NAADAC

CHANGING MINDS: IMPLEMENTING HARM REDUCTION

JUNE 12, 2019

CAPTIONING PROVIDED BY:

CAPTIONACCESS

For assistance email
support@captionaccess.com

www.captionaccess.com

* * * * *

This is being provided in a rough-draft format. Communication Access Realtime Translation (CART) is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

* * * * *

>> SAMSON TEKLEMARIAM: Hello, everyone, and welcome to today's webinar on Changing Minds: Implementing Harm Reduction Using a Learning Collaborative Model presented by Suzy Langevin.

It's great that you can join us today. My name is Samson Teklemariam. I am the director of training and professional development for NAADAC, the Association for Addiction Professionals. I'll be the organizer for today's event.

This online training is produced by NAADAC, the Association for Addiction Professionals. And closed captioning is provided by Caption Access. Please check your most recent confirmation email or our Q&A and chat box for the link to the closed captioning.

You can find information about this webinar and many others by going to w□ww.naadac.org/webinars. This is also the permanent home page for the webinar series. So make sure to bookmark it. Every NAADAC webinar also has its own web page that houses everything you need to know about that particular webinar.

You can choose from our list of recorded on demand webinars, register for it, watch the recording after the live event, take the quiz, and make a payment if you are not a NAADAC member. You must be registered for any webinar live or recorded in order to receive a certificate GoToWebinar also provides us with a time tracking tool that verifies that those who pass the CE quiz not only were registered but they also watched the entire webinar. We are obligated to do this by the organizations that approve our training for continued education. You can download the PowerPoint slides. But remember, looking at the slides alone does not qualify one for receiving a certificate.

To access material from this webinar, the web address is, as you'll see on the screen, □ w□ww.naadac.org/implementing-harm-reduction-webinar. You can go to this web page now or in the future when you need information related to this webinar. You can also get to this page by just going to our website, clicking on the education tab, and then clicking on webinars. You'll be able to scroll through the current time period, and you'll click on today's webinar title. And this will give you access to the recorded version

of the webinar. The quiz, and any answers that are posed to the questions given to the presenter during today's webinar.

This webinar is approved for one continuing education hour. And our website contains a full list of accepting boards and organizations. As you know, it is free to watch this webinar. But if you want a CE certificate, it will be emailed to you only if you take these four steps. Of course, watch this entire webinar, pass the online quiz which will be posted on the website. And you'll see it on this slide later this evening or by tomorrow morning at the latest. If applicable, submit payment for the CE certificate. Or you can join NAADAC. As a reminder, the fee is $15 for one continuing education credit. A link to download the certificate will then be emailed to you within 21 days or less of completing the quiz.

We are using GoToWebinar for today's live event. Here are some important instructions. What you've done is you've entered into what's called listen only mode. That means your mic is automatically muted to prevent any disruptive background noise. If you have any trouble hearing the presenter for any reason, I recommend switching to a telephone line as some internet connections are not strong enough to handle webinars. If you have any questions for the presenter, just type them into the questions box in the go to webinar control panel. It looks just like the one you see here on my slide. We'll go ahead and gather those questions. And if time permits, I'll pose the questions to the presenter.

Otherwise, we will collect these questions and send it to the presenter for her to answer and post onto our website. Of course, this only applies to the live presentation. If you are washing a recorded version, there are no planes of posing live questions. Instead you'll have access to the Q&A document that is posted on the website. Now, let me tell you about today's very skilled presenter.

Suzy Langevin oversees the provision of integrated services for mental health and substance use disorders. This includes developing and implementing trainings in harm reduction, stage-wise treatment, expert and motivational interviewing. She has presented at regional conferences on the implementation of integrated treatment. She also provides both individual and group treatment to clients diagnosed with disorders

using evidence-based models. In 2014 Suzy received the ABH Excellence in Outcomes Award as a member of the CR for PTSD group. She is also a member of the motivational interviewing network of trainers. Prior to her current role, she has experienced in juvenile justice, in patient, psychiatry units, foster care, emergency mental health and outpatient clinic administration.

NAADAC is delighted to provide this webinar that is presented by this wonderful professional. So Suzy, if you are ready, I will hand this over to you.

>> SUZY LANGEVIN. Great. Thank you, Samson. I want to take a minute to also thank NAADAC for the opportunity to share with all of you some of the work that we've been doing here at Open Sky related to implementing harm reduction and other implementation projects and what our process has looked like for that.

So taking a look at our first slide. And just looking at what hoping to get out of today, we'd like to become familiar with the structure of the learning collaborative model as a method of staff development and understand how using this model for a topic that requires a perspective shift like harm reduction is really well suited to what a learning collaborative has to offer.

