Indian Health Service
2012 National Behavioral Health Conference
June 25-28, 2012 • Bloomington, Minnesota

Leadership Summit: Leading the Way Toward Integrated Treatment

IHS Pre-Conference

Presented by Dr.Timothy Sheehan
and Jon Hartman, Hazelden

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House Keeping

- Please be sure to sign in and out on the Sign In Sheets located near the entrance to this room.
- Please complete the evaluation at the end of this presentation.
- For more information on Continuing Education Units (CEUs), please visit the Registration Desk

Comfort Room

- To promote wellness and self-care, a Comfort Room is available in Atrium Room 8 for your use.
- If you need further assistance, please visit the Indian Health Service Division of Behavioral Health booth.

Partnerships

- We are grateful for the IHS inclusion of this important topic as a pre-conference. The IHS has exemplified the power of federal partnerships as this conference was created.
- Internal and external partnerships are critically important as we "lead the way toward integrated treatment."

References:

- We will be referencing Dartmouth/Hazelden Co-Occurring Disorders Program and its Administrator's Guide, published by Hazelden with Dartmouth Psychiatric Research Center.
- A reference list for the CDP Administrator's Guide is available upon request.

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Crisis Hotline Numbers

Suicide Prevention Lifeline Number:

- 1-800-273-TALK (8255)

National Domestic Violence Hotline:

- 1-800-799-SAFE (7233) or TTY 1-800-787-3224

National Child Abuse Hotline:

- 1-800-4-A-CHILD

Sexual Assault Hotline:

- 1-800-262-9800

Objectives

- Identify the benefits and challenges of integrated treatment
- Discuss the philosophy and research behind the evidence-based Dartmouth PRC/Hazelden Co-occurring Disorders Program (CDP)
- Evaluate your organization’s capability for treating patients with non-severe co-occurring disorders, using the DDCAT and DDCMHT tools

Objectives

- Learn practical tools from providers who have already implemented integrated treatment within their own programs.
- Identify the top leadership challenges (system, program, and staff level) to the delivery of integrated services and develop specific, actionable plans to address those barriers
- Describe how evidence-based practices can be fully implemented in a co-occurring disorders program

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Agenda

Morning – Part I

- Prevalence of Co-Occurring Disorders, Defining Integrated Treatment, Federal and State Trends
- Benefits of Integrated Treatment, Challenges, and Opportunities
- Stages of Organizational Change
- Learning from the Early Adopters
- Vision

Afternoon – Part II

- Assessing Program Capacity
- Enhancing Program Capacity
- Developing an Action Plan

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Hazelden Main Campus, Center City, MN

Hazelden Locations

- **Minnesota:** Started in 1949 with inpatient services, now delivers comprehensive services in five different states for adolescents and adults
- **Newberg, Oregon** – *noted for health care professionals – addiction treatment program, acquired in 2002*
- **Chicago, Illinois** – *Sober Residence and outpatient services – 1993*
- **New York, New York** – *Outpatient Services, 1992 and new Tribeca Twelve, a Sober Living Residence in collaboration with Columbia University*
- **Naples, Florida** – Outpatient & Residential Services, 2010

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Hazelden Today

Recovery Services

Research

Public Education

Graduate School

Public Advocacy

Publishing

Prevalence of Co-Occurring Disorders

Co-morbidity of Substance Use and Psychiatric Disorders

Among a sample of about 10,000 adults:

- 13.5% had an alcohol use disorder. Of those, 36.6% also had a psychiatric disorder
- 6.1% had a drug use disorder. Of those, 53.1% also had a psychiatric disorder.
- 22.5% had a psychiatric disorder. Of those, 28.9% also had an alcohol or drug use disorder

	%	ODDS RATIO
Alcohol Use	**13.5**	
Psychiatric Disorder	36.6	2.3
Drug Use	**6.1**	
Psychiatric Disorder	53.1	4.5
Psychiatric Disorder	**22.5**	
Alcohol or Drug Disorder	28.9	2.7

Source: Regier et al. 1990

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Prevalence of Co-Occurring Disorders

Twelve-Month Prevalence of Index Substance Use and Co-occurring Mood and Anxiety Disorders of Treated Persons

INDEX DIAGNOSIS	% CO-MORBID MOOD	% CO-MORBID ANXIETY	% CO-MORBID SUBSTANCE USE
Any Substance Use Disorder	19.67	17.71	
Alcohol	18.85	17.05	
Drug	31.80	25.36	
Mood Disorder			19.97
Anxiety Disorder			14.96

