ETHICAL DILEMMA: BALANCING PROFESSIONAL ROLES AND SCOPE OF PRACTICE IN AN EVOLVING CLINICAL ENVIRONMENT

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OBJECTIVE

To provide tools and education
to help bridge the gap between

working with people
with Dual Disorders

TO

working with people
on their Dual Disorder

BARRIERS TO INTEGRATED TREATMENT

- Worries about practicing outside boundaries of role and scope
- Discomfort with change in traditional practices
- RF45
- Misunderstanding that substance use disorders can only be addressed in Rule 31 programs
- Misunderstanding about individual licensure (only substance abuse specialists can diagnose and treat substance abuse conditions and only mental health specialists can address mental health conditions and their symptoms)

- **The real barrier**: Training and competency in integrated treatment

BEHAVIORAL HEALTH AFFECTS EVERYONE

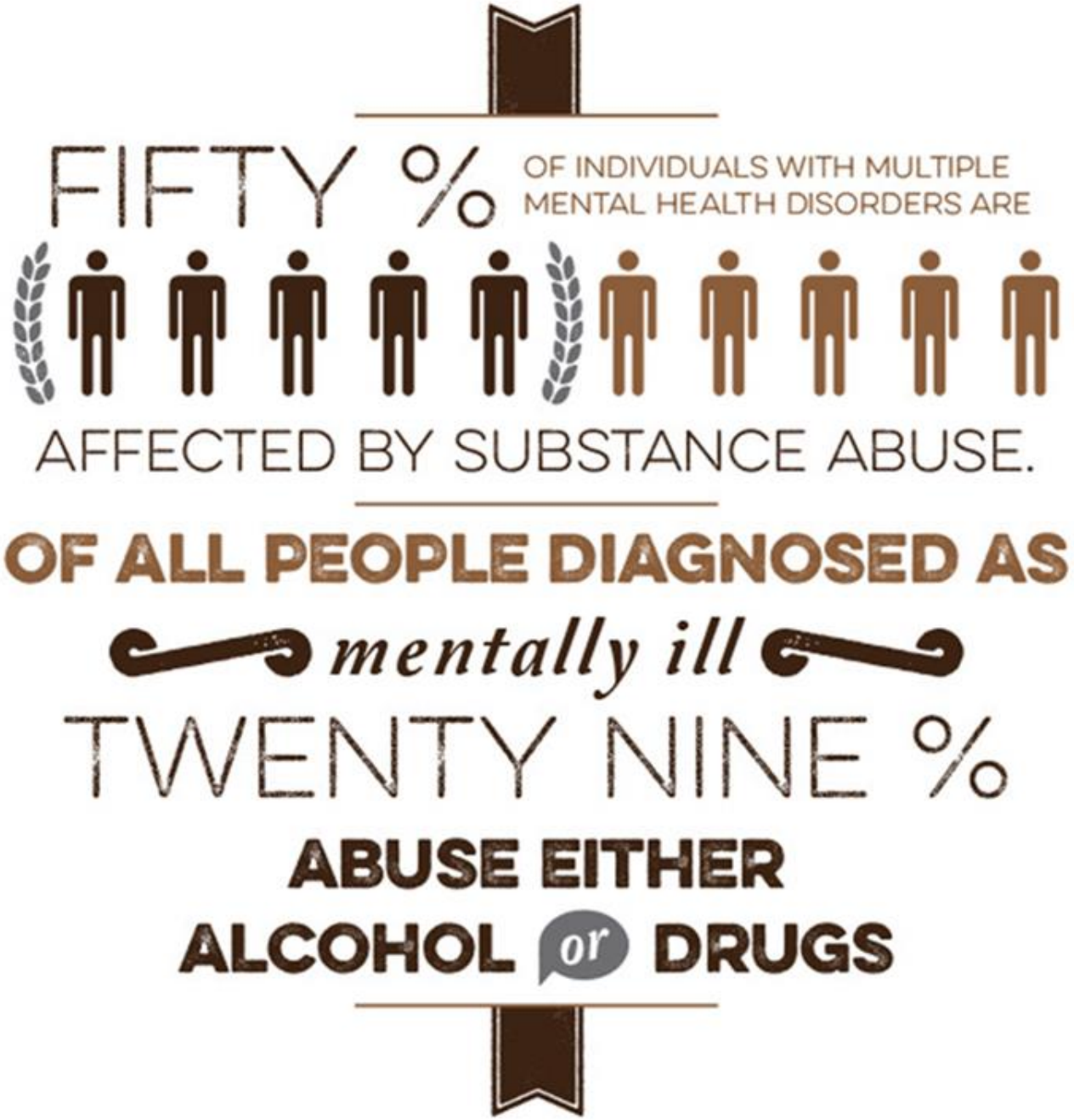
- ~Half of Americans will meet criteria for mental illness at some point

- > Half of Americans know someone in recovery from substance use problem

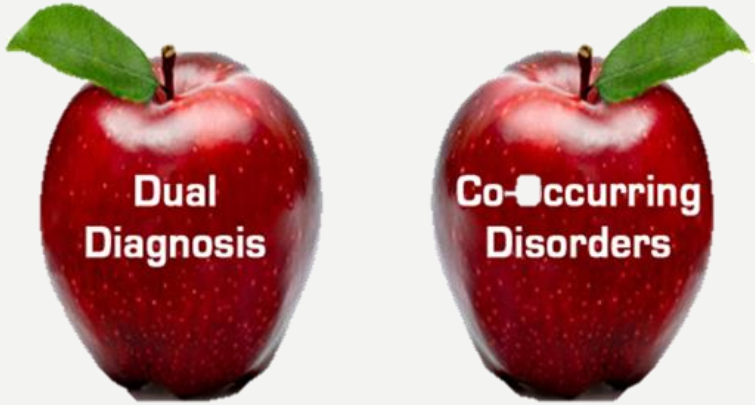
- Positive emotional health helps maintain physical health; engage productively with families, employers, friends; & respond to adversity w/ resilience and hope

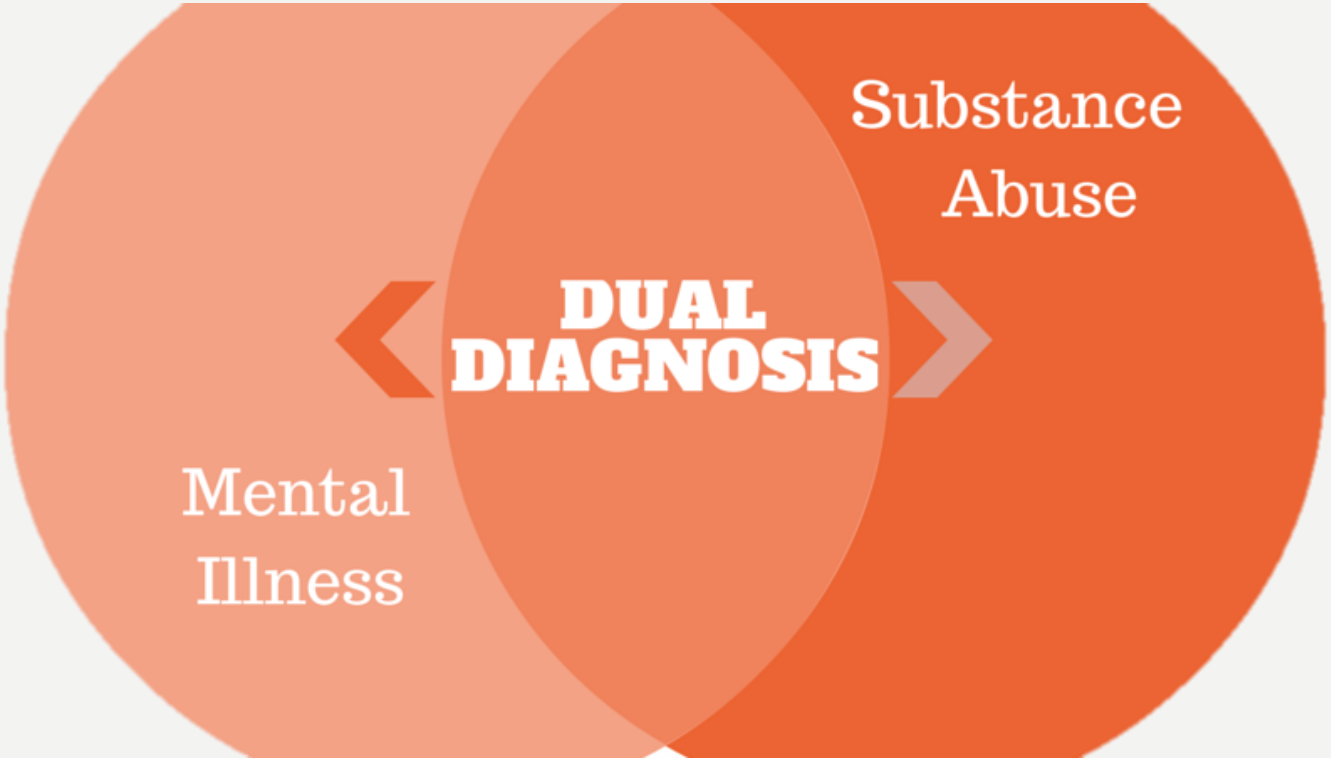
Source & Slide: SAMHSA (2012)

Of those with severe mental illnesses



WHO WE ARE TALKING ABOUT





CO-OCCURRING DISORDERS

COMPLICATIONS OF SUD ON MI

- Increased vulnerability to mental health relapse and repeated hospitalization
- More florid psychotic symptoms
- Inability to manage finances and live independently
- Housing instability and homelessness
- Non-adherence with medications and treatment
- Increased vulnerability to HIV infection and hepatitis, as well as opportunistic diseases