We also want to make sure that we're going to stop and just highlight some ways to measure changes and staff attitude and how that can translate to impact on practice.

So really taking a look at this overall structure and seeing how it's a good fit for topics like this and maybe a good fit for other types of topics that you're looking to implement in your agencies as well.

So I want to make sure that we're all working from the same perspective. Excuse me. I went too far. From the same perspective when we think about and talk about what we mean when we say harm reduction. When we're thinking harm reduction we really want to think about the idea that our main goal did to keep people healthy and safe. We want that to happen whether somebody is currently interested in changing how they're using substances or if they're not. So we want to have a grounded and a compassionate and pragmatic approach that really honors and respects people's individual dignity and individual right to make choices.

There were certainly some philosophical and practical barriers that can come up when implementing harm reduction which we'll talk about when those concerns come up in our implementation process a little bit later in the training.

Samson, so I know you have some ability to control the polling question. So I'm going to turn it over to you to look at those.

>> SAMSON TEKLEMARIAM: Thanks, Suzy. Everyone, this is a chance to interact with the presenter. I'm going to go ahead and launch this polling question. You should see it pop-up on your screen. And some. You are answering already. The question says, what's the current come format level with harm reduction intervention at your agency? And there are four options, A, very comfortable,, comfortable; C, somewhat comfortable; D, not at all comfortable; abstinence only.

So we'll get to interact. I'll give you 20 more seconds to answer the question and I'm show the results on the screen so that Suzy, our presenter, can speak to those.

Excellent. Thank you so much, everyone. Three quarters of the people in today's webinar have already answered. That's about 76% have answered. I'm going to go ahead and close the poll. Thank you so much for interacting with us. We have one more of those coming up.

I'm going to share the results on the screen. So everyone should be able to see those results now. And Suzy, go ahead and speak to those results, and then we will move on with our presentation.

>> SUZY LANGEVIN: So I think this is actually indicative of where we are as a field with human services that we have a broad range of level of comfort that exist with the individual and organizational level. It's nice to see that sort of almost two-thirds when we're looking at the top two categories can have some comfort with this. But we've still got room to grow and room to get people get comfortable and familiar with this particular type of intervention.

>> SAMSON TEKLEMARIAM: Excellent. Thanks, Suzy. And our second poll question for today, I'm going to go ahead and launch that here. Just like the first one, you guys can interact with our presenter by answering the poll question that should be

popping up on your screen in just a moment. And I'm going to go ahead and read this out for you.

How often are harm reduction interventions used at your organization? A, frequently; B, often; C, sometimes, or D, never. Looks like a lot of you are used to this. You've answered already. Thank you all so much for your interaction. Awesome. Thank you so much. A few more people were able to vote. We are at 80%. That's great. So 80% of those in attendance have answered the question here. I'm going to go ahead and close that poll now and share the results. And we will turn this over to Suzy.

>> SUZY LANGEVIN: And I think this is also really indicative on both the micro and macro levels what this often looks like. That we can be onboard with harm reduction as a philosophy, as an idea, how we then translate that into practice and an ongoing systemic way is often a roadblock for a lot of agencies to figure out that translation process.

We'll talk about what are some strategies that we've used to help them smooth that gap between practice.

We ended up somewhere else. Give me just one second to back up. Hold on.

Samson, do you know what's happening with the slides?

>> SAMSON TEKLEMARIAM: Yep. I'm going to go ahead and get you right back to where you are. And then you'll take over using your keyboard. No worries. No worries. There we go. So we're on background slide. And I'll mute myself. And you can take over from here.

>> SUZY LANGEVIN: Okay. Thank you. Thank you, Samson, I appreciate it. So to give you a little bit of background on our agency and where we were at when we undertook this process, we are a community mental health agency. And the programs where we were implementing harm reduction, we were serving adult as with serious mental illness. So the individuals that were referred to us were referred by our State Department of mental health. And these are individuals who are diagnosed with a

serious mental illness. About half are also diagnosed with a co-occurring substance use disorder.

When we include nicotine use disorder in that category, the number actually sky rockets to over 90% having a co-occurring diagnosis. Cigarette and tobacco uses are incredibly common particularly for people who are experiencing symptoms of psychosis. So we see a really large overlap there.

Despite the fact that we have 50% of our individuals we're serving dealing with this issue, we really didn't have any specific strategies for unified way that we went about looking at how are staff approaching the substance use work that they're doing with individuals. It would come out in individual supervisions. It would come out only a case-by-case basis. But there wasn't really a unified way we were teaching people to think about this idea of substance use.