Source: Grant et al. 2004

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Prevalence of Co-Occurring Disorders

Twelve-Month Prevalence of Index Substance Use and Co-occurring Mood and Anxiety Disorders of Treated Persons

INDEX DIAGNOSIS	% CO-MORBID MOOD	% CO-MORBID ANXIETY	% CO-MORBID SUBSTANCE USE
Any Substance Use Disorder	NA	NA	
Alcohol	40.69	33.98	
Drug	60.31	42.63	
Mood Disorder			20.78
Anxiety Disorder			16.51

Source: Grant et al. 2004

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Prevalence of Co-Occurring Disorders

Psychiatric Disorders in Addiction Treatment

Two studies of prevalence rates in addiction treatment setting had similar findings. Persons with substance use disorders are also likely to have mood and anxiety disorders.

DISORDER	CACCIOLA	ROSS
Mood Disorder	10–45%	31.4%
Anxiety Disorder	10–46%	45.4%
Post-traumatic Stress Disorder	15–45%	NA
Antisocial Personality Disorder	25–50%	36.5%
Borderline Personality Disorder	10–30%	NA
Schizophrenia	< 5%	4.3%

Source: Cacciola et al. 2001; Ross, Glaser, and Germanson 1988

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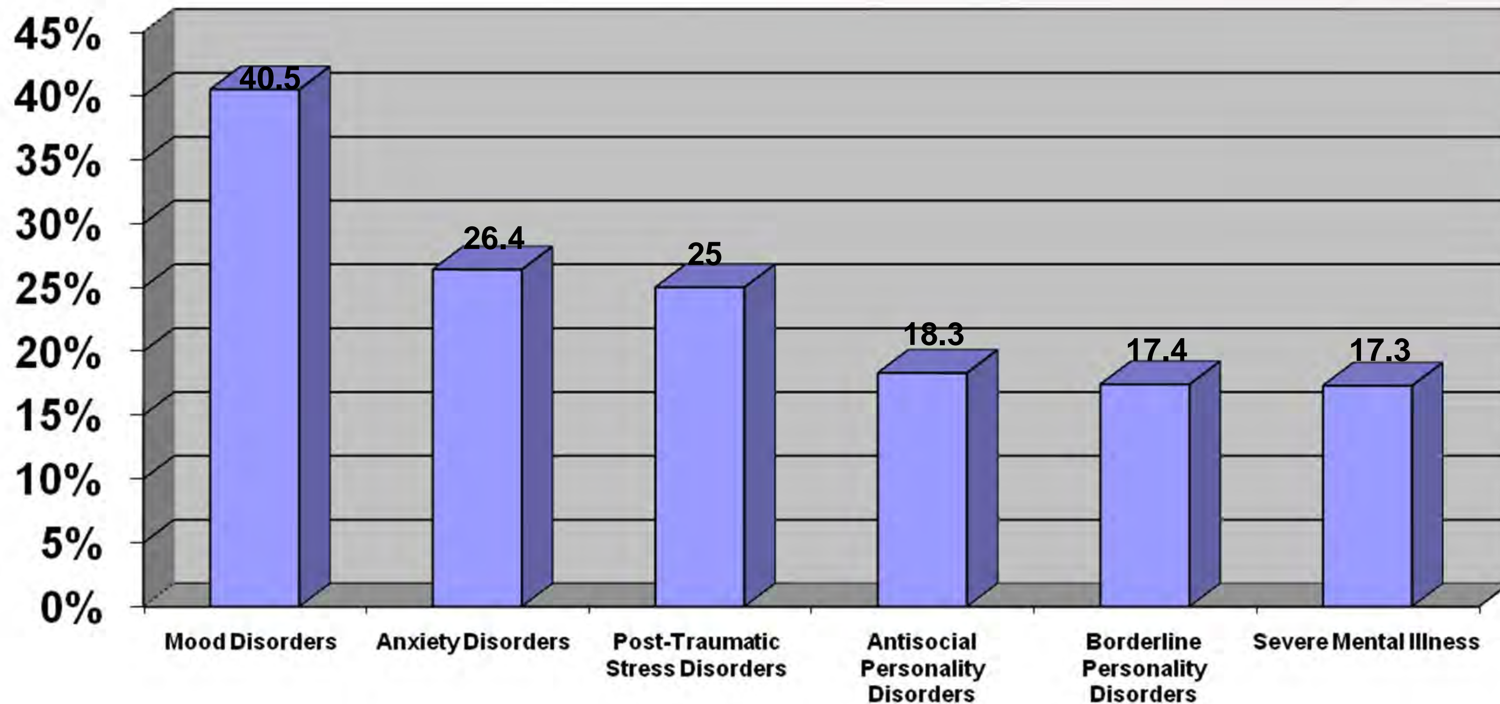
Prevalence of Co-Occurring Disorders