RESULTS OF COD

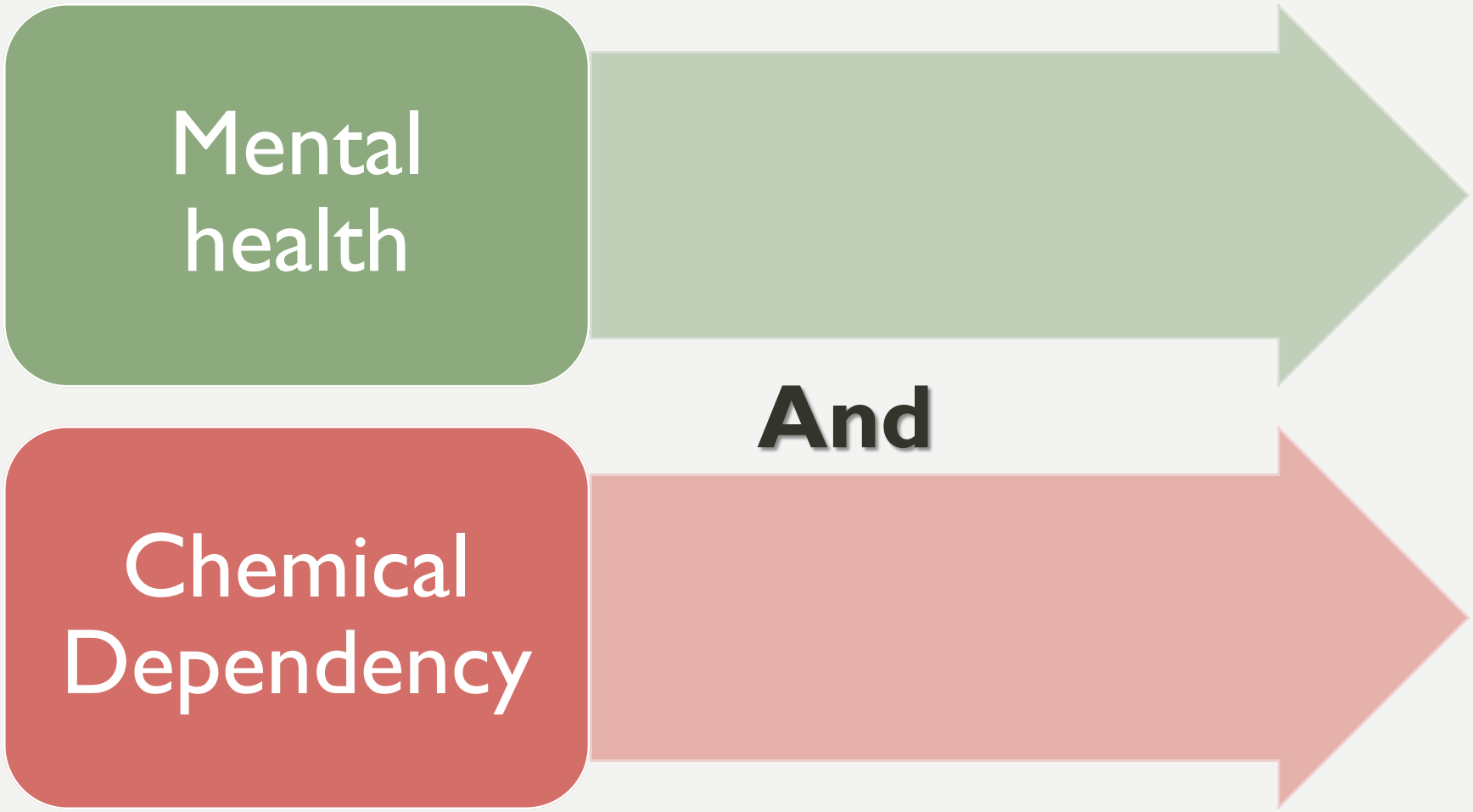
- Lower satisfaction with familial relationships
- Lowered ability to sustain social relationships
- Increased family burden
- Increased risk of violence, either committed or perceived
- Increased risk of incarceration
- Increased depression and suicidality often accompanied by episodes of SIB
- Higher service utilization and costs

COMPLICATING FACTORS FOUND IN PEOPLE WITH CO-OCCURRING DISORDERS

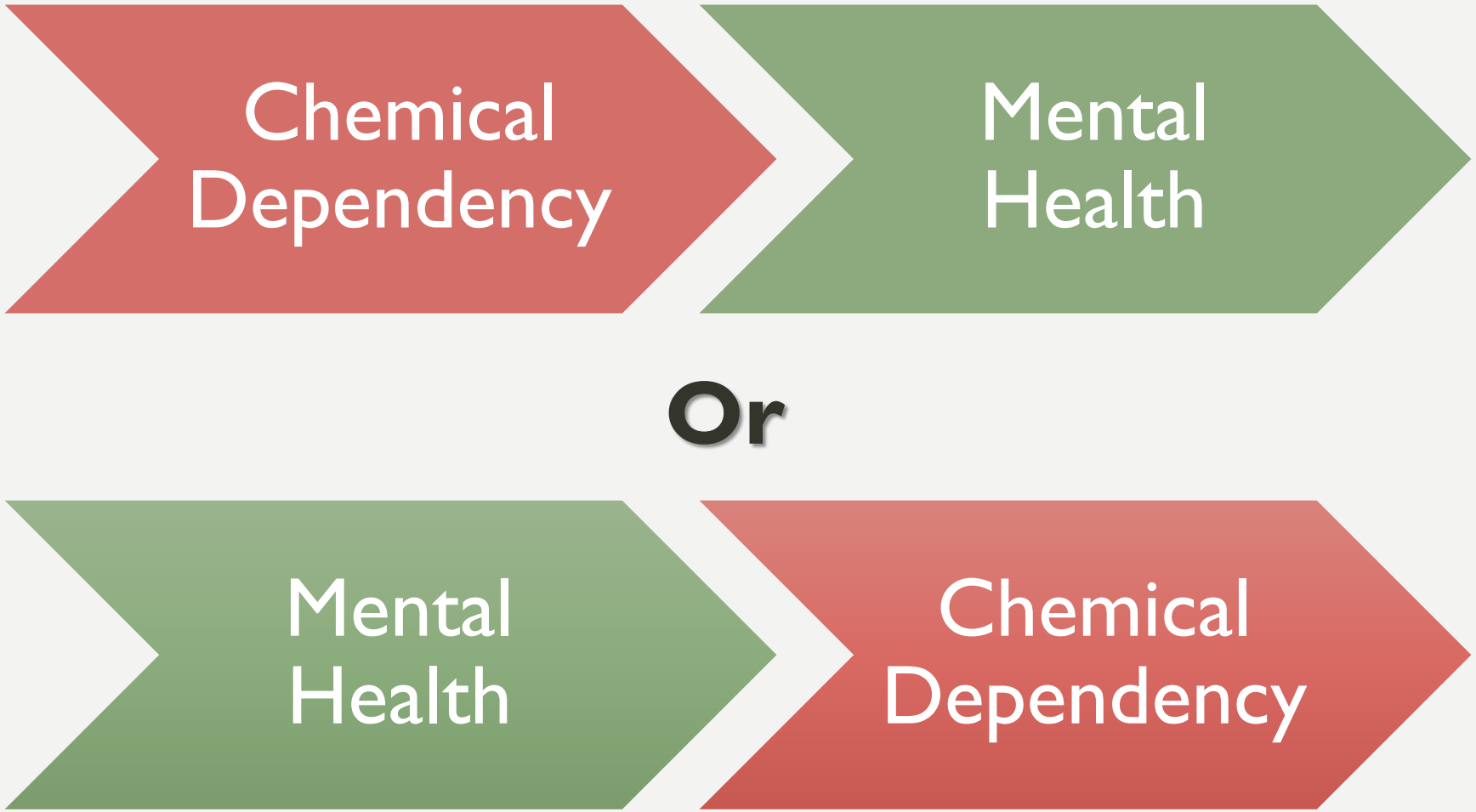
1. Acute & chronic substance use can produce mental health symptoms
2. Substance withdrawal can cause mental health symptoms
3. Substance use can mask mental health symptoms

1. Psychiatric disorders can look like symptoms that come with substance use
2. Acute and chronic substance use can make psychiatric disorders worse
3. Acute and chronic psychiatric disorders can be a barrier to the recovery process from substance use disorders