That led to a lot of frustration on the part of our staff teams simply because there was there issue that was affecting half of the people we were working with that we didn't have a specific thought process behind how we were addressing it. The other thing that's interesting about our service is that, because these are referrals from the State Department of Mental Health, individuals staying enrolled in our program had nothing to do with their status around substance use.

So people with be living in group living environments, receiving supports in apartments, and there was no ability to discharge because somebody was continuing to use. The only reason that we actually would discharge would be for a lack of engagement. So people who were not using the services that were being provided. And we were also finding that that tended to be our folks that had co-occurring disorders, those the ones that we were most easily losing out of treatment.

So we really needed some kind of unified way to do this. So we had this problem. It was affecting more than half of our individuals we served. No vision or process. And we know that saying don't stop using isn't an option. Or the only option. So what are we to do in that set of circumstances?

We decided to launch a process called a Learning Collaborative. And we did this in conjunction with a consultant that we worked with out of New York State by the name of Rusty Foster who I cannot thank enough for his guidance and leadership that helped us along with this process.

So a learning collaborative is a method for process improvement. It comes from the quality world. And it's a yearlong project to implement a specific goal. In our case we were focused on improving our team's abilities to practice stage-wise intervention for individuals with co-occurring disorders. Meaning that people would have a set of interventions that they felt like made sense, wherever the person was in the spectrum in relation this their substance use issues.

We worked with programs across our adult mental health service division, and those programs were selected based on their readiness for change and their ability to implement these program level changes.

As I said, it's a process improvement model. So it's something called the plan-do-study-act model or PDSA. And we'll talk about what each of those look like.

So why did we choose this model? Why a learning collaborative? We knew that we didn't want to get ourselves into a project that was going to be ongoing forever and ever and ever. That is not something that works for our very frantic-pace in human services.

But asking programs to commit to a one-year project seems like a much more reasonable ask of our program staff. It's also very action oriented. We have a specific workplan and a specific work product that we're looking to develop. And we know that that's the outcome that we're reaching towards. It's practice, impact driven, developing an outcomes collection plan, and then collecting those outcomes is an inherent part of the learning collaborative model.

We have to look at, did what we were trying to do happen? If not, what can we do differently? If yes, how do we expand this out to something that can be rolled out beyond just these pilots.

It also draws in program expertise and experience. We developed our team with people from every level of these programs. We had frontline staff, frontline supervisors, clinical supervisors, all a part for this process to develop what this training would look like. And then how would we continue to carry forward that message in the program?

So we mentioned that it's plan, do, study, act is the model that you follow. So we were looking at each of those discrete entities of having a specific goal. In our plan phase we were really looking to develop our training products. How are we going to teach people about these ideas, and then how were we going to follow-up with that outside? So our first part of our workgroup was really intensely focused on what are we going to talk to people about? How are we going to do it? Not just the content but also the process that made the most sense.

Then we rolled that out. We took this training to various places in the agency and we had as a group, people trained in the harm reduction philosophy. We then undertook a period of time where we really evaluated how did this work? And we'll talk about what were those specific out come measures we used and how did we collect those? And then our last part is to really figure out how do we stand this up across the agency? How do we expand beyond these pilot sites and take what we've learned and put it into practice across adult mental health services?

In terms of the study piece, the outcomes that we collected, we wanted to have a few different data points that could reflect what we were looking to see happen. So we completed a fidelity index called the Dual Diagnosis Capability Index for Mental Health Treatment Programs or the DDC MHT and also had individuals complete the harm reduction acceptability scale. We'll talk about what each of those looks like.

So harm reduction acceptability scale is a standard and valid reliable tool to measure staff attitudes towards harm reduction concepts and interventions. It's set up as a five point Likert scale. And there are also standard and reverse coded items. So if somebody just circles all fives, you know that's not a valid completion of the instrument because they'll be coded the wrong way for some of those.

We administered this survey to staff about a month prior to them getting the initial training. And then we administered it again one to three months after the initial training. This was really intentional. We didn't want to get the day after and first blush, people telling us what they knew we wanted to hear based on what we had just talked about yesterday, kind of results on the second administration of the HRAS.

So we purposely stretched that out and did it down the line a bit further down the road. We also had this collected anonymously. We had staff choose their own coding to be able to identify whose it was but it was something that was completely anonymous to those of us who were running the training because we wanted to get people's actual perspective. We wanted to get how they really felt about this topic and we wanted to make sure that they didn't think it was going to impact their employment status or performance reviews. So we wanted to make this as user friendly for the staff that were involved in the pilot as possible.