Figure 6:
Addiction Treatment Provider Estimates by Psychiatric Disorder



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Integrated Treatment

Mental health and substance use disorder treatment that is:

- delivered concurrently
- by the same team or group of clinicians
- within the same program

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Integrated Treatment

- Integrated treatment is associated with:
  - reduced substance use,
  - improvement in psychiatric symptoms and functioning,
  - decreased hospitalization,
  - increased housing stability,
  - fewer arrests, and
  - improved quality of life

**Drake et al., 2001*

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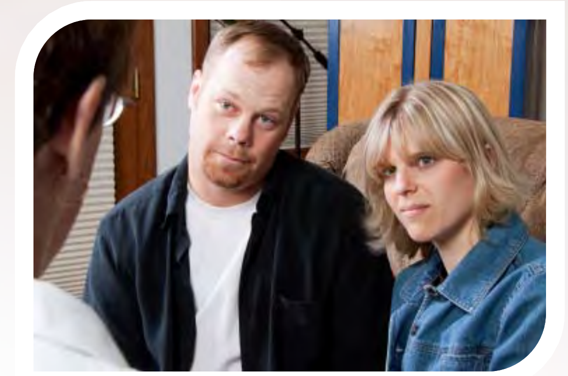
Benefits of Integrated Treatment



- Reduced need for coordination
- Reduced frustration for clients
- Shared decision-making responsibilities
- Families and significant others are included
- Transparent practices help everyone involved share responsibility
- Clients are empowered to treat their own illness and manage their own recovery
- The client and his/her family has more choice in treatment, more ability for self-management, and a higher satisfaction with care

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Stages of Change

STAGES OF CHANGE

- Precontemplation
- Contemplation
- Action
- Maintenance

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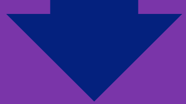
Stages of Change

STAGES OF CHANGE



- **Precontemplation**
- **Contemplation**
- **Action**
- **Maintenance**

We know how stages of change apply to individuals.

How do these stages apply to organizational change?

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Clinical and Programmatic Stages of Change: Parallel Processes

CLINICAL CHANGE PROCESS	PROGRAM CHANGE PROCESS
Screening & Assessment	Screening & Assessment
Treatment or Recovery Plan	Implementation or Change Plan
Outcomes	Outcomes
Relapse Prevention	Monitoring and Sustainability

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Measuring Co-Occurring Capability

1. Generic terms “integrated” or “enhanced” are “feel good” rhetoric but lack specificity.
2. Systems and providers seek guidance, objective criteria and benchmarks for providing the best possible services.
3. Patients and families should be informed about the range of services, to express preferences and make educated treatment decisions.
4. Change efforts can be focused and outcomes of these initiatives assessed.

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Tools for Measuring Co-Occurring Capability

- DDCAT (Dual Diagnosis Capability in Addiction Treatment)
- DDCMHT (Dual Diagnosis Capability in Mental Health Treatment)

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Program Definitions

Addiction-Only Services (AOS)

These addiction treatment programs cannot accommodate patients with co-occurring mental health disorders that require ongoing treatment, no matter how stable or functional the patient.

Mental Health-Only Services (MHOS)

These psychiatric treatment programs cannot accommodate patients with co-occurring substance use disorders that require ongoing treatment, no matter how stable or functional the patient.

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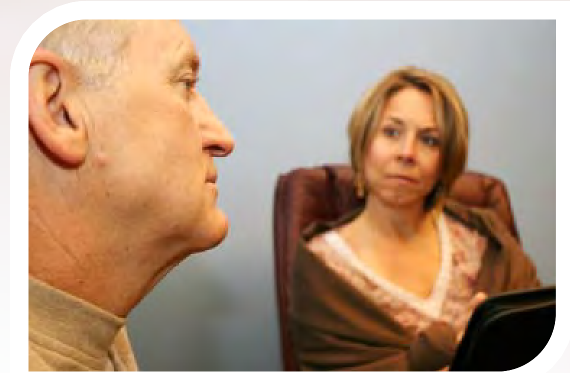
Program Definitions



Dual Diagnosis Capable (DDC)

Addiction treatment programs at the **DDC** level have a primary focus on treating substance use disorders. These programs are also capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health disorders related to an emotional, behavioral, or cognitive disorder.