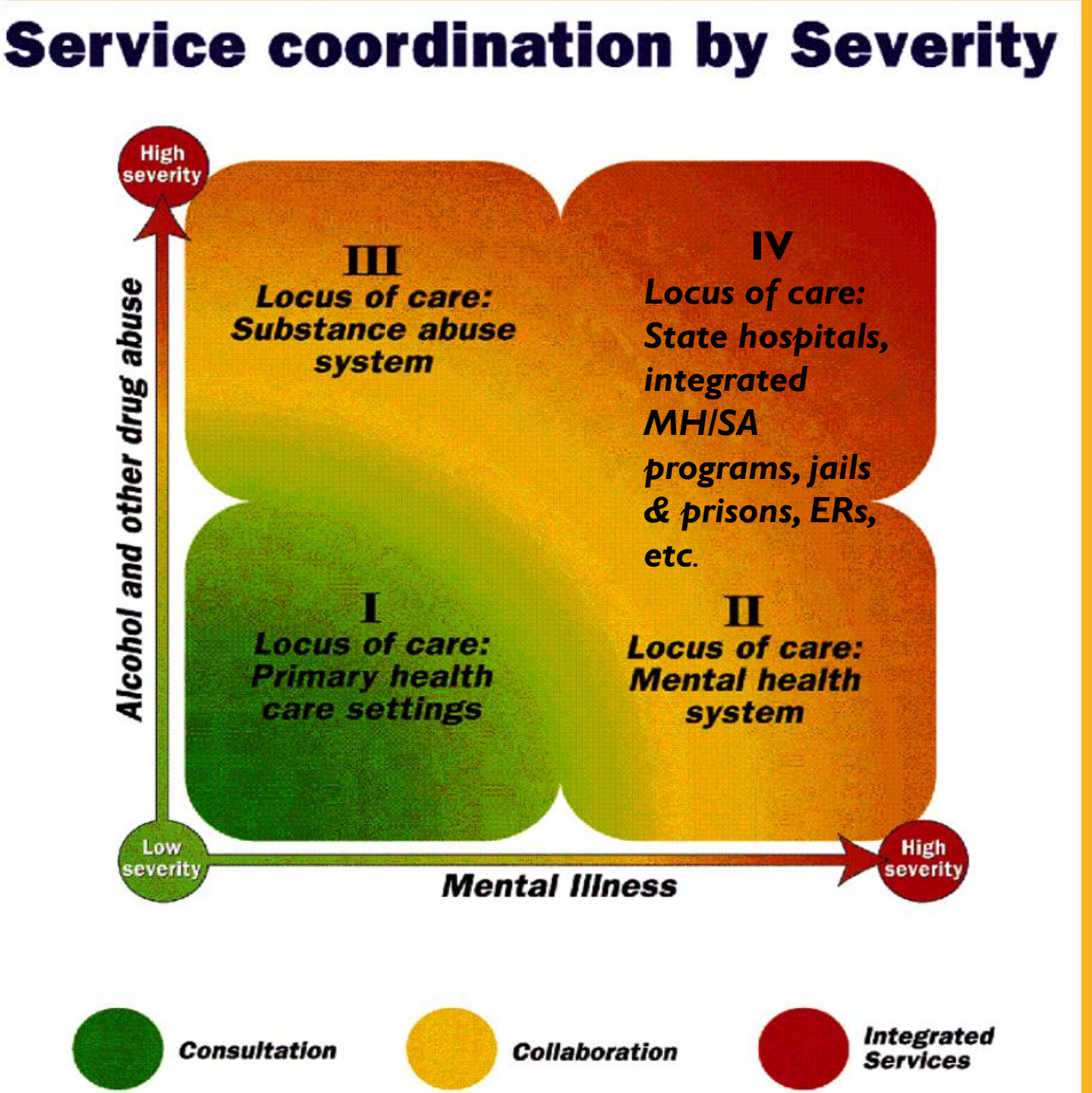
PARALLEL TREATMENT



SEQUENTIAL TREATMENT

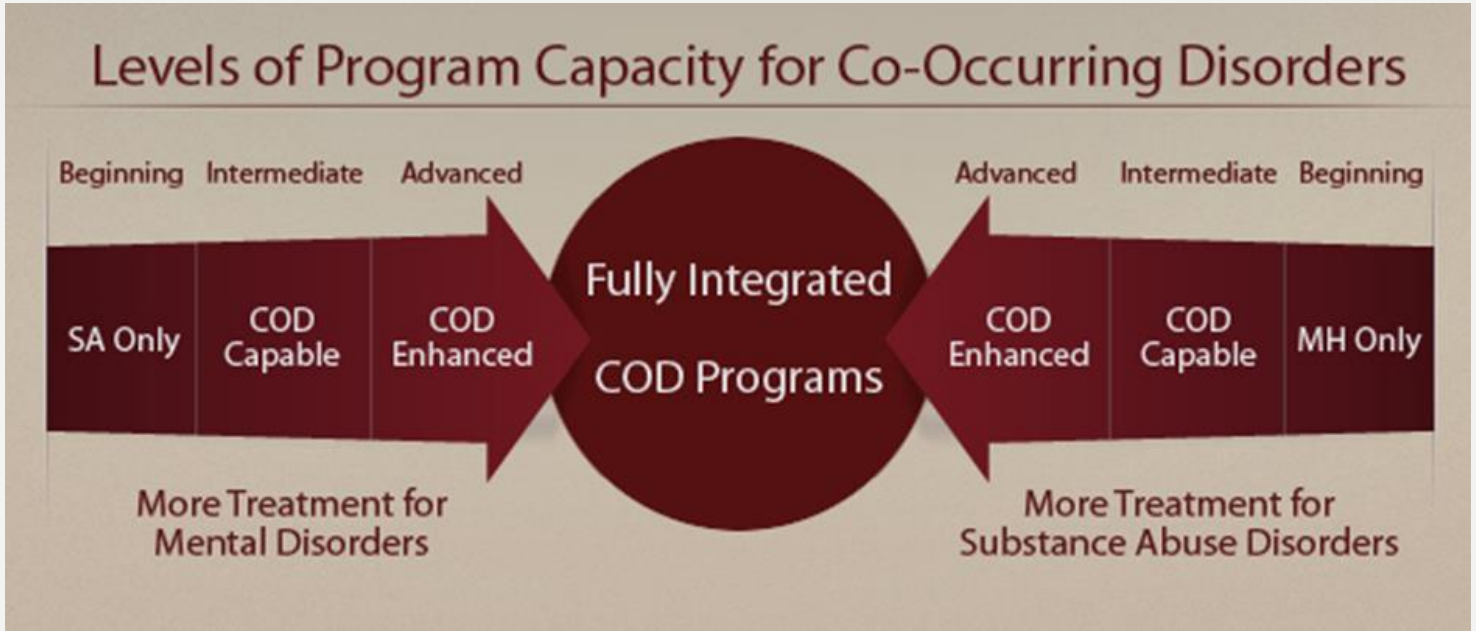


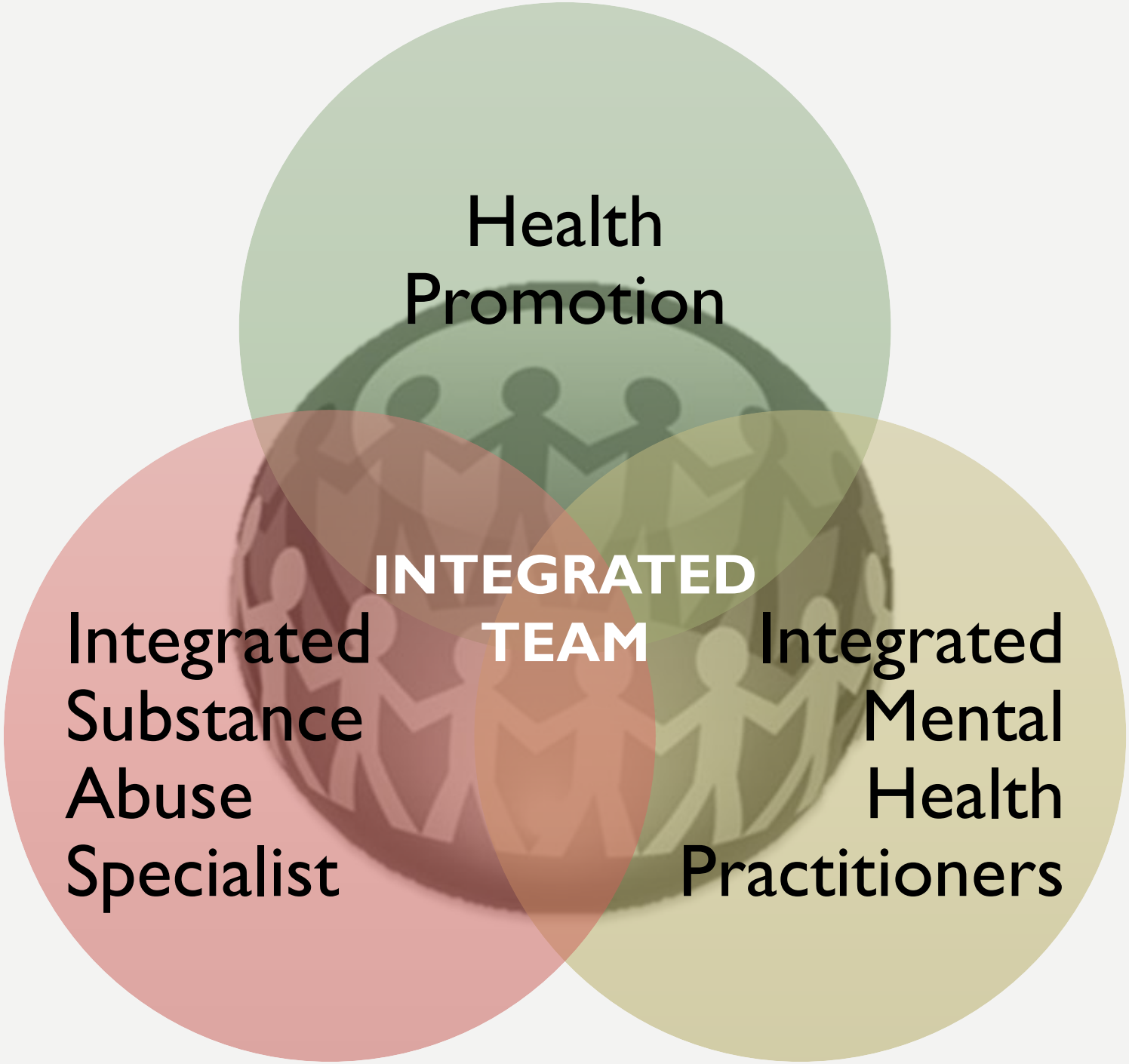
SAMHSA MATRIX



DUAL DIAGNOSIS CAPABILITY CLASSIFICATION BASED ON: ASAM PATIENT PLACEMENT CRITERIA 2ND REVISION

- AOS – Addiction Only Services
- DDC – Dual Diagnosis Capable
- DDE – Dual Diagnosis Enhanced