These are some examples of the questions that are used on the harm reduction acceptability scale. So as you can see, it covers ground around honest information about how to use elicit drugs more safely. The top right green box is an example of a reverse coded item, looking at measures designed to reduce harm associated with drug or alcohol use are acceptable only if they lead the clients to pursue abstinence. So that's an example of one of those ones where a lower number would actually indicate a higher attitude of accepting harm reduction.

We also use the Dual Diagnosis Capability Index and mental health treatment index. This is a fidelity measurement for programs providing services for co-occurring disorders. What was particularly useful about the DDC-MHT is that it rates programs from mental health only to dual diagnosis enhanced. So it's not saying, inherently that people who are doing mental health treatment are quote/unquote doing anything wrong. It's looking at how equipped are you to be able to handle these issues side-by-side.

Those scores are arrived at using a standardized Rubric. So there's very clear instructions on what merits a one or two or three on each item. And it gives you a really standardized way to approach what's going on in programs.

It uses both interviews with staff members, leadership and individuals serves as well as chart audit to take a look at what's being documented in the treatment record to overall assess what's going on in these programs.

There's also another version of the DDC-MHT that's geared towards substance use providers. And we'll look at a program from substance use only to co-occurring enhanced. No matter which perspective you're coming to the table with whether it's substance use treatment or mental health treatment, there's a scale to corresponds to that in terms at looking at fidelity.

So when we started to develop the training itself, and looked at how are we going to get people comfortable with both the concept and the strategies around harm reduction, we wanted to be thoughtful about where and how we were giving this training.

So because this was a topic that can be really challenging for people to wrap their heads around and bring up a lot of emotional or reactions for people that have experience with substance use in their personal lives outside of work, we wanted to do what we could to make this training as comfortable as possible.

At our agency, our model for training is often bringing large groups of people together for multiple programs and delivering training at our main office. And for this topic that didn't feel like a good fit. So we went out and conducted these trainings actually in team meetings that would increase the comfort level among practitioners to share their honest feedback and really be able to put their concerns on the table in an environment that felt a little safer, a little bit more protects than this brand new group of people.

We worked to really incorporate adult learning principles as we developed this training. We didn't want this to be a lecture-based experience for people. We wanted them to really get in, think about the concept, work with the concept and be able to apply it to what they were doing in their everyday job. So we wanted to provide the rational why harm reduction was the model we were choosing to go with.

We wanted to provide opportunities within the training itself to troubleshoot and consult on cases in real-time, these things were happening. People had questions about how does this work for this individual I have in front of me at 3:00 o'clock today. We were able to troubleshoot of some of that in person. We also made sure to weave discussion questions throughout to support self-directed learning and help the individuals in the training really get a sense of how is this going to fit with everything else I already do?

As a result, we divided the training into a few different sections. We wanted to make sure we covered guiding principles of harm reduction or the theoretical underpinnings, what were some of the strategies. So how do we organize our work? And then what are some of the specific techniques that we're going to use when we're working from a harm reduction perspective, specifically to reduce harm related substance use.

So these next few slides are just some examples from the training that we did around what were some of the things that we provided to people in that training. This is an example of one of those guiding principle slides where we were looking at how do we approach this work theoretically from a harm reduction perspective? This is really where we wanted people to understand the why behind the implementation. And this is where we wanted to get the buy in from people about this is something that might make sense. This is something that might work for you. Understand where it comes from so you understand why it's worth the next hour of conversation we're going to have about how you're going to do this in practice.

We also talked about strategies. So these were really about organizing the work on a broader scale, perhaps not the day-to-day interventions. We looked at those a little bit later. But this is really about how do you organize yourself to sit down with somebody from a harm reduction perspective?

So as you can see here, we were really looking to help people understand the underpinning, how we do treatment planning, for example, around the harm reduction perspective? That our goal is to work with individuals to understand priorities and their

life issues, that they're goals might not be our goals. And that's okay. So do we prioritize and shift that to make sense in our treatment planning process?

One of the most important things we had to do was make harm reduction not feel like this really outside the box concept. We wanted people to gain some familiarity and comfort level with harm reduction by understanding where they are actually already applying these concepts in their own life and in their work, to help bring down the level of anxiety that people feel around the topic as big as harm reduction.

One of the challenges that always comes up when you're talking about harm reduction is people are concerned about risk management. There's a strong concern that if I haven't explicitly told somebody, I don't want you to do this, I'm giving them explicit permission to do it. So we try to use these real-life examples and use different ways and to think about harm reduction to make it not feel so antithetical to the risk management perspective.