Mental health programs at the DDC level have a primary focus on treating psychiatric disorders. These programs are also capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring substance use disorders.

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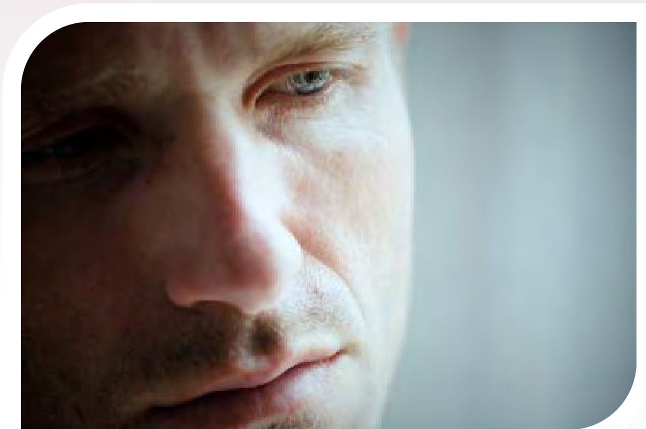
Program Definitions

Dual Diagnosis Enhanced (DDE)



These addiction treatment programs are designed to treat patients who have unstable or disabling co-occurring mental health disorders in addition to a substance use disorder.

These mental health treatment programs are designed to treat patients who have unstable or disabling co-occurring substance use disorders in addition to a psychiatric disorder.

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DDCAT/DDCMHT Framework

- Policy
- Program Structure, Program Milieu
- Clinical Practices
- Assessment, Treatment, Continuity of Care
- Workforce
- Staffing, Training

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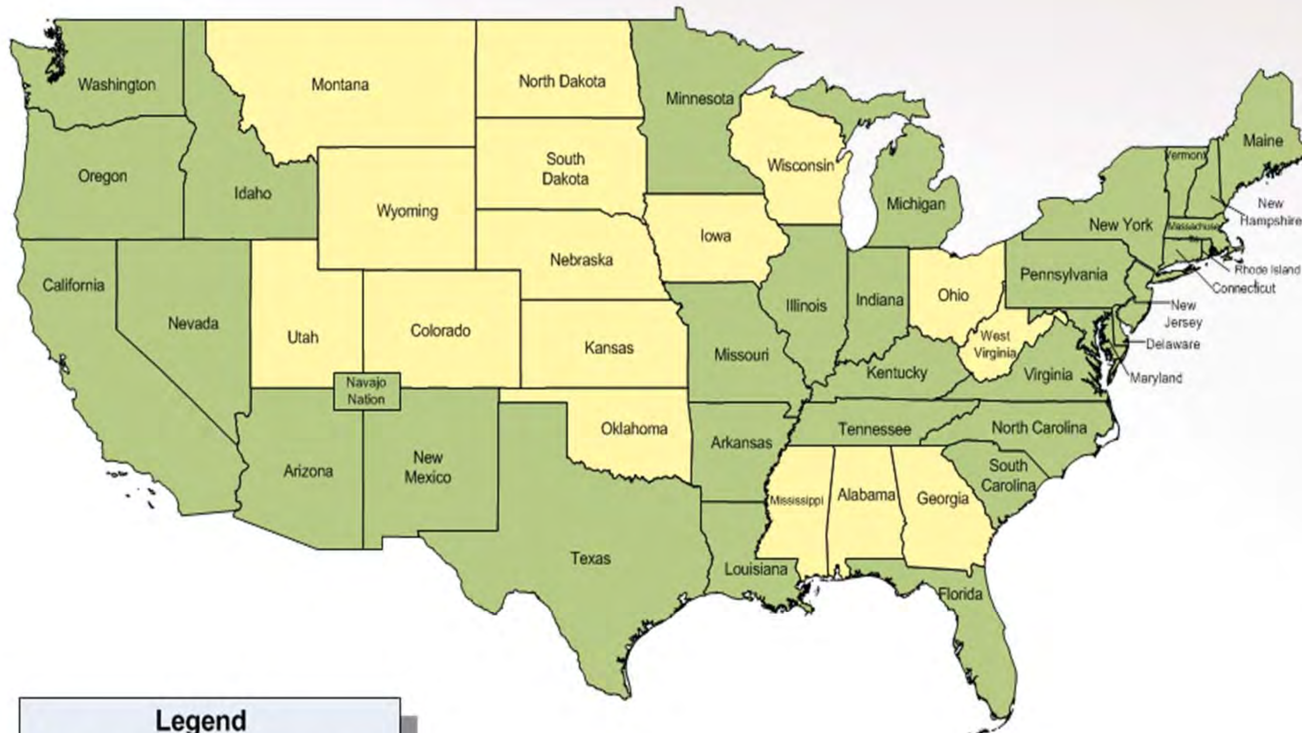
A Common Yardstick