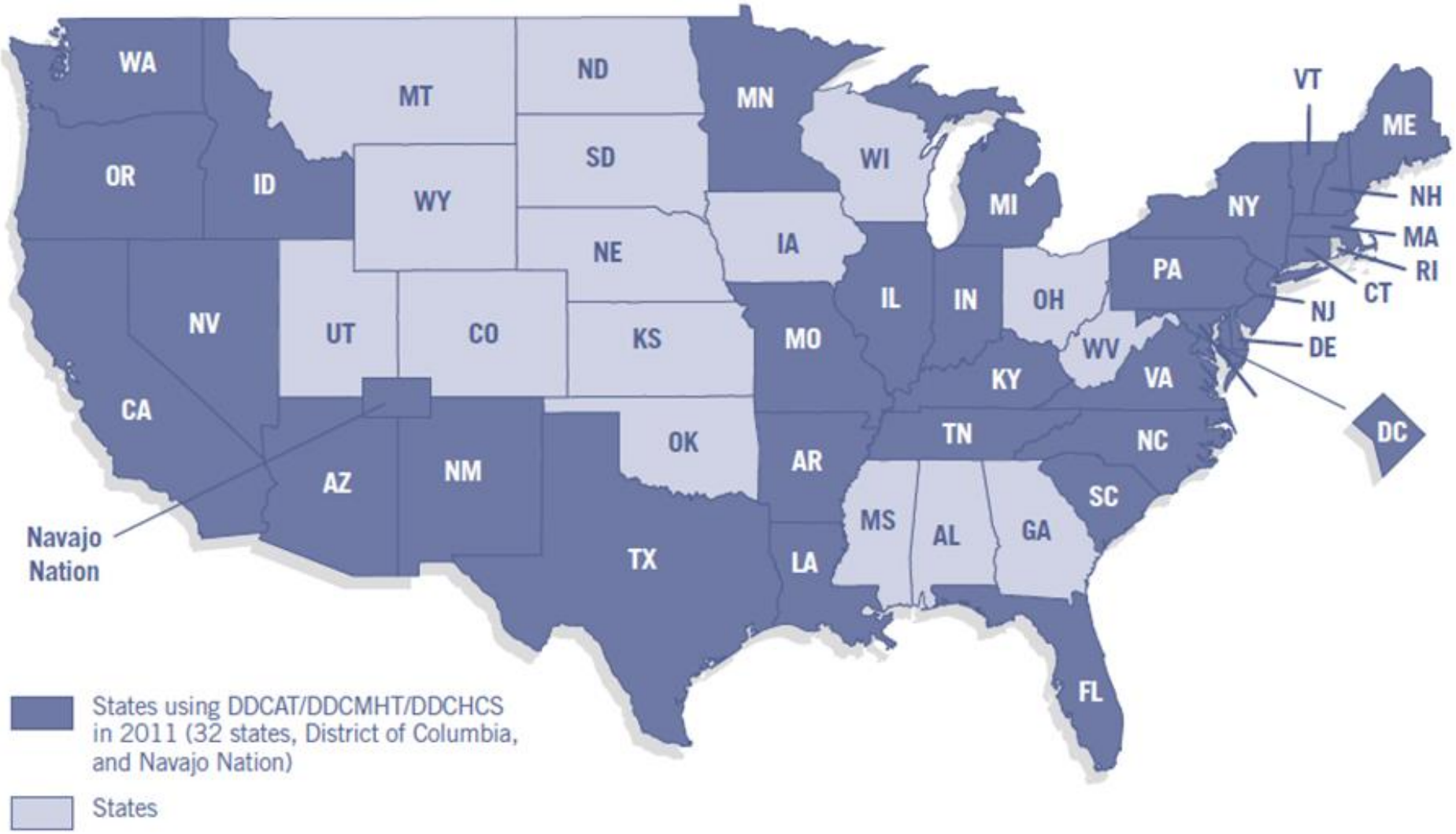



Health Promotion
INTEGRATED TEAM
Integrated Substance Abuse Specialist
Integrated Mental Health Practitioners

EVIDENCE-BASED PRACTICES IDENTIFIED BY SAMHSA

- **Integrated Treatment for Dual Disorders**
- Assertive Community Treatment Teams
- Supported Employment
- Illness Management and Recovery
- Family Psychoeducation

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



Hazelden Publishing

Behavioral Health Evolution

Innovative resources for treating substance use, mental health, and co-occurring disorders

Indexes measure program across seven dimensions

Providers who want to evolve their programs may use the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index or the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index to objectively measure their programs.

The DDCAT and DDCMHT establish benchmarks for providing evidence-based treatment services to people with co-occurring disorders. The indexes ask questions about seven dimensions within three primary areas of policy, clinical practice, and workforce.

Policy	
Dimension 1: Program Structure	Do your overall program structure and policies help or inhibit providing services for individuals with co-occurring disorders?
Dimension 2: Program Milieu	Are the staff and physical environment welcoming and receptive to individuals with co-occurring disorders?
Clinical practice	
Dimension 3: Assessment	How does your staff make distinctions between symptoms, substance-induced disorders, or actual psychiatric disorders that may need treatment?
Dimension 4: Treatment	How do your clinical assessment and treatment procedures and protocols rate in relation to co-occurring disorder assessment and treatment?
Dimension 5: Continuity of Care	How does your program handle continuing care and monitoring for individuals with co-occurring disorders?
Workforce	
Dimension 6: Staffing	Do any staff members have expertise in assessing and treating individuals with co-occurring disorders?
Dimension 7: Training	Are staff members adequately trained and supported for the assessment and treatment of individuals with co-occurring disorders?

DDCAT / DDCMHT Files

These instruments identify the scoring used and program areas assessed in the DDCAT or DDCMHT. Download these files (PDF):

- DDCAT Rating Scale
- DDCMHT Rating Scale

Visit these pages at SAMHSA.gov for more information:

- DDCAT Toolkit
- DDCMHT Toolkit

For the most accuracy, it is recommended that a person outside your organization perform the DDCAT / DDCMHT evaluation.

INTEGRATED TREATMENT IS ASSOCIATED WITH LOWER COSTS AND BETTER OUTCOMES

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

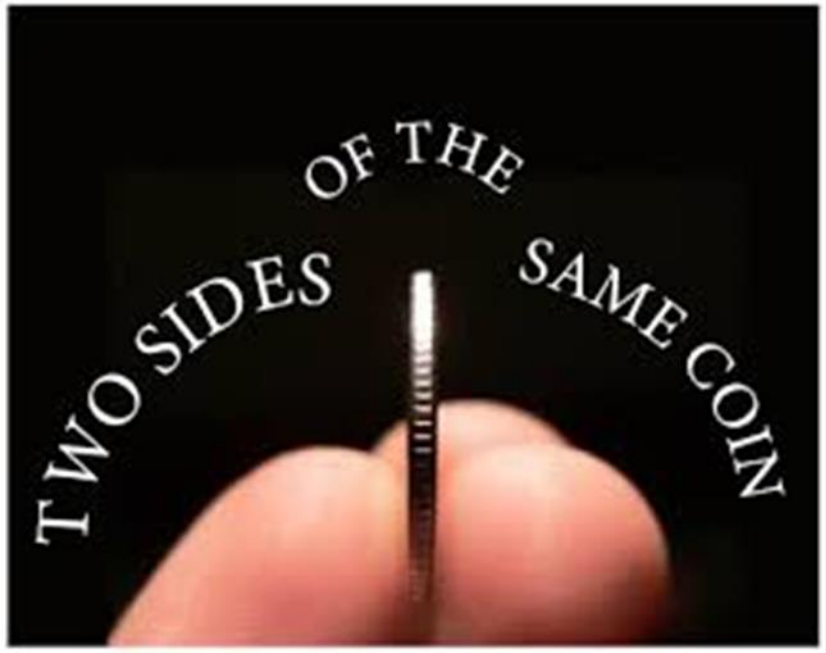
WHAT IS INTEGRATED TREATMENT?

Treatment…

- by the same clinicians
- for both disorders
- at the same time

WHY FOCUS ON DUAL DISORDERS? WHY USE INTEGRATED TREATMENT?

- Substance use disorders are common in people with severe mental illness
- Mental illness is common among people with substance use disorders
- Dual disorders lead to worse outcomes and higher costs than single disorders



INTEGRATED TREATMENT FOR PEOPLE WITH CO-OCCURRING DISORDERS

- Unified treatment approach
- Both mental illness and substance abuse:
  - Viewed as primary
  - Targeted for concurrent treatment
  - Services are provided by the same person or team
- Recovery is seen along a continuum
- Shared perspective of treatment
- Core value: "Shared decision making"

Mueser, Noordsy, Drake, & fox (2003)

RESEARCH SUPPORTING INTEGRATED TREATMENT

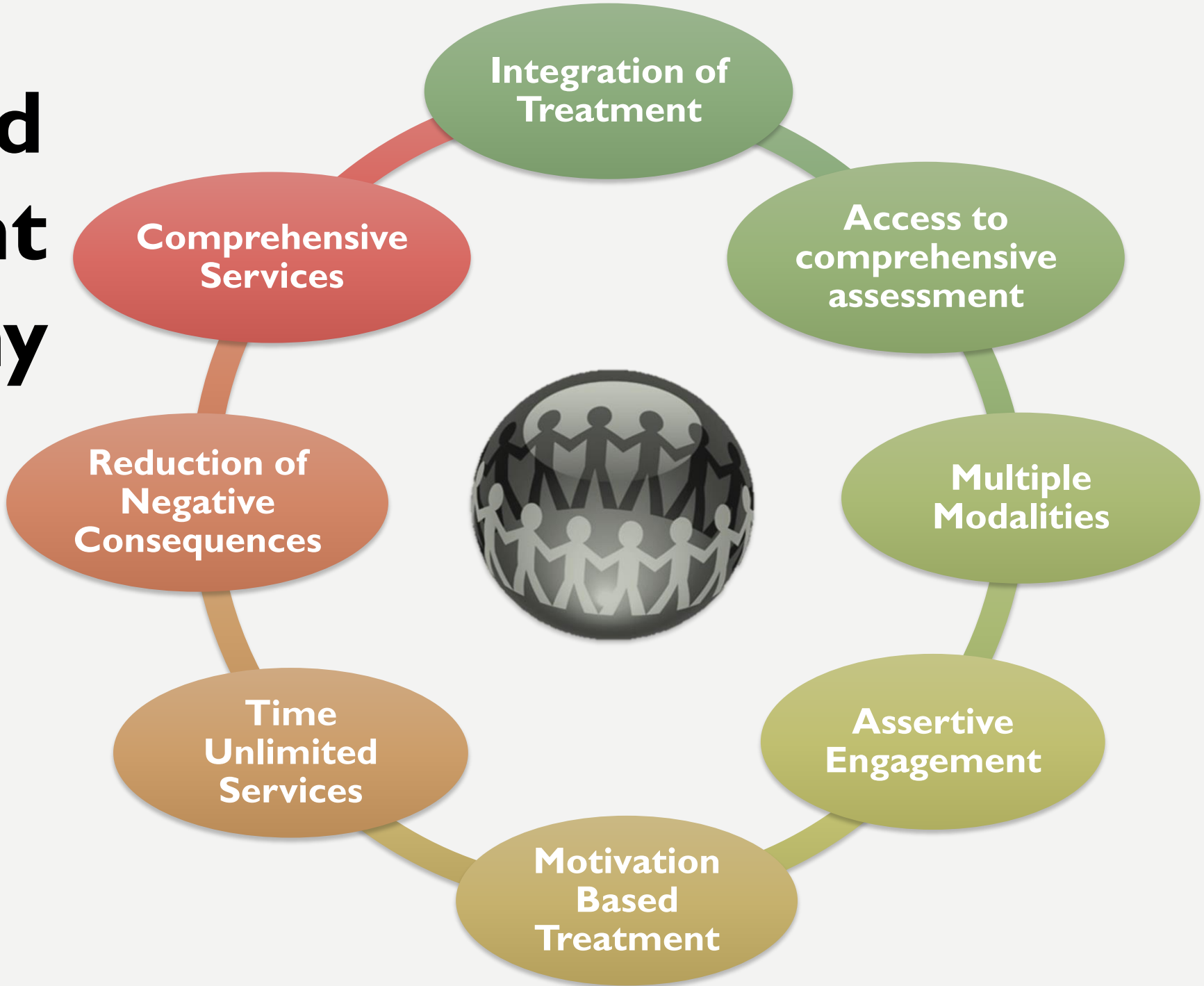
- Stayed in treatment longer and more of them had extended periods of abstinence
- Had greater reductions in in-patient admissions and arrests
- Reported more improvement in social functioning
- An increased perception of having enough money to pay for their basic needs

From 2006 randomized clinical trial comparing IDDT and a supportive group treatment for substance use disorders control group.