I often talk with my teams about the idea that harm reduction is doing something which is better risk management than doing nothing if we can't find the person because we turned them off by saying they have to stop using.

So it's a theoretical shift for sure, and this helps soften the blow a little bit when people are able to see, oh, I already do some of these things? Why do I think so differently about substance use? So as you can see, we kind of work through some different examples around bike helmet, sports protective gear, sunblock. So we work with people to understand that we all, every day make choices to engage in certain behaviors that are inherently risky. It doesn't mean we don't do them. It means we take precautions to limit that risk. And that's all harm reduction really is.

So that has really been a successful strategy to help lower the bar for people to clear mentally that they can accept harm reduction as an acceptable way to work with this. We also give people the example of in driving a car, using an automobile is an inherently risky thing. What are some of the strategies that we use to mitigate those risks? People are very easily able to say things like seatbelts and highway signs. So

when we're able to make this a little bit more real for people, a little bit more tangible, we found that we have a lot more success in getting people onboard with it as a concept.

We also work to really highlight some of the specific techniques we use to work from a harm reduction perspective. Often times we have staff coming into our direct care positions that are brand new to the field or at the very much least brand new to working with this population with adults that are diagnosed with SMI. So we often times have people who really want to get in, they want to help. They want to do their best work, and they just are looking for direction on kind of tell me what to do.

So this specific technique section does a nice job of giving people some really concrete markers for here's the things that you can do with somebody in order to reduce their risk.

One of the ones in particular that we talk a lot about here at our agency is housing first and having housing not be contingent on somebody's sobriety which can be a challenge for people to wrap their brain around because that is so often the inducement that's used for people is that you need to be sober to be in sober housing or things like that. So we work really hard to make sure that people get this sense of we're going to continue to house people regardless of their substance use status and have some good conversations about that in this process.

This is an example of one of those discussion questions that we peppered into the training to get people thinking and talking about this concept on sort of a broader scale. And so really flush out what does it mean to have this perspective?

This question in particular, is there such a thing as a harmful behavior that would be inappropriate to address with a harm reduction approach? Really helped inspire good discussion about what does abstinence really mean? And that abstinence is one possible intervention on a scale, that it's not only the intervention, and it's not often our frontline intersection for other types of issues that we're working with people on.

For example, we would talk about interpersonal violence. And just because somebody has been interpersonally violate violent doesn't mean we don't keep them away from people all of the time. So there's -- some of those conversations did help

people gain a different perspective on, we often treat this issue quite differently than we treat other issues. While that's one option on the take, let's consider the whole range that might be available for this particular issue as well.

So that was the training package. Again it was offered in staff meetings to small groups. And people in general had really good feedback about the training itself. However, I think all of us know that one in done trainings are notoriously ineffective at actually changing people's practice. It gives a framework. It gives a structure to what people might wouldn't to do. But without the ongoing back end support and supervision and consultation in the programs, there just isn't the ability to keep that going all on your own.

So we knew that an important part of this process was going to be figuring out how do we provide that ongoing support and consultation in a way that's useful for the folks that have gotten this training?

So-- [NO AUDIO]

>> SAMSON TEKLEMARIAM: Hi, Suzy. I think your audio may have been disconnected. If you can hear me, just start back from where you said, "training" and see if you can check your audio.

>> SUZY LANGEVIN: Develop something called our case consultation form.

>> SAMSON TEKLEMARIAM: Hi, Suzy. Can you hear me? This is Samson.

>> SUZY LANGEVIN: I can, yes.

>> SAMSON TEKLEMARIAM: Yes. Sorry, so your audio actually blanked out. It just came back in. Um, I think it was right around the start of this slide that we loft, you know, not more than 10 or 15 seconds of what you were saying. So if you can go back and start that over again. I can hear you perfectly now. But it just blanked out for a moment.

>> SUZY LANGEVIN: Great. Thank you so much. So, um, we-- I was saying that, one of the things that we knew that was going to be so important is providing ongoing support and consultation to staff members back in the programs after this

training was complete. We know one and done trainings are really notoriously ineffective at actually changing people's practice patterns. So we needed to figure out how are we going to provide that ongoing support and consultation to continue this practice going after the training happened?

So the way that we looked to do that was by developing a case consultation form that helped people have a targeted, efficient and action oriented way to talk about how they were implementing these interventions that also had accountability in it. That people are going to be expected to follow-up and say, I tried this it worked. It didn't work and get more of that ongoing support as we go.