States Utilizing the DDCAT/DDCMHT/DDCHCS Measure as of April 2011



Legend

- States using DDCAT/DDCMHT/DDCHCS in 2011 (32 states, District of Columbia and Navajo Nation)
- States

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Evolving Toward Integration

- States using the DDCAT/DDCMHT measures
  - 2006: 8
  - 2012: 34
- 34 States have merged Mental Health and Addiction Services into Behavioral Health Divisions
- IC&RC member Boards in 18 states currently offer Co-Occurring credentials
- SAMHSA merged its MH and SA Block Grants into a single process in 2011
  - Funding streams remain separate – *for now*

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What We're Seeing and Learning

- Uncertainty, wariness, trepidation
  - Parity isn't going to fix everything
- Integration, integration, integration
  - Different things to different people
  - It's more than just MH + CD = COD
  - Recovery-oriented and client-centered
- Huge variances across states and agencies
- Success factors
  - Top-to-bottom steadfastness
  - Innovation with a willingness to fail
  - Focus on the client rather than the system

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Thanks to

- Rodney Bragg, TN Dept of Mental Health and Developmental Disabilities
- Julienne Giard, CT DMHAS
- Nick Nichols, VT Dept of Mental Health
- Phil Welches, Gateway Foundation
- The COSIG Learning Community on Co-Occurring Integration
- The DDCAT, DDCMHT, and DDCHCS Learning Community
- The National Council Co-Occurring Disorders Learning Collaborative

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Learning from early adopters

- Executive leadership engagement is critical
- Lessons learned:
  - Buy-in ≠ Engagement
  - Management needs to be unified
    - “Motivational interviewing works surprisingly well with executives too”
  - Articulate the “why”
    - Clearly
    - Consistently
    - Often

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Champion model

- Finding a champion is critical to rallying the troops
- Lessons learned:
  - Not the existing COD expert
  - Not the trainer
  - Don't identify him/her as the "champion"
  - Clinical supervisor is ideal

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Change is a process

- Stages of Change at the agency level
  - “Meet ‘em where they’re at”
- Lessons learned:
  - Regular check-ins with leaders and champions
    - Training itself is a long-term process
    - Practice improvement collaboratives
    - Check-ins alone yield progress in intervals
  - Clearly identified change plans
    - Responsibilities and benchmarks
    - Reinforce and celebrate successes
  - Expect and normalize setbacks

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Staffing and Development

- Co-Occurring Disorders ⇄ MH + CD
- Lessons learned
  - Gain some traction before training clinicians
    - Research into practice… requires practice!
  - Old habits die hard
    - New skills are uncomfortable and awkward
      - For clinicians, it can feel personal
    - Supervision and case presentations provide objectivity
    - Expect resistance; reinforce the "why"

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Sustaining change

- For early adopters, sustainability remains a challenge
  - Funding, turnover, and inertia are all contributors
  - Fidelity to stage-wise treatment model a consistent challenge
- Lessons learned
  - Ongoing need for workforce development
  - Ongoing fidelity assessments
    - Position as opportunities, not ratings
    - “it’s about the process, not the number”
  - Ongoing “peer support” networks
    - Cross-agency peer communities

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Rolling with Resistance

- Stasis is comfortable
- Organizational change is even harder than institutional change
  - Collaboration works… to an extent
  - Directives work… to an extent
  - Evolutionary and organic change… works.

