Northwest Frontier ATTC
Unifying science, education and services to transform lives.

Addiction Messenger

SERIES 36 - October 2009 Volume 12, Issue 10 *Ideas for Treatment Improvement*

Integrating SA & MH Services

Part 1 - Do You Provide Integrated Care?

What is integrated care? How capable is your agency of serving clients with dual diagnosis? How can you assess your agency's "dual diagnosis capability"? This series of the Addiction Messenger will explore those questions and provide information on screening, assessment, treatment planning, interventions, long term care and recovery for your clients having both mental and substance use disorders.

Dual Diagnosis Capability in Addiction Treatmentthe Robert Wood Johnson Foundation and the SAMHSA Co-Occurring State Incentive Grant program developed an instrument, the ***Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index*** (McGovern, Matzkin and Giard, 2007), to assess an addiction treatment program's capacity for delivering services to clients with co-occurring disorders. Conducting and scoring the DDCAT produces scores that place an agency on a continuum ranging from Alcohol Only Services (AOS) to Dual Diagnosis Capable (DDC) to Dual Diagnosis Enhanced (DDE).

The DDCAT evaluates 35 program elements that are subdivided into 7 dimensions. The first, **Program Structure**, focuses on general agency organizational factors that foster or inhibit the development of integrated COD services. **Program Milieu,** the second dimension, focuses on the culture of the agency and whether the staff and physical environment are receptive and welcoming to clients with COD. The third and fourth dimensions focus on the clinical processes of **Assessment** and **Treatment** by examining whether specific clinical activities achieve benchmarks characteristic of COD capability. The fifth, **Continuity of Care** examines long-term treatment issues and the availability of external support for persons with COD. Sixth, **Staffing,** reviews staffing patterns and operations that support integrated care. **Training,** the seventh and final dimension, assesses the appropriateness of staff training that facilitates the capacity of an agency to work effectively with persons having COD.

Most agencies fall somewhere on a continuum from AOS to DDC to DDE. To help you assess the degree to which your agency provides integrated care, each of the DDCAT's seven dimensions are described below in a way that illustrates what could be characterized as a Dual Diagnosis **Enhanced** service:

I. PROGRAM STRUCTURE

The agency mission statement reflects a capacity to provide both mental health and substance use services without barriers. Its licensure or state permit identifies

"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."

~ L.C. Megginson (frequently attributed to Charles Darwin) ~

Northwest Frontier
Addiction Technology
Transfer Center
810 D Street NE
Salem, OR 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

A project of OHSU
Department of Public Health
& Preventive Medicine

Steve Gallon, Ph.D.
Principal Investigator

Mary Anne Bryan, MS, LPC
Program Manager, Editor
bryanm@ohsu.edu

www.attcnetwork.org

Next Issue:
Screening & Assessment

Funded by Substance Abuse and Mental Health Services Administration

it as a facility that provides services to clients with both mental health and substance use disorders. There is a seamless flow from substance use to mental health services for clients with a shared responsibility and communication flow. In addition, the agency can be reimbursed for services provided to treat both mental health and substance related services equally.

II. PROGRAM MILIEU

The agency welcomes clients afflicted with a combination of mental and substance use disorders. It routinely accepts individuals with CODs regardless of severity and formally recognizes that intention in its mission statement, philosophy, policies, and protocols. The agency displays and provides educational materials for clients, family members, and the public that address both mental and substance use disorders.

III. CLINICAL PROCESS: ASSESSMENT

The presence of both substance use and mental disorders are routinely and systematically screened and diagnosed. The assessment includes a description of the client's past history and chronological/sequential relationship between substance use and psychiatric problems. The client's psychiatric symptom acuity, severity, persistence, and disability at the time of assessment are used as indicators of client needs. In addition, readiness for change is assessed and used to strategically and efficiently plan services that match client needs and service intensity.

IV. CLINICAL PROCESS: TREATMENT

Treatment plans indicate that both psychiatric and substance use disorders are addressed and that the interactive course of both disorders is continually assessed and monitored. This continued monitoring is documented in a standardized fashion within the client's record. Assessment of the client's readiness to change is also ongoing and used to determine treatment intensity and the utilization of outside community services.

Therapeutic interventions and practices target specific symptoms of mental disorders. Clinical guidelines are used to manage crisis and mental health emergencies and the agency is capable of evaluating, coordinating and managing the client's medication regimen and adherence when appropriate. A staff person, who is a prescriber, is fully integrated into the agency's treatment team. The prescriber does not provide services in an isolated or independent manner or as an external, add-on service. Instead, the prescriber is an active staff member involved in recovery planning and administrative decisions.

The focus of care is to maintain clients within the agency, unless the severity of their symptoms warrants alternative placement. This means that the agency is capable of on-going risk assessment and management of persons with interacting and exacerbating symptoms.

Education about mental and substance use disorders is provided and both clients and their family members (or significant others) receive education and support regarding COD characteristics, services, and the interactive course of the disorders to develop realistic expectations.

The agency provides clients with assistance to develop support systems through self-help groups. Clients are encouraged to use peer supports and role models that include consumer liaisons, recovery coaches, peer mentors, sponsors, and alumni groups when they are available. The client's recovery plan indicates that linkage with self-help groups and peer support is regularly discussed to foster transition to self-directed recovery as soon as the client is ready.