So this is the format-- excuse me. This is the format we use for case consultation. This is actually drawn from the IDDT practice, integrated dual disorder treatment. This is a practice that is published SAMHSA but is also available from --. And this is a really sort of comprehensive way to look at what's going on with somebody where we're looking at what is going on with this person today? What led us here? And then what are all these factors that we need to consider in order to make a plan moving forward?

One of the things that's really important about this is looking at somebody's stage of change and stage of treatment and seeing if there's a mismatch there. If somebody's not interested in changing and we're trying to use interventions like getting them to go to AA, there's not going to be a lot of agreement there. And we're going to feel that we're banging our head against the table, trying to get somebody to do what they don't want to do.

By seeing if we can match those interventions more appropriately and if somebody's not interested in changing, now we've got this model for harm reduction as a way to help support, we can really reduce that frustration on both the part of the individual and the staff member that's working with them and help people get on the same page.

As you can see there's a space for follow-up, meaning whether this is happening in a staff meeting or in individual supervision, we want to know what, how this goes,

what they're trying? What works? And what doesn't? So we can troubleshoot and often different solutions. This is a very cyclic process. And sometimes it's hit or miss. If we're not assessing stage of change properly, we might not be offering the right intervention. So we want to continue that conversation about did the intervention match for the person or do we need to choose a different path in? And harm reduction gives us that additional path.

So this is J'aime who is one of our program managers in our supported housing program. There is a live link that we put in the chat box as well as included with the FAQ document that gives you the link to this video of J'aime, talking a little bit about what their experience was like in supportive housing.

And the theme that has come up for our teams again and again is you know that you've done it right when this doesn't become a new concept anymore. It becomes how you do what you do. And when you have a new staff member walk in the door because we know turn over is a reality in our field, they get it right away because it's the way that everybody's operating. And that has been really the noticeable everything J'aime has seen in her program is by infusing it in the multiple levels in the program in training, in staff meeting, in individual supervision, that's where we're making changes to practice.

So outcomes. What did we discover? We know that evaluating how we did is a part of the learning collaborative process. And we were able to take a look and see, did this do what we wanted it to do?

So overall, taking a look at the standardized measure that we used, the harm reduction acceptability scale, we saw an average individual score decrease of almost 9%, or over 9%. Excuse me, for the staff members that have completed it pre and post training. Again we did this with a little bit of time after the training. So we will be able to see, did any of those attitudes generalize a little bit and take root and still come up a month to three months after the training?

We were really pleased with that number because this is notoriously a challenging topic to get people's attitude to change. So we saw an average change of about almost 10%, was really meaningful to us that this work had been worth it. At

looking at the DDC-MHT scores, you can see here they're broken up by the programs that were involved in this pilot. Over on the far right-hand sigh you see the average for the programs that worked through that model.

You can see there was over half a point difference. On a 5 point scale that was a big deal. So we were really excited that implementing something like harm reduction, giving people more skills increased our ability to get to this dual diagnosis enhanced place around our programming.

Two scores in particular that are help. For us to look at for this particular topic are the clinical process assessment score and the clinical process treatment score. So this is looking at to what degree are we assessing and integrating substance use treatment into those mental health treatment plans that we already provide?

So as you can see across the board we had increases on both of those scales. And one of the major places that you get the data for this particular items is somebody's client file. And on their physical treatment plan is substance use disorder included. So our treatment plans are dealt around mental health challenges. And when we can see that people are working to actively include substance use in those treatment plans, it let's us know that we've put this on a radar for people that may have not been there before. Or it puts it on our radar because they have something to do. You're not going to put something on a treatment plan if you have no idea what to do with it. So if you have somebody who is really committed to not changing their substance use, you're not going to put it on their treatment plan because you're not going to get any kind of interaction around it because they're not going to want to talk about it.

When we embrace harm reduction and add that to our bag of tricks, if you will, and people are able to pull out those interventions, then they can talk about substance use on a treatment plan. They can incorporate it into what they're doing because they have a way to talk about it that's respectful, that's collaborative, that doesn't alienate individuals and that keeps them in treatment. So that was one position that we were particularly glad to see was the increase in integration of talking about substance use in treatment planning.

So that's a quote from one of our team members that went through the training. They specifically said that they felt more educated and less nervous to talk about substance use with people. What I love about this quote is that it highlights two of the goals of adult learning. We're looking at giving people information. And we're also looking at increasing people's confidence. I think the learning collaborative model and the way that we've designed that training really help us do both these things at the same time. It wasn't just imparting information. It was also increasing comfort level.