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A vision for integrated recovery

Recovery

Community Resources
- Community-based Professional Support
- Medication Management
- Peer Recovery Groups
- Supported Employment
- Safe & Healthy Housing
- Family Care

Integrated Treatment Dimensions
- Program Structure and Mileu
- Screening and Assessment
- Evidence-based Treatment Approaches
- Continuity of Care
- Staffing Structure and Pattern
- Clinical Supervision & Professional Development
- Evaluation & Continuous Improvement

Environmental Preparedness
- Public Awareness
- Agency and Organization Readiness
- Integrated & Widespread Screening & Brief Intervention
- Public Education

External Factors
- Funding
- Public Policy
- Research

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Screening and Assessment

Screening:

The first phase of evaluation where the potential client is interviewed to determine if he or she is appropriate for that specific treatment facility and to determine the possible presence or absence of a substance use or mental health problem.

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Screening and Assessment

Assessment:

The second phase of evaluation where a systematic interview is necessary to verify the potential presence of a mental health or substance use disorder detected during the screening process.

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Complexities of Screening and Assessment

- Intoxication
- Withdrawal
- Substance-induced disorders
- Motivational factors
- Feelings, symptoms, and disorders

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Co-occurring Disorders Interactions

Substances and Negative Emotions

SUBSTANCE	NEGATIVE EMOTIONAL STATE	MIMICKED PSYCHIATRIC DISORDER
Alcohol	Depression; Anxiety	Mood Disorder; Anxiety Disorder
Benzodiazepines	Depression; Anxiety	Mood Disorder; Anxiety Disorder
Cocaine/Amphetamine/ Methamphetamine	Depression; Anxiety; Mood Swings; Impulsivity	Anxiety Disorder; Bipolar Disorder
Cannabis/Marijuana	Depression; Anxiety	Mood Disorder; Anxiety Disorder
Opiates/Heroin/ Prescription Narcotics	Depression	Mood Disorder
Polysubstance (Mixed Substance Use)	Depression; Anxiety; Mood Swings; Impulsivity	Mood Disorder; Anxiety Disorder; Bipolar Disorder

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Screening and Assessment

The choice of screening measures depends on:

1. The skill of the screening professional
2. The cost of the screening materials
3. How simple the scale is to interpret and use across disciplines
4. Psychometric qualities
5. The relevance of screening to prevalent disorders
6. Movement from very sensitive (generic) measures to more specific measures

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Evidence-Based Practices

The Integrated Combined Therapies model combines these three EBPs (Evidence-Based Practices) into a stage-wise treatment plan whereby:

- motivational enhancement therapy is first utilized to ***initiate change*** and engage the client in the therapeutic process;
- cognitive-behavioral therapy is then used to help ***make change*** within the client; and
- twelve step facilitation is essential to helping maintain and ***sustain changes***.

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Correspondence Between Stages of Change and Stages of Treatment

STAGES OF CHANGE	STAGES OF TREATMENT
• Precontemplation	• Engagement
• Contemplation	• Persuasion
• Action	• Active
• Maintenance	• Relapse Prevention

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Motivational Enhancement Therapy (MET)

- Begins with a data-driven, collaborative and honest assessment of motivation to change
- Motivational interviewing to increase desire to work on substance use and/or mental health problems
- The MET therapist matches his or her approach to patient's level of motivation: "stage-wise treatment"
- Primary emphasis on instilling motivation to change & maintain the desire to change from within, as opposed to external motivation (e.g., coercion)
- Multiple studies have found positive outcomes, including treatment retention and engagement

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Motivational Enhancement Therapy (MET)

- MET ascertains patient life goals
- MET helps patient identify and articulate how life goals are affected by substance and mental health problems
- MET highlights the discrepancy between life goals, who the person wants to be, and the impact of substance use or mental health problems
- The MET therapist tries to solidify a motivation for change
- The MET therapist collaborates with the patient to evaluate the success of the change plan and suggests options (including professional help) if the plan is ineffective

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Cognitive Behavioral Therapy (CBT)

- Based on principles of learning
- Includes broad range of techniques, such as social skills training, cognitive restructuring, relapse prevention skills, & coping skills training
- Temporal emphasis on the here-and-now
- Focus on
  1. Reducing urges to use
  2. Managing mental health symptoms
  3. Preventing relapses into substance use or mental health problems
  4. Developing more adaptive living & coping skills

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Cognitive Behavioral Therapy (CBT)

- Associated with positive outcomes across a variety of settings (addiction treatment, mental health) and with a broad range of disorders (addiction and psychiatric)
- The therapeutic techniques are found in most addiction treatment, such as Relapse Prevention Therapy, Coping Skills Training, Anger Management
- CBT has been found effective with specific psychiatric disorders and heterogeneous disorder clusters
- CBT is a generically effective psychosocial intervention for any number of disorders: A psychotherapeutic equivalent of aspirin

