TALKING POINTS FOR 6/13/14 BH LEGISLATIVE TASK FORCE

What works well in your practice?

- An integrated model with Multi-disciplinary Teams that include a CDP as well as Master's Level MH Providers, Medical Assistants, RN's, BA Level Clinicians, Program Assistant and a dedicated Medical Provider
- Daily huddles for brief shared communication of essential client information, especially for complex clients
- Training all staff in Stages of Change and Motivational Interviewing. Providing staff with drug specific education to help them better identify substance use issues and better educate their clients.
- Use of medication assisted therapies such as Campral, Naltrexone, Suboxone, Gabapentin, Vivitrol etc.

What unique services do you provide?

- Integrated BH model which puts CD provider on a multi-disciplinary team.
    - The most unique element for us has been that our CD providers are both CD and mental health clinicians with expertise in integrating interventions with full knowledge of both mental health and substance use disorder needs. They are the true models of integration and in their unique expertise are able to coach mental health clinicians in a manner that joins with their experience and expertise.
    - The additional new role of MA's on each team for tighter connection with client's Primary Care Providers.
- Bi-directional care model.
    - Co-occurring capable Behavioral Health Professional located in the community providing brief services at PCP Clinics;
    - Psychiatric consultation with ready access via phone for PCP's and assistance with a multitude of CD issues as well as MH
- Primary Care located at the Community Behavioral Health Clinic
- Using stage-wise case management and treatment interventions in all life domains
- Engagement, active co-occurring treatment, and skill building groups that address mental health, physical health and substance use disorders in the same group setting in an integrated manner.

How to clients get referred to you?

- Walk in Intake.
- PCP, ER, DMHP, CD agencies, probation, juvenile justice system, schools, etc.
- Our staff in PCP settings bridge new or existing clients to us, the CBHC, as needed

What is your experience making or receiving referrals for your clients to or from other health systems? Can they get all of their needs met?

- There are very few options for COD inpatient referral that meet the needs of complex clients with multiple co morbidities, including detox
- More and more we see the need for and effectiveness of adjunctive medications for addiction. PCPs are not always comfortable prescribing these medications, or lack knowledge of how to prescribe such medications, especially when a client has co-morbid conditions.
- Severe lack of options for Opiate Replacement Therapy to include Suboxone and Methadone providers.

What do you see working well in the current chemical dependency system? Where do you see opportunities for improvement?

- The availability, albeit shrinking, of 'flexible funding' which allows the CD clinician the ability to provide the right services, at the right time and at the right place.
- ***For Improvement*** –
    - A streamlining of paperwork though the integration of CD intake and assessment criteria with the MH intake and assessment criteria
    - Understanding co-morbidity and skills to tailor services to a population that may need a slower paced, more flexible treatment modality.
    - Use of a harm reduction framework
    - Helping clients meet their basic needs regardless of sobriety
    - **TARGET should go.**
    - Wet, damp and dry housing options for those in different stages of recovery.

concerns/opportunities as most state chemical dependency funding becomes integrated

- Flexible state funds have been critical to the work of integrating COD services at KMHS. These have been dramatically reduced and are a risk of elimination as a result of Medicaid Expansion. It is erroneously believed that increased Medicaid eligibility will allow for more funds to serve this population when they do not cover the cost involved in engaging and retaining clients with co-occurring severe mental illness and substance use disorders in integrated treatment.
- People don't come to a CBHC initially for CD reasons, yet we know the impact CD has on the majority of them in terms of their mental and physical health, so we spend a lot of time doing pre-engagement work that is not reimbursable in the traditional FFS system.

If we didn't we would never engage them and their issues would go unaddressed and their health compromised. Because we do the engagement work, many do commit to COD treatment.

- Services critical to effective COD services at KMHS at risk with this new funding formula:
  - Engagement and outreach of mental health clients for CD services by CD staff
  - COD Consultation and Training by CD staff for MH and medical providers
  - Drop in groups designed for early engagement prior to assessment
  - Services for those who do not meet criteria for chemical dependence but whose abuse of substances greatly impact their ability to manage illnesses and recovery
- Because there are few trained COD clinicians, it can take more than one service provider to deliver an integrated treatment approach. Current funding does not allow for reimbursement for more than one provider during a single session. This is a disincentive to integrated care and impacts workforce development in the service setting.
- A loss of ability to serve clients before they are ready to change. We find that it often takes a significant period of time developing relationship, providing early engagement services, and addressing basic needs before a client with COD issues is willing and ready to consider reducing use or becoming abstinent. If we could only serve those in action stage of treatment in a managed care system, many clients would not be helped and would have a potential for more serious progression of their illnesses.
- A lack adequate training in our colleges for the provision of integrated COD treatment
- We often find it much more beneficial to treat the parent separately from the child as well as together in family therapy. As the parent addresses his and/or her issues that impact effective parenting and recovery, the child has a greater opportunity for improvement, healing, recovery. If this could happen as a part of the child's service and be reimbursable without having to send the parent to another outside provider, we would have greater opportunity to impact a positive family outcome.

What do you see as best practices?

- stage-wise case-management and treatment using motivational interviewing and motivation enhancement strategies
- cognitive behavioral therapies,
- medication assisted treatment,
- illness management strategies,
- assertive outreach,
- trauma informed services,
- vocational rehabilitation
- family services.

- **For Youth** –
    - family system based interventions.
    - The Change Companies Interactive Journaling System, an example of an EBP that is stage of change congruent and addresses needs of youth on a continuum of substance involvement and readiness to change.
    - Claudia Black's Family Strategies: Practical Tools for Professionals Treating Families Impacted by Addiction - good example of a practice that is very effective.
- A strong menu of options that include a number of EBPs and promising practices is optimal and seems to increase engagement, and finds the fit for them that works most effectively based on their stage of change, specific illnesses, trauma experience, learning ability, developmental level.
- Use of life coaches and peer counselors.

What do you see as traps to avoid?

- A regulatory environment that becomes excessively restrictive and prevents us from doing the right thing, at the right time, at the right place. MH and CD regulations that are simply combined rather than developed to support a truly integrated system.
- Prescribing specific EBPs only.
- Mandating integration of services without an adequate workforce to provide the care.