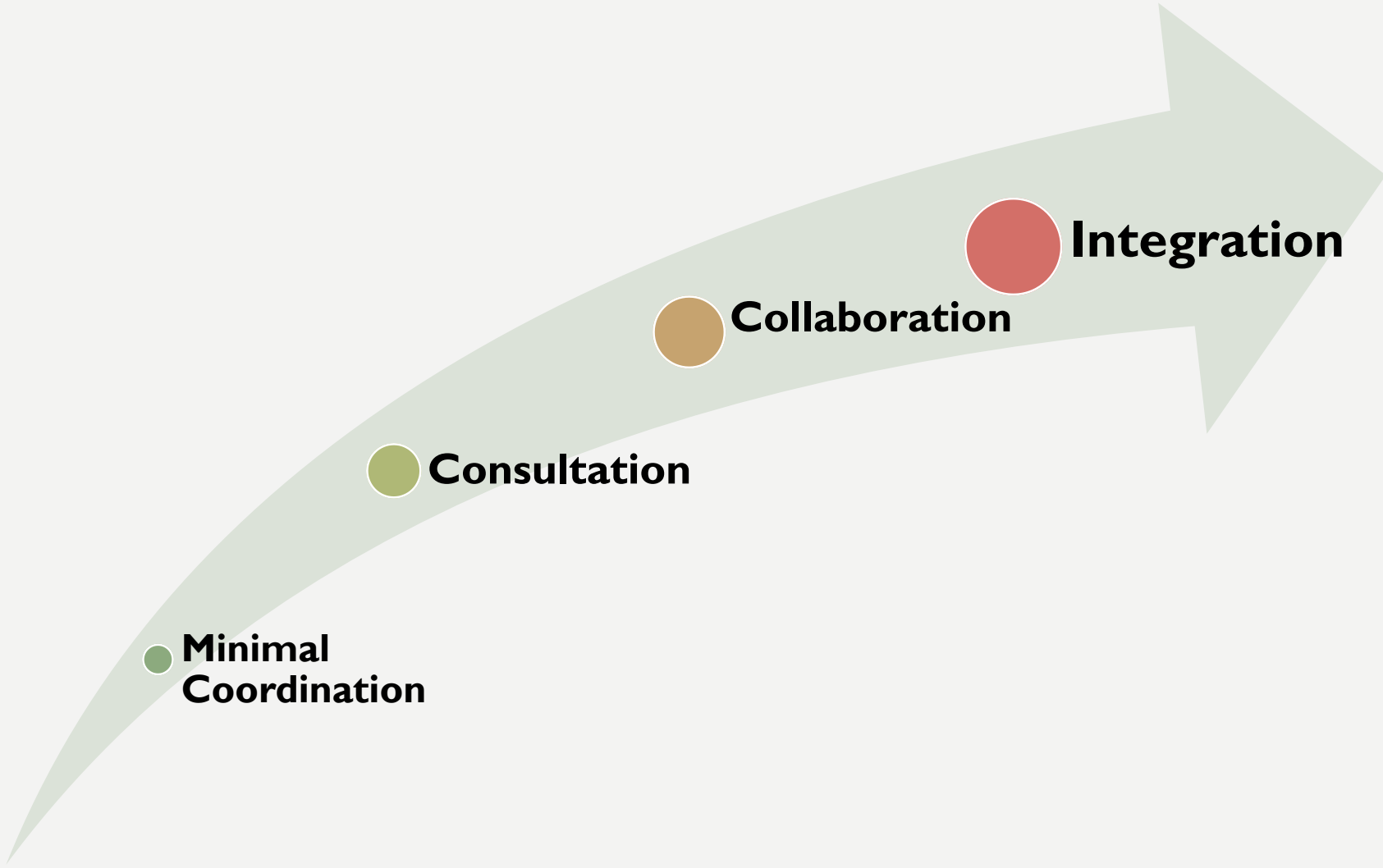
KEY COMPONENTS OF INTEGRATED TREATMENT

- Treating both conditions simultaneously
- Helping individuals identify their motivations
- Working with clients wherever they are in the change process
- Reducing risks related to the conditions
- Addressing other needs that interfere with treatment success
- Increasing client knowledge of how the conditions interact

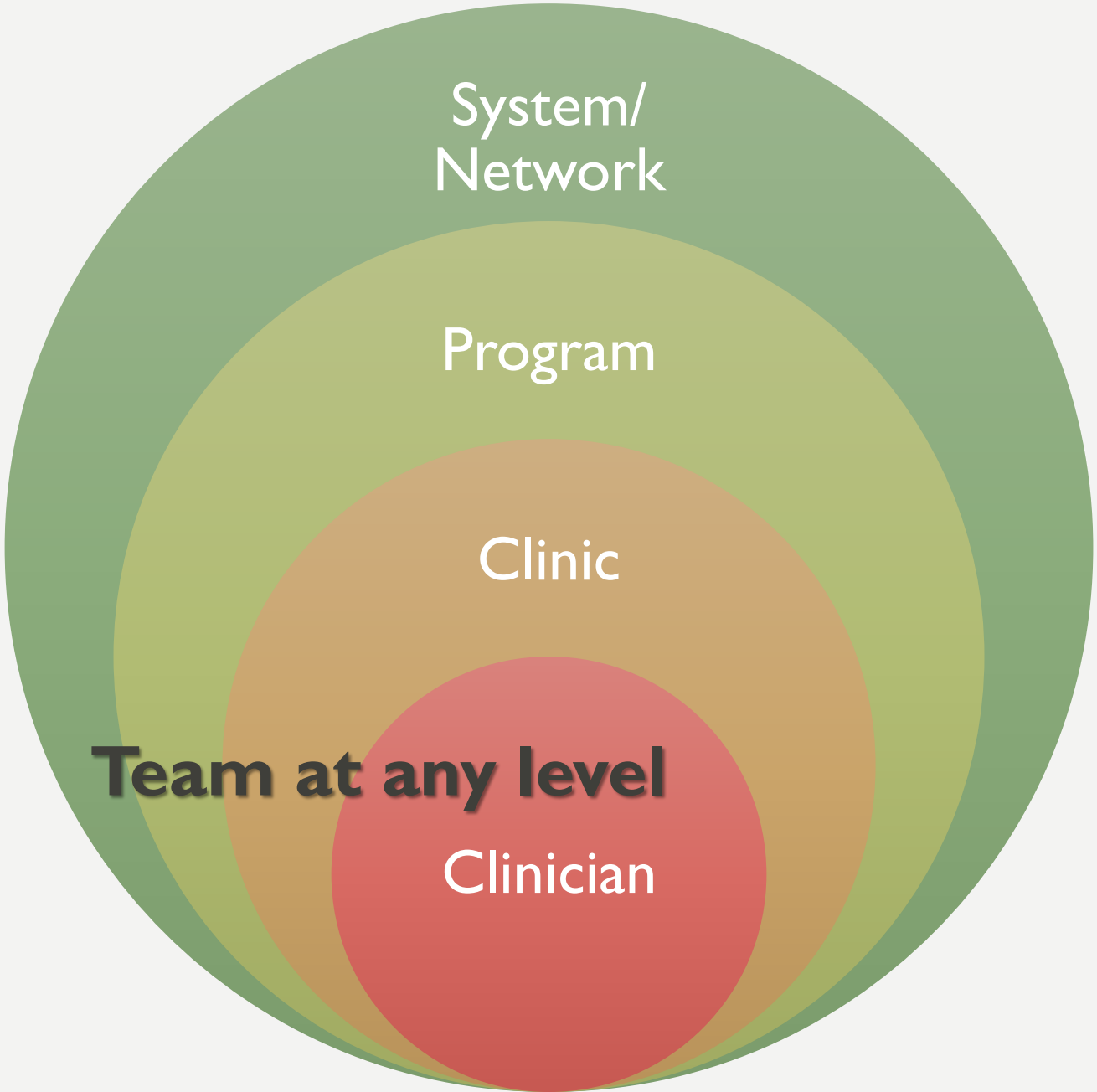
Integrated Treatment Philosophy



LEVELS OF INTEGRATION



SERVICE COORDINATION & INTEGRATION



Minimal coordination, consultation, collaboration, and **integration** are not discrete points, but bands along a continuum of contact and coordination among service providers. "Minimal coordination" is the lowest band along the continuum, and integration the highest band. Please note that these bands refer to *behavior*, not to organizational structure or location. "Minimal coordination" may characterize provision of services by two persons in the same agency working in the same building; "integration" may exist even if providers are in separate agencies in separate buildings.

Minimal coordination: "Minimal coordination" treatment exists if a service provider meets any of the following: (1) is aware of the condition or treatment but has no contact with other providers, or (2) has referred a person with a co-occurring condition to another provider with no or negligible follow-up.