This is Lauren, who is one of our outreach counselors. And she went through this process. And Lauren was one of my favorite stories out of this project because, as she was watching the training, you could sort of see the lightbulb moment of this is the way I can so this work that feels okay to me. And to have that happen and have people get something out of that in the moment is so important.

Again, there's a video testimony from Lauren about what her experience was like. The link will be in the chat box as well as in the FAQ.

And this quote came from another person that was a part of this process. "when working on harm reduction, together we can look at a situation in hits whole and focus on the victories, as small as they may seem, these small changes and choices add up to achieving goals." I think sometimes substance use can feel overwhelming. It can feel like it has infiltrated so many aspects of someone's life that we don't even know where to start.

When we can have our perspective be our frontline is always to think about health and safety. That gives us a reality nice organizing principle to be able to start working.

One of the challenges that sometimes comes up around working from the harm reduction perspective is this idea that harm reduction has to be a bridged abstinence. I think this quote sums up that we're looking at the whole situation. We're looking at small victories. We're not basing our success or failure whether or not somebody is sober. We're basing it on, is the person working towards what they're all working towards? And that's the backbone of harm reduction.

What does people's quality of life look like? And are there changing we can make to help them get closer to what they'd like to see. Knowing that this was the impact that it had on people who are part of the project, it was really affirming that we had made some good choices along the way.

So what did we learn from this process and what do we know about implementation using a learning collaborative model? Learning collaborative models are really well suited to topics like harm reduction that require a perspective shift. So as an agency, we have a lot of experience with implementing evidence-based treatment models. And we have a structured way that we do that. We knew looking at harm reduction that wasn't going to be enough. That wasn't going to be the model that was going to make sense to get us through this process of helping people change their perspective.

By taking this approach of going in a different direction and using this multiple pronged multifaceted model of a learning collaborative, it helped us achieve the buy in we were looking for that's necessary for perspective shift.

So if you have one of these concepts that you're thinking about in your agency, something that you know is going to impact practice in a positive way but is going to require a little bit more organizational umph than just training a bunch of people and tell them to go do it, I really recommend thinking about this model and thinking that through.

So some of the things that think about when you're looking at a learning collaborative model is you want to make sure that your programs are selecting are programs that have a good chance of success. And some of the things that go into that are an invested leadership staff. Whether that's a program manager or program director, someone who has some say on how the program runs that's interested and invested in making this work.

One of the other factors that can be important is looking at the level of staff turnover. We had four programs that participated in this pilot. I would say three of the four had very stable staff teams. And that made a huge difference in being able to implement this. When we have that solid core of people that we can lien on and rely

onto take this perspective shift and apply it to their work every day, we're going to be way ahead of just having to play catch up training people all the time.

The other thing that we looked for was what are the programs that can see some immediate opportunity to apply this information? So we have about half of the individuals that we serve that have co-occurring substance use disorder along with a serious mental health diagnosis but they're not evenly distributed throughout the agency. There are some programs that see more of this issue. Some programs that see less. We wanted to make sure we were piloting this in programs that had that issue on the forefront, coming up all the time so that there will be opportunities for people to try this out and see what worked and what didn't.

So that was another important factor at looking at the clinical presentation of individuals in the program to see, are we going to get a lot of bang for our buck for bringing this into this program?

We needed to make sure that we built and developed ongoing support activities to support staff learning and changed behavior. We relied a lot on supervision, and supervision occurring at multiple levels. So happening in one-on-one conversations with frontline supervisors and clinical supervisions and team level meeting to reinforce that this is the concept on the table and something we have as an available intervention for every person that we're thinking about this particular issue with.

We want whole sites, whole programs to be invested in making change happen. And that needs to come from sort of all organizational levels that are involved in this process. So as I mentioned, our sort of-- our edict as an agency is to serve individuals with serious mental health challenges. Which means that tends to be the focus of things like our HR processes and to make substance use really show up and be present and be a part of what we're addressing in people, that needs to start right when people are coming through the door. So we needed to make sure that job descriptions mentioned that injury work would not just be with people who have mental health challenges but also people with substance use disorder. We needed to make sure that when we were interviewing, we included questions about not just the mental health stuff but the substance use stuff as well.

We wanted to take this holistic approach to are we onboarding people for whom harm reduction is going to be a consistent intervention? Are we bringing people in for whom this won't feel like it needs to be this massive shift with some guidance and some support they'll be able to make this happen?