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Twelve-Step Facilitation (TSF) Therapy

- NIAAA (TSF) & NIDA (Individual and Group Drug Counseling) manual-guided therapies
- TSF provides a structured therapeutic introduction to peer recovery support groups
- Informational and experiential
- Debunks common myths and addresses common apprehensions
- Associated with abstinence and other positive outcomes at 3-year follow-up (Project Match; NIDA Cocaine Collaborative Studies)
- Focus on skills & support for the long term

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Integrating Combined Therapies (ICT)

- Combining effective treatments to maximize patient response and outcomes are common in routine health care (e.g hypertension) and psychiatry (e.g. depression).
- Psychosocial interventions for co-occurring disorders can also be combined to maximize outcomes.
- The combination of MET and CBT has been evaluated in several studies and found effective for substance use disorders, and the combination of MET, CBT and TSF was recently studied and found effective for alcohol use disorders (Miller et al, NIAAA COMBINE Study, 2007)
- The combination of MET/CBT/TSF has been integrated and adapted for persons with co-occurring disorders: ICT

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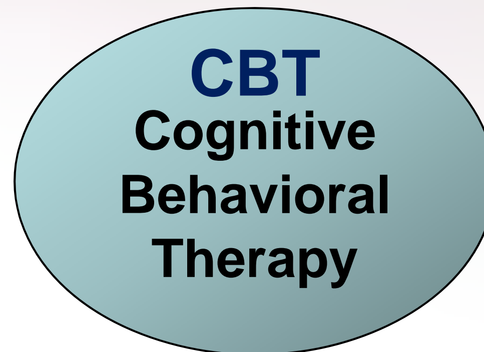
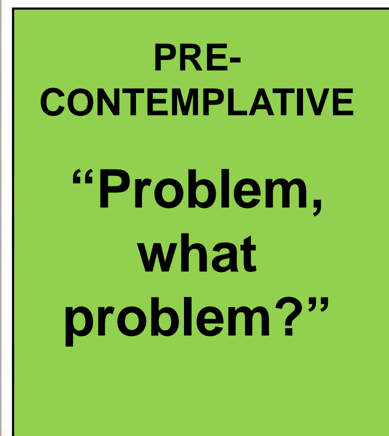
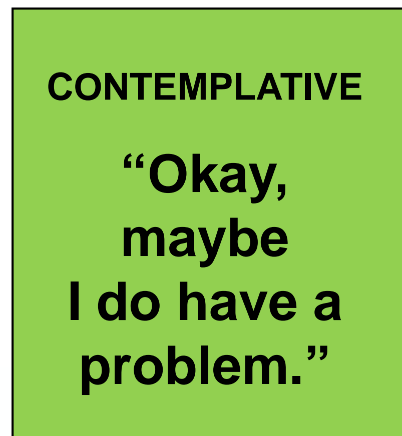
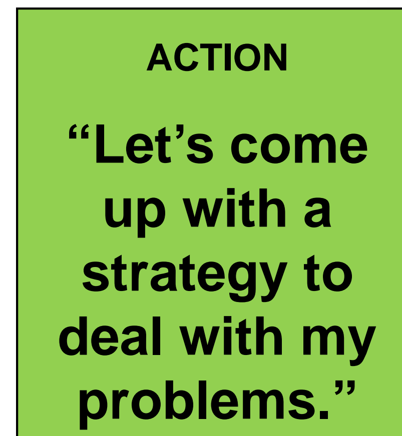
Integrating Combined Therapies (ICT)









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DDCAT & DDCMHT (3.2): Dimensions and Content of 35 items

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

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Developing a Program Implementation or Change Plan Using DDCAT/DDCMHT Data

1. Identify the DDCAT/DDCMHT dimension (Goal)
2. Identify the DDCAT/DDCMHT item(s) (Objectives)
3. Identify the “Intervention”
4. Identify the Responsible Persons
5. Identify the Target Date
6. Identify Measurable Outcomes

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Objective Assessments Using the DDCAT

- Site visit (yields data beyond self-report)
- Multiple sources:
  1) Documents and materials
  2) Ethnographic observation
  3) Interviews with staff and patients
- Unit of analysis: Program
- “Triangulation” of data

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DDCAT: Self vs. Independent Ratings (n=14 agencies in Australia)

5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00

Hobart
Wodonga
Mackay
Brisbane
Canberra
Canberra TC
Perth
Mandurah
Darwin

Baseline DDCAT Score
Self DDCAT Score

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Materials

References and Downloads | FAQs

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit

Introduction | Applications | Methodology | Scoring and Profile Interpretation | DDCAT Elements and Program Enhancement

Levels of Program Capacity for Co-Occurring Disorders

Individuals with co-occurring substance use and mental health disorders respond to integrated treatment that addresses both problems at once. Programs can increase their ability to welcome consumers with co-occurring disorders and provide effective screening, assessment, and treatment.