V. CONTINUITY OF CARE

The agency supports a recovery philosophy (vs. symptom remission only) for both disorders and maintains a continuum of care for clients with COD together with the provision of follow-up services. The client's COD are addressed throughout the care planning process. Discharge plans include a focus on needed follow-up services for both mental and substance use disorders. The agency assists with client psychotropic medication planning, access and monitoring, and assures the availability of sufficient supplies of needed medications at discharge. Difficulties linking or continuing with self-help support groups are anticipated, discussed, and resolved whenever possible. Assistance that supports transition to a less intensive level of care is provided.

VI. STAFFING

Pharmacotherapy for mental and substance use disorders is provided through the services of an on-site psychiatrist, physician or other prescribing professional. The prescriber is an active participant

in the full range of the agency's clinical activities, is seen as an integral member of the clinical team, and may also serve in a clinical decision-making or supervisory role.

The agency employs staff with at least 50% having specific expertise or competencies in the care of mental disorders to enhance the agency's capacity to treat the complexities of clients with COD. Those who are unlicensed or who have insufficient competence or experience are provided with formal supervision that addresses the knowledge, skills and attitudes essential to effective care for COD. Documentation is available that demonstrates this arrangement, including regularly scheduled supervision activities.

The agency has a routine, formalized protocol for the delivery of care to clients with COD. This process allows for a systematic and critical review of targeted interventions for COD cases. Documentation of this formalized process is available. COD-specific case reviews and formal utilization review are conducted to support COD treatment and to continually monitor the appropriateness and effectiveness of services provided. In addition, the agency maintains staff or enlists volunteers who can serve as COD peer/alumni supports to conduct COD-specific case and utilization review processes.

VII. Training

The agency requires, and when necessary provides, basic training in COD issues (screening & assessment, signs & symptoms, prevalence, and interventions) for all agency staff and requires advanced training in COD issues for select staff. The agency has at least 90% of staff who are cross-trained in COD services. Cross-training is incorporated into the overall training plan for the agency.

Service Improvement Opportunities

Agencies can secure the services of a DDCAT evaluator to complete an assessment of their capabilities. The conducting and scoring of the DDCAT provides an agency with scores on the seven dimensions and categorizes the agency as Alcohol Only Services (AOS), Dual Diagnosis Capable (DDC) or Dual Diagnosis Enhanced (DDE). DDCAT results can be reviewed with the agency and a strategic plan developed to identify targets and objectives for improving the integration of COD services. DDCAT assessments can also be conducted at two or more points in time to allow the agency a chance to use the process as a quality improvement measure which illustrates change or stabilization within the seven dimensions. For more information about a DDCAT evaluation, contact the Northwest Frontier ATTC at 503-373-1322 or by sending an e-mail to Jennifer Verbeck at verbeck@ohsu.edu.

The next issue in this AM series will further illustrate the integration of services by examining screening, assessment and treatment planning.

Sources

McGovern, MP et al., **Assessing the Dual Diagnosis Capability of Addiction Treatment Agencies: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.** Journal of Dual Diagnosis, Vol 3(2), p. 111-123, 2007.

Addiction Treatment Services, Dartmouth Psychiaatric Research Center. Downloaded from the World Wide Web at: http://dms.dartmouth.edu/prc/dual/atsr/ on September 30, 2009.

Earn 2 Continuing Education Hours

by Reading all 3 issues of an Addiction Messenger series, completing the registration form and returning the test that are in the last issue of the series (Part 3). Cost is $20. Mail to NFATTC 810 D Street NE, Salem, OR 97301 or FAX to 503-373-7348 or contact bryanm@ohsu.edu

Northwest Frontier ATTC
810 “D” Street NE
Salem, Oregon 97301
Phone: (503) 373-1322
FAX: (503) 373-7348

Fall 2009 – Winter 2010 Course Schedule

NFATTC Trainings in Oregon and Washington

Developing Effective Treatment Plans (“Treatment Planning MATRS”)
December 4, 2009 – Tualatin, OR
1-day Course (7 CE Hours) - designed to help counselors develop treatment plans that are individualized, strength-based, and oriented toward specific client needs. Course is focused on using assessment information effectively in treatment planning and ongoing case management.

*

Cognitive Behavioral Therapy
December 10-11, 2009 – Tualatin, OR
December 14-15, 2009 – Seattle, WA
January 21-22, 2010 – Eugene, OR
February 25-26, 2010 – Grants Pass, OR
1.5 -day Course (10 CE Hours) – focuses on building skills in the use of cognitive behavioral therapy for counseling interventions. Participants will have the opportunity to develop or improve skills in the use of CBT appropriate for those clients with substance use disorders and mental health issues.

*

Introduction to Using Motivational Incentives (“PAMI - Promoting Awareness of Motivational Incentives”)
December 11, 2009 – Salem, OR
3-hour Course (3 CE Hours) - designed to build awareness of the use of Motivational Incentives as an evidence-based therapeutic strategy to enhance client retention in addiction treatment. Principles, history, research, and suggestions for overcoming implementation barriers are discussed.

*

Supervisory Tools for Enhancing Counselor Motivational Interviewing Skills (“MIA:STEP”)
February 4-5, 2010 – Portland, OR
2-day Course (12 CE Hours) ~ designed for clinical supervisors who want to maintain and build the MI skills of counselors and other direct service providers. Tools presented fortify a supervisor’s ability to provide structured, focused, and effective clinical supervision. Participants are introduced to an effective strategy for observation-based MI-oriented clinical supervision.