Consultation: Consultation is a relatively informal process for treating persons with co-occurring disorders, involving two or more service providers. Interaction between or among providers is informal, episodic, and limited. Consultation may involve transmission of medical/clinical information, or occasional exchange of information about the person's status and progress. *The threshold for "consultation" relative to "minimal coordination" is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.*

Collaboration: Collaboration is a more formal process of sharing responsibility for treating a person with co-occurring conditions, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated by different providers, the roles and responsibilities of the providers are clear, and the responsibilities of all providers include formal and planned communication with other providers. *The threshold for "collaboration" relative to "consultation" is the existence of formal agreements and/or expectations for continuing contact between providers.*

Integration: Integration requires the participation of substance abuse and mental health services providers in the development of a single treatment plan addressing both sets of conditions, and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. *The threshold for "integration" relative to "collaboration" is the shared responsibility for the development and implementation of a treatment plan that addresses the co-occurring disorder. Although integrated services may often be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if s/he is qualified to provide services that are intended to address both co-occurring conditions.*

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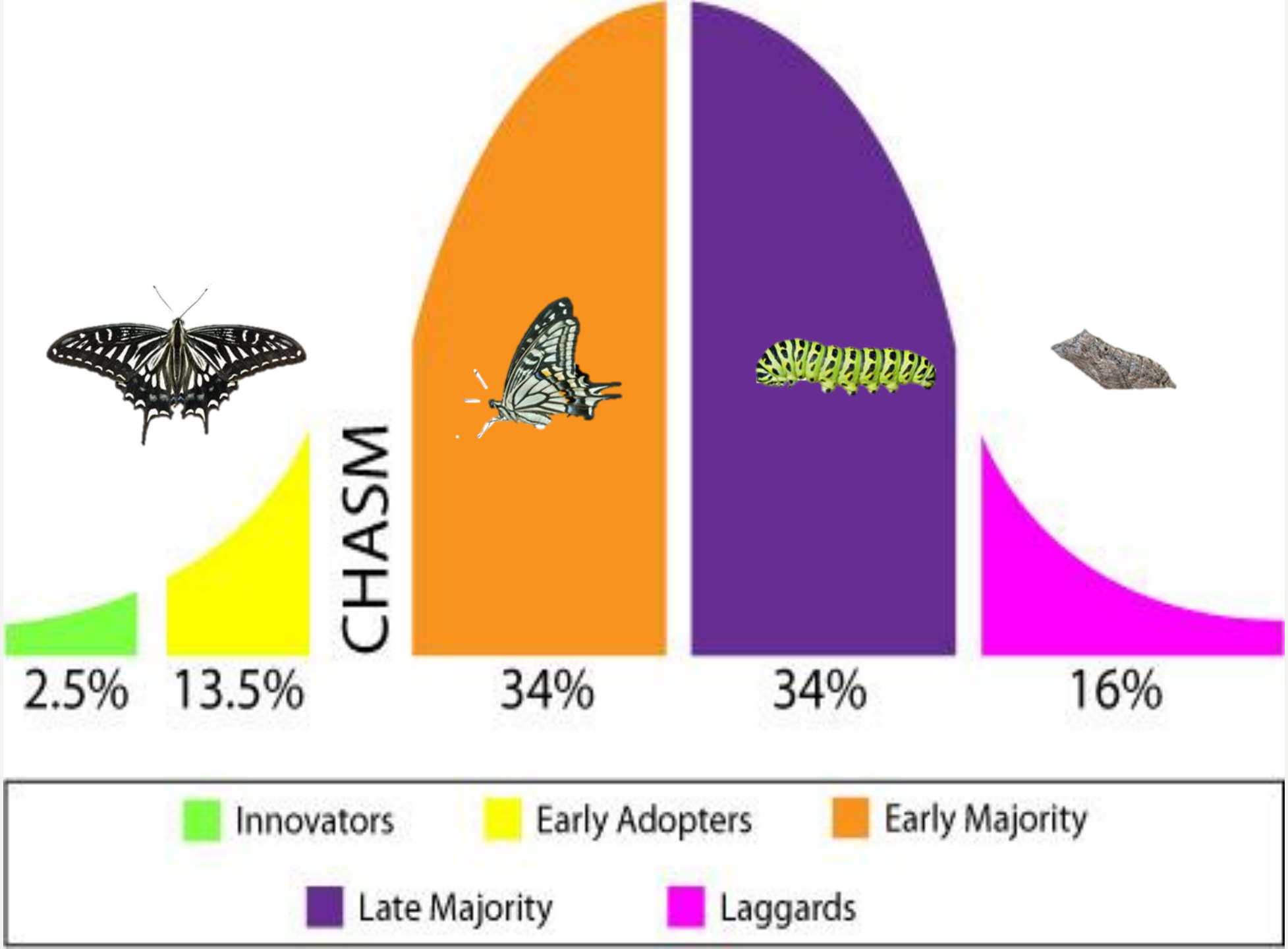
COMPONENTS OF CHANGE