Learn More

About the DDCAT Toolkit

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index is a program-level assessment used to inform addiction treatment

continuity of care, staffing and training. Programs are ranked along a continuum from Addiction Only Services, Dual Diagnosis Capable, and Dual Diagnosis Enhanced. This measure is being used in over 30 states to improve services for individuals with co-occurring mental health and substance use disorders.

Is the DDCAT right for me?

Two co-occurring capability measures described on this site: the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and the

the best guidance for increasing the co-occurring capability of your program. If your program has a history of providing mental health treatment services, see the DDCMHT site.

Explore the DDCAT Elements and Program Enhancement

- » I. Program Structure
- » II. P... Milieu
- » ...rocess: Assessment
- » IV. Clinical Process: Treatment
- » V. Continuity of Care
- » VI. Staffing
- » VII. Training

http://www.samhsa.gov/co-occuring/ddcat

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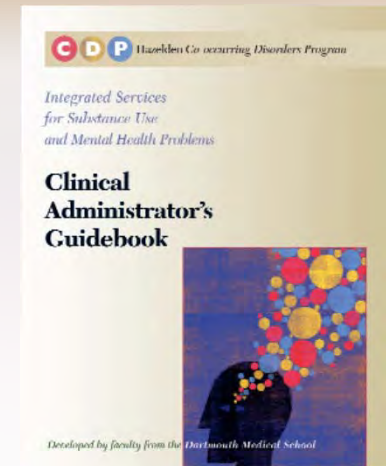
CDP Clinical Administrator’s Guidebook



- Provides overview of how to assess program services
- Offers concrete suggestions and tools to raise DDCAT or DDCMHT scores on each benchmark item from AOS/MHOS to DDC or from DDC to DDE
- Evaluates the cost implications of specific changes
- Outlines change strategies: Leadership, change team, level of motivation or “buy-in”, how to utilize implementation/change plans and measure outcomes
- Includes CD-Rom with most necessary materials for implementation

The Co-Occurring Disorders Program (CDP)

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Evidence-Based Resources for Behavioral Health

The Co-Occurring Disorders Program (CDP)

Together, the six components help you improve your ability to:

1) Assess Organizational Capacity
2) Screen and Assess Clients
3) Integrate Combined Therapies
4) Apply Cognitive-Behavioral Therapy
5) Help Clients Manage Medications
6) Engage Families

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Focus on Integrated Treatment

Interactive online training for co-occurring disorders treatment

Focus on Integrated Treatment (FIT) is the missing link to achieving the CCDP and CCDPD certifications. Sign on today and develop the skills needed to be part of a co-occurring disorders treatment team-serving clients with an integrated treatment approach.

Features | Courses | Certification | Support

Focus on Integrated Treatment

Learn about

the integrated treatment of co-occurring disorders.

Key features

- ✓ Clinician and Clinical Administrator Collections
- ✓ Courses in stagewise treatment, screening and assessment, motivational interviewing, and more
- ✓ CE hours awarded toward IC&RC and other certifications
- ✓ Cost-effective at $15 per module

COURSES AND PRICING

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The Development of FIT

- A collaboration between:
  - ✓ Dartmouth Psychiatric Research Center
  - ✓ Research Foundation for Mental Hygiene (includes OMH, NY OASAS, and CPI – Center for Practice Innovations)
  - ✓ New York State Psychiatric Institute/Columbia University
- Implemented state-wide in New York since November 2009

An Overview of FIT

- 35 comprehensive module distance learning program
- Modules take no more than 60 minutes to complete
- Highly interactive and graphic
  - ✓ videos of real clients sharing their stories,
  - ✓ clinical vignettes,
  - ✓ interactive exercises,
  - ✓ expert panel sessions
  - ✓ online testing upon completion
- Modules can be segmented for use by clinicians, clinical supervisors and clinic administrators

Dartmouth PRC HAZELDEN

Thank you for participating, and for leading the way toward integrated treatment

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