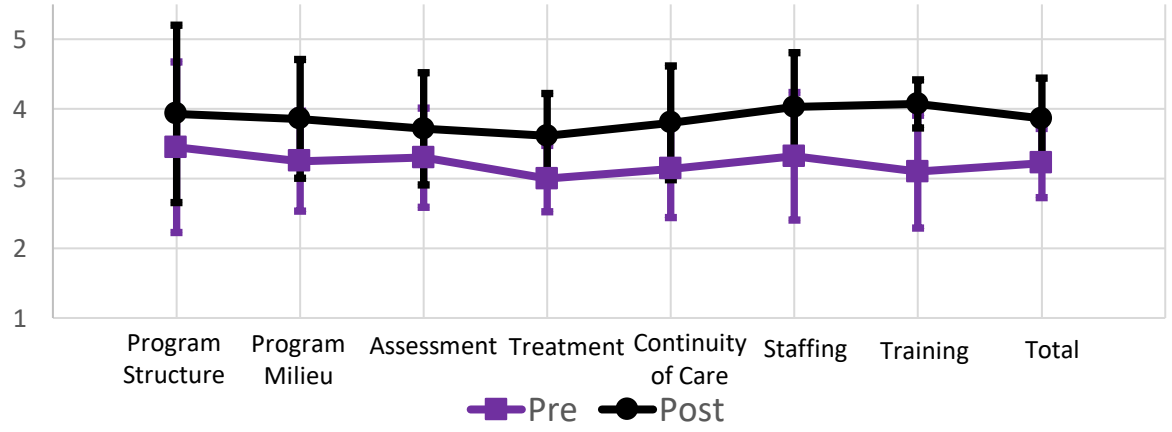
Follow-up DDCAT virtual site visits were conducted between May – July, 2021 to evaluate improvement efforts. Programs received a final DDCAT summary report documenting baseline and follow-up review DDCAT scores along with a brief narrative of changes and improvements made during the project. Of note, there was some program-level attrition at this phase of the project, with three programs not completing the follow-up DDCAT site visit. Of these, two programs declined due to competing demands on staff time and a 3rd program was in process of closing its doors and thus unable to further participate.

Given a primary project aim to help agencies improve service integration for co-occurring disorders, it is noteworthy that the mean DDCAT total score across the seven program at follow-up was 3.86 (SD = .53). This represents a substantive increase over the mean score at baseline (3.21), and impressive magnitude of improvement in these programs' capability to offer integrated services for persons with co-occurring disorders. In statistical terms, this order of improvement equates to a Cohen's D effect size of 1.23 (as a reference, Cohen [1988] outlines 'small' effects as .20 - .50, 'medium' effects as .50 - .80, and 'large' effects as .80+). It is clear that, on average, these seven programs evidenced substantive improvements over the course of the project in their capacity to offer integrated services for their COD clientele.

It's important to also consider change at the level of the seven remaining individual programs. At baseline, DDCAT scores had classified five of these programs at an Addiction Only Services (AOS) level and two at a Dual Diagnosis Capable (DDC) level. At follow-up, this was reversed with just two programs still classified at an AOS level and now the remaining five at a DDC level. That dual diagnosis service capability was achieved at project conclusion by 71% of these programs suggests that their future clients will be offered useful, integrated services to address co-occurring MH and SUD challenges.

As for change in DDCAT dimension scores, Figure 3 depicts sample means at baseline and follow-up and corresponding +/- standard deviation. On average, increases were observed in all DDCAT dimensions, with Training as the dimension for which improvement was of greatest magnitude. Of further note, most remaining programs increased service capability in 4-5 DDCAT dimensions with improvements commonly including increased capability to assess for co-occurring disorders, effectively coordinate care, and provide staffing and training appropriate to the provision of COD treatment services.

Figure 3: Mean Baseline and Follow-up DDCAT Dimension and Total Score



SUMMARY AND DISCUSSION

The primary goal of this project was to improve COD services for clients by having program leaders engage in an intensive TA process that combined the use of the DDCAT Index and the NIATx process improvement model. This goal was achieved with noteworthy results. The results in the proceeding section demonstrate a clinically meaningful change in practice for most of the participating programs. Moving from an Addiction Only Services to Dual Diagnosis Capable level of care, as several of these program did, represents a significant increase in COD service capacity. The commitment and dedication of these programs to improve COD services in the midst of a global pandemic and using existing resources was impressive. All ten programs completed the intensive phases of this year-long project and completed change projects using the NIATx process improvement model. Thus, there is good reason to expect that project participation was beneficial to all of the involved programs, including those unable to complete the follow-up DDCAT site visit at project conclusion. For many of the programs that did complete the follow-up DDCAT assessment, change in one specific target area resulted in changes across several dimensions. For example, one program focused on increasing client referrals to MH programs and ended up increasing its scores in all seven DDCAT dimensions. An additional benefit of this project was demonstrating to the OCBH how investments in an Intensive TA project can successfully lead to structural program changes and identity strategic statewide policy changes that can improve care.

One of the reasons that the Northwest ATTC created this intensive TA process was to assess the impact and value of investing resources in a few programs to support implementation of integrated services. Guided by expectations of the Substance Abuse and Mental Health Administration (SAMHSA) as our federal sponsoring agency, the Northwest ATTC has shifted its focus in recent years from engaging primarily in dissemination and training activities (i.e. training workshops, webinars, publications) to providing more intensive services to help programs adopt and implement useful treatment and recovery practices. This is labor-intensive, with a $10,000 per-program expense for this project to cover costs of coordination and consultants who provided DDCAT reviews as well as Change Leader Academy training and coaching, and may suggest need in the future for creative cost-sharing efforts to extend or scale up such efforts to other programs. Findings from this project clearly evidence the value that this level of technical assistance provide to support change efforts and enhance COD services and yield a significant return on investment. Although this project did not measure change at the client level, previous research[6] demonstrates that providing integrated treatment does improve client outcomes and is more cost effective than providing services separately.

Supporting the renewed interest in integration of MH and SUD services, this project provides a model for assisting programs to align policy, practice, and training efforts to support COD services. The retention of programs in this intensive TA effort suggests a perceived sense of value of the services offered. The project also demonstrates the value of using a continuous improvement method that relies on available resources to improve services.

[6] Drake RE, O'Neal, E.L., Wallach MA. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. Journal of Substance Abuse Treatment. 2008;34:123-128. Donald M, Dower J, Kavanagh D. Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomized controlled trials. Social Science & Medicine. 2005;60:1371-138

Data collected through various surveys and interviews with participating providers indicate investing their time and resources into this ITA project was valuable and helped them to enhance their COD services. Change leaders and executive sponsors reported benefitting from the following:

- ✓ An objective assessment of COD capacity to guide their change efforts and identify concrete targets for improvement.
- ✓ An increased understanding of how to operationalize COD services.
- ✓ Improved awareness and attention of staff towards clients' mental health needs through DDCAT training.
- ✓ A systematic approach to change that relied on data.
- ✓ NIATx tools to strengthen improvement efforts and facilitated staff engagement.
- ✓ The focus on using a team to impact improvement efforts and implement change.
- ✓ Ongoing support and feedback from the Northwest ATTC DDCAT reviewers and NIATx coach.

Overall, program goals were achieved using existing resources, despite the on-going challenges of system-level barriers to integration. The DDCAT index paired with the NIATx model for process improvement provided program leaders with an effective strategy to further enhance program infrastructure for offering and improving COD services.