Resistance

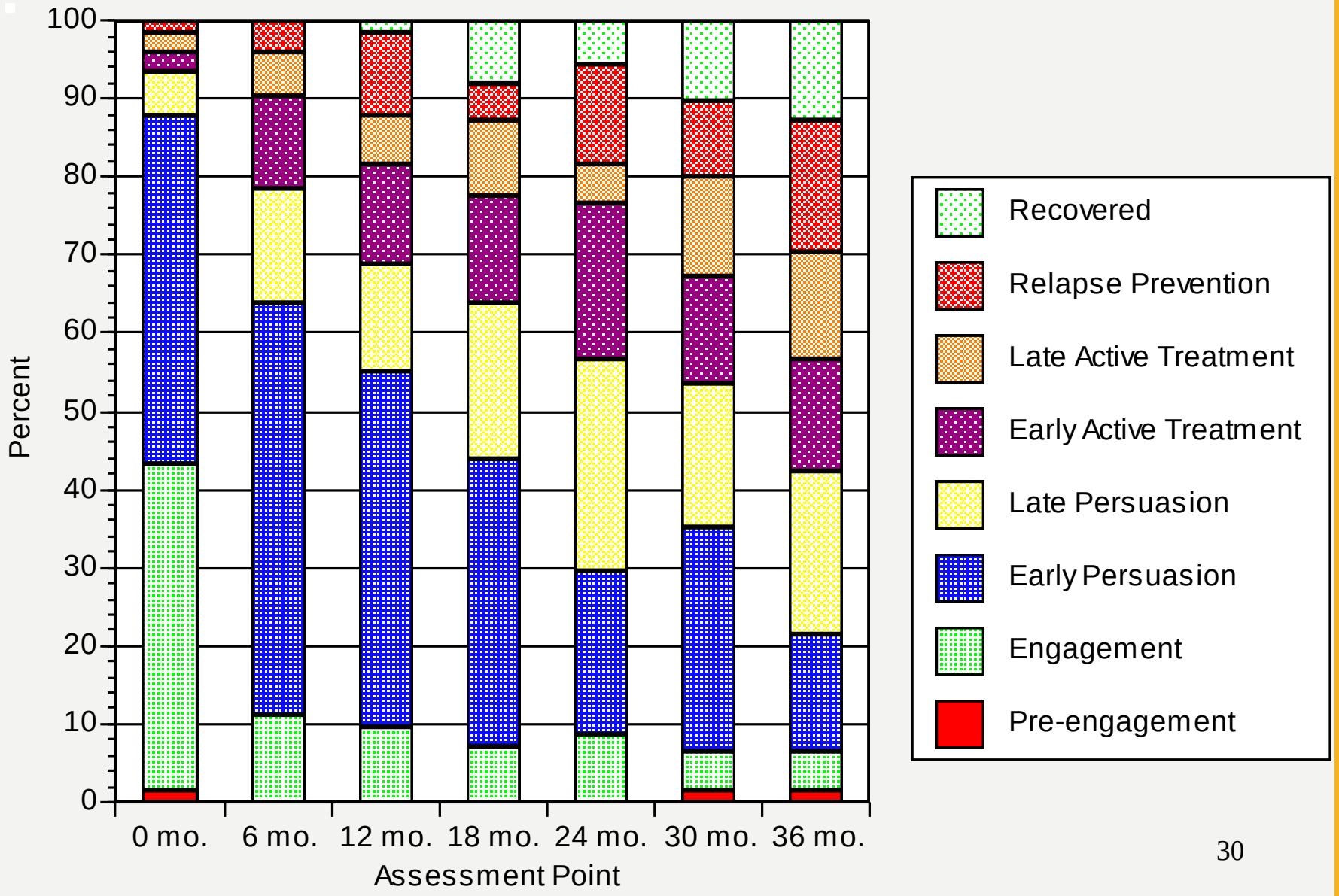
Ambivalence

Motivation

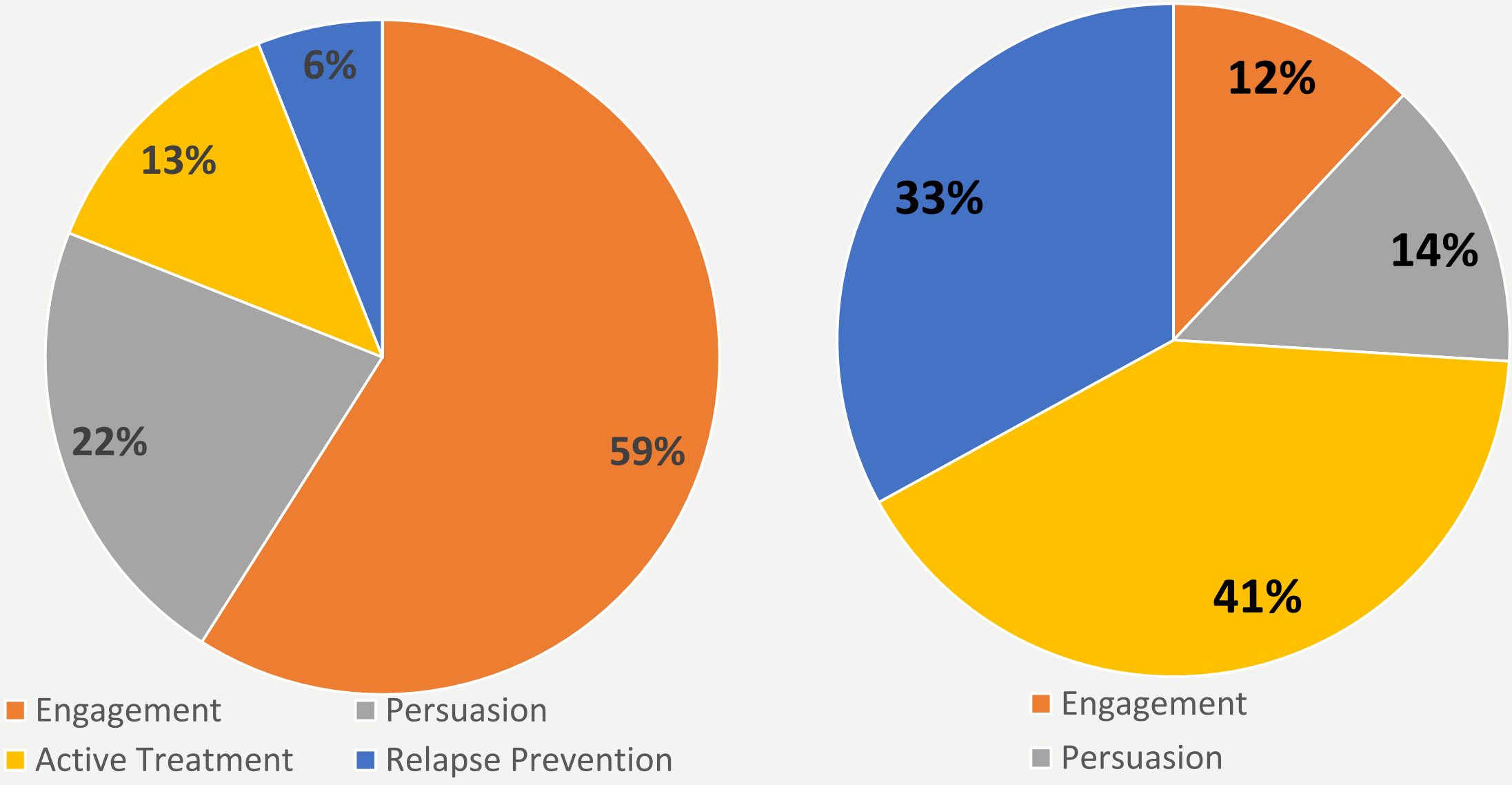

Precontemplation
Contemplation
Preparation
Action
Maintenance
Stages of Change


CHASM
2.5%
13.5%
34%
34%
16%
Innovators
Early Adopters
Early Majority
Late Majority
Laggards

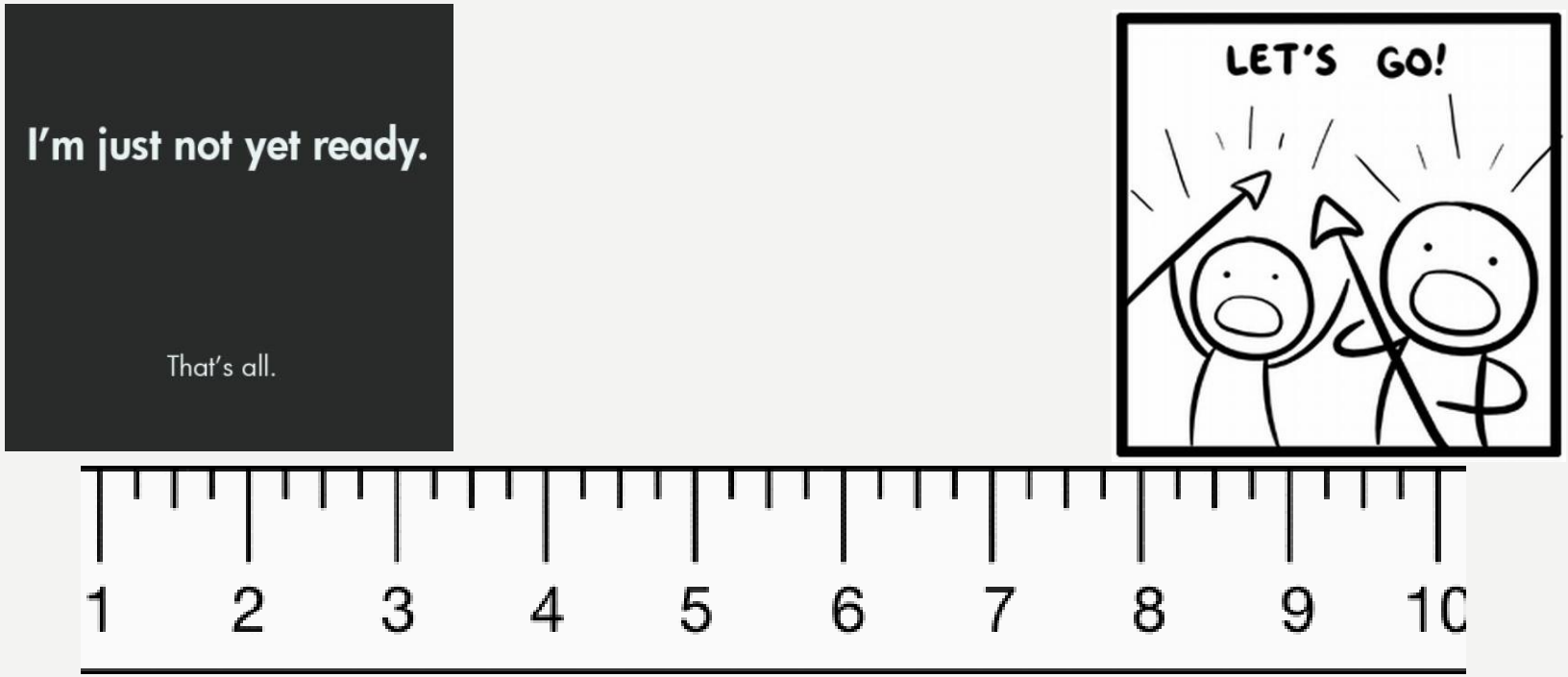
ATTAINING REMISSION OCCURS IN STAGES

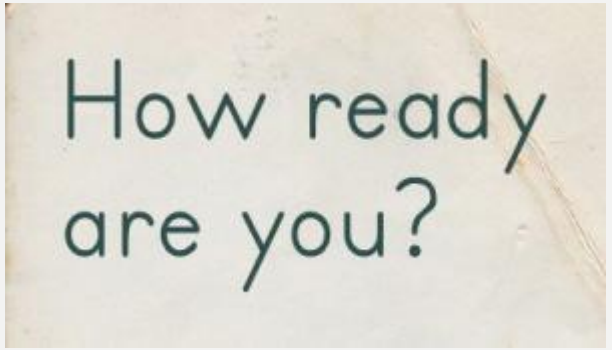


MEETING THE NEEDS OF THE PEOPLE WE SERVE



READINESS RULER





CLINICIAN SKILLS & TOOLS GO HAND-IN-HAND

- Fidelity Standards
  - DDCAT
  - DDCMHT
  - IDDT
- Assessment Tools
- Clinical Skills
- Group Supervision Process

Integrated Dual Diagnosis Treatment Supervisors' Guide

Dianne Asher, LSCSW, CADC I
Bryan Knowles, MSW
Grant Clowers, LSCSW

School of Social Welfare
Office of Mental Health Research and Training

IDDT SKILLS

- ❑Open ended questions
- ❑Affirmations
- ❑Simple reflections
- ❑Amplified reflections
- ❑Double-sided reflections
- ❑Shifting focus
- ❑Agreement with a twist
- ❑Summarizing
- ❑Eliciting change talk
- ❑Express empathy
- ❑Develop discrepancy
- ❑Avoiding argumentation
- ❑Roll with resistance
- ❑Support self-efficacy
- ❑Recognize ambivalence
- ❑Importance/Readiness/Confidence Ruler
- ❑Recognize change talk
- ❑Permission to give advice
- ❑Making an action plan
- ❑Automatic thought record
- ❑Increase positive thoughts
- ❑Increase positive activities
- ❑Relaxation skills
- ❑Identify social problems
- ❑Increase social skills
- ❑Mental illness Relapse Prevention Worksheet
- ❑Longitudinal assessment
- ❑Payoff Matrix
- ❑Contextual Analysis
- ❑Engage with family

Integrated Dual Disorders Core Competencies		
IDD T Competency Area	Specific Skills	Self or Supervisor Rating
A. Stage-wise Treatment		Low 1 High 5
1. Utilize Stages of Tx. to develop appropriate interventions	• Accurate use of Substance Abuse Treatment Scale • Understands and can verbalize the goal of each stage. • Tx. Plans demonstrate interventions consistent with the client's stage of tx. (e.g., not requiring abstinence in persuasion stages, focus is on client's goals and how Dual Dx. affects them) • Offers informed treatment recommendations during group supervision. • Document individual intervention(s) detailing how the intervention was implemented, intended goal of intervention, outcome of intervention, and plan for future intervention(s) based on result.	1 2 3 4 5
B. Assessment		
1. Uses appropriate assessment skills to gain relevant information about client's dual disorder, as well as to increase client's awareness of impact of the dual disorders.	• Completes Longitudinal Assessments with appropriate specificity and linking interactions between mental health and substance abuse. • Uses Contextual Assessment to understand global trends in mental health/substance abuse behaviors, as well as exploring specific events. • Demonstrates consistent assessment of client functioning on an ongoing basis.	1 2 3 4 5

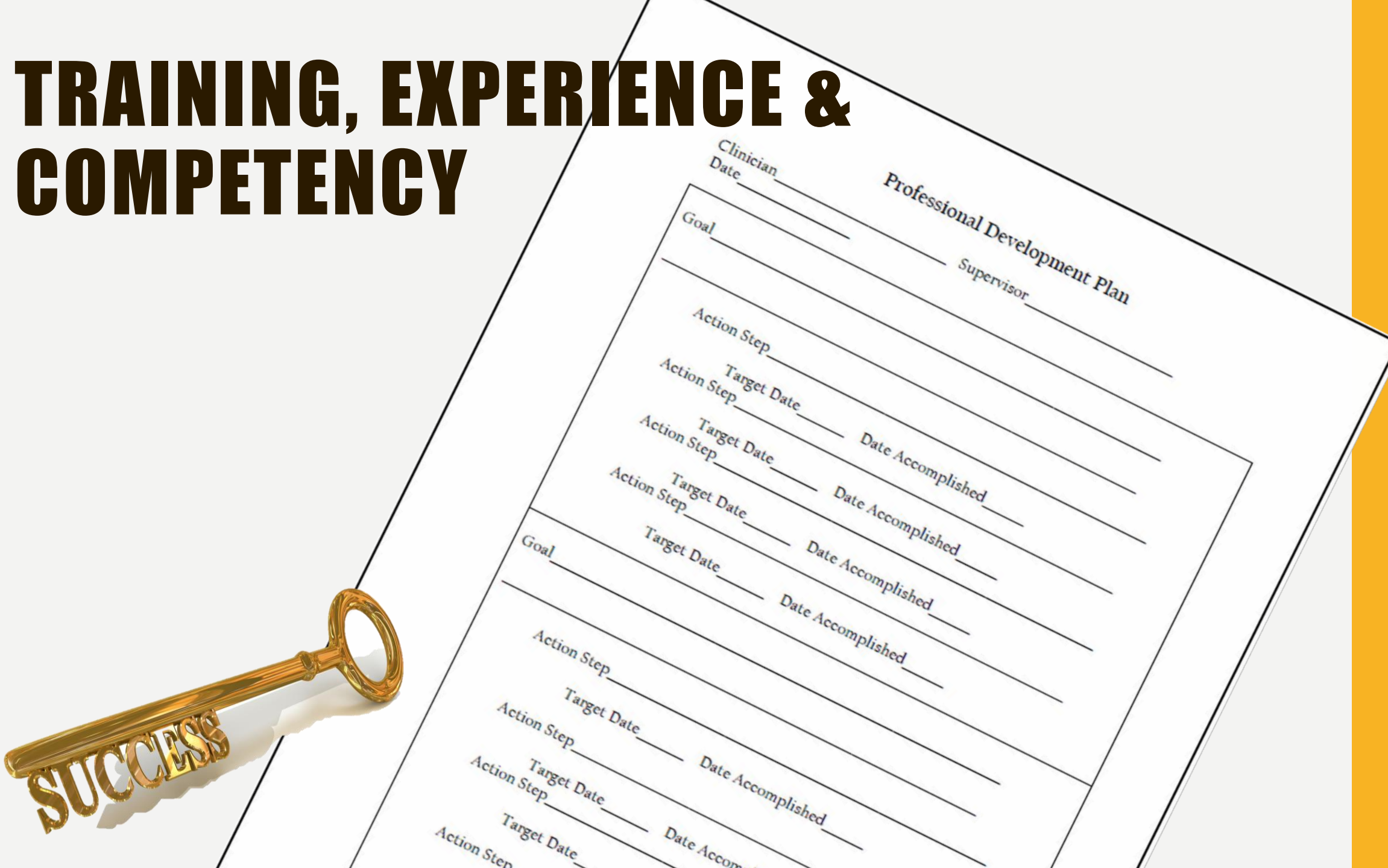
Integrated Dual Disorders Core Competencies		
C. Engagement		
1. Demonstrates ability to effectively build rapport and trust and ability to relate to a wide variety of people.	• Projects warmth and interest when speaking with clients. • Changes their engagement style depending on the nature of the person they are working with. • Tolerant of different levels of readiness to engage for clients. • Effective use of self-disclosure and sharing of common interests with clients. • Reports by clients that they have a positive working relationship with their case manager.	1 2 3 4 5
2. Demonstrates ability to assertively outreach clients who are difficult to engage.	• Uses multiple strategies for engaging including phone calls, home visits, writing letters, and/or contacting family members (with release). • Contacts clients multiple times per month. • Is not quick to want to close out clients who do not engage immediately.	1 2 3 4 5
3. Demonstrates ability to self-reflect on personal barriers to engagement with clients as well as empathize with factors related to client's difficulty with engagement.	• Asks for feedback from supervisor or co-workers during group supervision on how they can more effectively engage with specific clients	1 2 3 4 5

Integrated Dual Disorders Core Competencies		
D. Persuasion stage interventions		
1. Demonstrate the spirit/values of Motivational Interviewing	• Makes effort to avoid judgmental language. • Able to adopt client's point of view. • Describes and demonstrates work with clients as collaborative rather than prescriptive. • Demonstrates respect for client's ability/right to self-determination. •	1 2 3 4 5
2. Demonstrates competent use of Motivational Interviewing ba skills.	• Use of open-ended questions • Use of affirmations to validate client's experience, progress and insight. • Demonstrates ability to form reflective statements (simple, amplified, and double-sided) • Use of summary statements to help keep conversation on track, to transition between topics, and to link together ideas that have been elicited during the conversation. • Utilizes basic motivational tools (e.g., importance/confidence ruler, payoff matrix, values card sort)	1 2 3 4 5
3. Demonstrates ability to use Motivational Interviewing skills and tools to elicit change talk.	• Listens empathically • Does not directly oppose client's resistance; instead uses resistance as a resource to further understand client's motivations. • Uses all skills and tools to develop discrepancy between client's own goals and current behavior (without aggressive confrontation). • Supports client's self-efficacy to increase confidence to make a change.	1 2 3 4 5

Integrated Dual Disorders Core Competencies		
E. Active Stage interventions		
1. Demonstrates ability to use cognitive-behavioral techniques to develop more adaptive perceptions and behaviors.	• Assists client in examining the interaction between thoughts/emotions/behaviors. • Assist client to adapt cognitive-behavioral responses by increasing client awareness of thoughts, increasing client skills in reframing thoughts, and following up on client's use of reframing skills in everyday life.	1 2 3 4 5
2. Demonstrates ability to develop Relapse Prevention Plan	• Thoroughly explore client's triggers and consequences of substance use/mental health relapse. • Use the above information to develop a specific and thorough plan to cope with cues/triggers/cravings/symptoms using a variety of strategies and supports	1 2 3 4 5
3. Demonstrates ability to assist client in developing a healthy, recovery-oriented lifestyle.	Development and expansion of positive support system, including family, social supports, self-help resources, community offerings, job and/or education opportunities. Makes appropriate referrals to additional services (e.g., treatment groups, self-help groups, individual treatment, supported employment)	1 2 3 4 5

Integrated Dual Disorders Core Competencies		
4. Assess and ameliorate maladaptive life skills.	• Explores client interests and resources to develop appropriate leisure skills. • Demonstrates and transfers skills for relaxation/stress management. • Educates and role-plays with client regarding social skills (e.g., effective communication, assertiveness, problem-solving)	1 2 3 4 5
F. Relapse Prevention/Recovery skills		
1. Demonstrates collaboration with client to ensure continued recovery from substance abuse and mental illness.	• Revisit and revise Relapse Prevention Plan as needed. • Attitude toward relapse is non-judgmental and seeks to use relapse as a learning opportunity. • Seeks ways to help client become interdependent with community and work toward graduated disengagement from case management services.	1 2 3 4 5
G. Family Psychoeducation on Dual Disordrs		
1. Demonstrates an understanding of/ ability to engage family in the recovery process	• Able to describe how involving family (as determined by the client) benefits the client's recovery. • Able to provide family with education about dual disorders and integrated treatment. • Able to assist family in developing coping skills to optimize client's recovery.	1 2 3 4 5
H. Dual Diagnosis Group Treatment		
1. Demonstrates and communicates the importance of stage-wise group DD treatment.	Able to explore and expand client's motivation for group treatment. Demonstrates ability to remove barriers to accessing group treatment. Acts in a support capacity to assist client in successfully engaging in/and maintaining group treatment. Documentation shows clients participating is stage-appropriate groups or ongoing efforts to engage in groups.	1 2 3 4 5

TRAINING, EXPERIENCE & COMPETENCY



GROUP SUPERVISION PROCESS

Step 1: Hand out Strengths and Longitudinal assessments, as well as any other IDDT evaluations

Step 2: What is the client goal(s) and what help do I specifically need from the group?

Step 3: What is the current situation and what has been already tried?

Step 4: What does the team need clarified from the assessments?

Step 5: Brainstorming

Step 6: What will be my plan based upon the suggestions made?

Step 7: Supervisor Follow-Up

COLLABORATIVE CARE

IN BRIEF

The integration of physical and mental health care is an important aspect of the Medicaid health home model. Collaborative care programs are one approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor patients' progress. These programs have been shown to be both clinically-effective and cost-effective for a variety of mental health conditions, in a variety of settings, using several different payment mechanisms. This brief highlights the collaborative care model as one approach to implementing integrated care under the Medicaid health homes authority.

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-irc-collaborative-5-13.pdf

SHARED DECISION MAKING

Ottawa Personal Decision Guide For People Facing Tough Health or Social Decisions

You will be guided through four steps:

1. Clarify the decision.
2. Identify your decision making needs.
3. Explore your needs.
4. Plan the next steps.

1 Clarify the decision.

What decision do you face?		
What is your reason for making this decision?		
When do you need to make a choice?		
How far along are you with making a choice?	❑ I have not yet thought about options ❑ I am thinking about the options	❑ I am close to making a choice ❑ I have already made a choice
Are you leaning toward one option?	❑ Yes If yes, which one?	❑ No

http://med.dartmouth-hitchcock.org/documents/OPDG_2pg.pdf

MOTIVATIONAL STRATEGIES

- People are motivated to learn things if they are relevant to personal goals
- Explore how illness has interfered with goals
- Convey hope and confidence in person
- Help person explore costs and benefits of change

INTEGRATED TREATMENT IN A NUTSHELL

Treating both mental health and substance use disorders means:

- at the same time
- in the same location
- with the same treatment providers

Appreciation for and understanding of the interrelationship between the person's mental health and substance use

Always connected with what is important to the person

START SEEING PEOPLE'S NEEDS AS OPPORTUNITIES TO USE DIFFERENT APPROACHES AND SKILLS

YOU'VE GOT TO ASK YOURSELF ONE QUESTION:

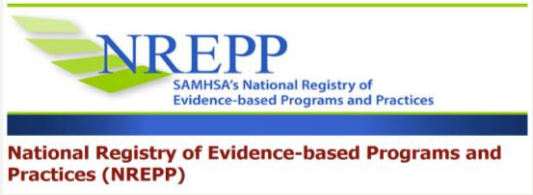
DO I KNOW WHAT'S HOLDING ME BACK?

WHAT'S YOUR PERSPECTIVE?

1. Substance Use Disorder Treatment alone
2. Mental Health Treatment alone
3. Integrated Treatment

RESOURCES

- http://www.samhsa.gov/nrepp



- http://www.bhevolution.org/public/ddcat.page

- http://ahsr.dartmouth.edu/docs/DDCAT_Toolkit.pdf

- http://mentalhealthsocwel.drupal.ku.edu/sites/mentalhealthsocwel.drupal.ku.edu/files/docs/IDDT%20Supervisors%27%20Reference%20Guide%206-15-09.pdf

- http://med.dartmouth-hitchcock.org/csdm_toolkits/workshop_for_non-physicians.html

Dartmouth-Hitchcock