We also wanted to make sure that we were highlighting it in orientation and in onboarding. They were talking about the idea that co-occurring disorders happen, co-occurring disorders are in most cases not the norm but are not the exception rather but the norm. So we wanted to have that be on the table throughout our orientation and onboarding process and make sure people are talking about how would you address these issues? Here's what we think about these issues. Here's our theoretical way at this and some practical ways we carry that out. That learning starts from day one and starts operating from that place of this is the expectation of how we're going to do this work.

And lastly we really needed to let go of some of our ideas about how we've done things before. This was a new concept. It was a novel concept. And it was a different way of working than what we've done in the past. So we needed to get creative. We couldn't just offer the same, let's do a one-day training at the office and expect that it's going to change things. We had to come up with a different way in.

And some of the things that we considered and I would encourage you to consider as you think about implementation and where, when, and how do you deliver train and support? Who are your messages that make the most sense? How do you get people invested and involved in the training process and feel comfortable sharing what they actually think? Sharing the things that are going to be most help. To really get this off the ground?

When we're doing ongoing support, how do we help people feel like they've got what they need to be able to carry out and continue doing this work? How do we talk to people about self-care? How do we talk to people about risk management concerns, about those philosophical differences that can come up and make people uncomfortable? How do we create cultures where people feel comfortable offering that

feedback. And where, when and how we decide to deliver training and support make a big difference in how that's received?

We also wanted to make sure that we had training structures that were flexible to meet needs of air variety of learning styles and audiences. Adult learners are a unique group. And some of the strategies that work for regular classroom learning are not all that effective for on the job training. So we really wanted to address and make sure that our structures were supportive of where individuals were at in this process.

We talk about stage-wise intervention for individuals. We also have to have stage-wise intervention for staff and work with people to meet them where they're at and get them the support they need in their learning style, in their timing that's going to make sense for them.

So those are just some thoughts about implementation in general, the learning collaborative process, in particular the things that we found to be helpful about this process.

So you'll see here there's just some references and some things that I put together, both these treatment-- this training rather as well as resource that's we used in our process for implementation.

I think we do have a few minutes left in there are any questions that people have and wanted to bring up.

>> SAMSON TEKLEMARIAM: Yes, Suzy. Thank you so much for this incredible guidance on how to implement harm reduction. We do. I think we have time for some questions here. Let me go ahead and start with our first.

Our first question is from James Fully asks, early in the presentation, you mentioned includes abstinence. Do you mean that is it can include abstinence or that it always does include abstinence?

>> SUZY LANGEVIN: That is a great question. I would say it can include abstinence. One of the mental hurdles that we have a lot of is people believing that harm reduction is only a worthwhile intervention if it later leads to somebody deciding to become abstinent. The position that we really take at a team in training this is harm

reduction is a good goal in and of itself. We want to keep people healthy. We want to keep people safe. And we're going to do that as long as we need to do. And if that's for the continuation of somebody's time with that, we're okay with that.

>> SAMSON TEKLEMARIAM: Awesome. Thank you. And great answer there. James Fully thank you for the question. Our next question coming from Leo. Leo refers to ACEs, at verse childhood experiences. And shares that harm reduction is something he really loves and appreciates. However, is recognizing that it may not work for someone with adverse childhood experiences who are wrestling with anxiety, depression and PTSD altogether. And is wondering, which segment needs to be addressed first? Removing the substance or finding a mental balance?

>> SUZY LANGEVIN: That is a wonderful question and one I feel like, if I had the answers to, I'd be a millionaire by now.

Our agency has been working over the last year to implement seeking safety which is a model that-- has published and that we found object really valuable. What I like about seeking safety in particular is the focus is on what do you need to feel safe?

And it addresses those ACEs, those adverse childhood experiences and through the lens of how is this helping you feel safe or helping you not feel safe? So it's less about, you need to stop using in order to fully address the mental health challenges. And more about that immediate need for safety. What it also does is sets up-- I hesitate to call it a hierarchy. That's more like a DBT term. But it acknowledges substance use for a long time has probably been somebody's most efficient way and effective way of coping.

I do a lot of PTSD work. It's one of my clinical subspecialties. And I talk to people all the time about substance use being an avoidance technique. And avoidance techniques work fantastic until they don't anymore. Until those avoidance techniques are actually putting you in danger.

So I think it's something that you address alongside which is one of the reasons we do seek safety because it's that co-occurring way of addressing those issues. But it acknowledges that people need to do skill building into for sobriety to be a reasonable

goal to maintain. We can't take away everything that somebody has to work with and expect that that's going to go okay until we've given them other tools to supplement that. So I think it's a both and rather than on either/or which is going to be worked out for each individual what's going to be helpful for them.

>> SAMSON TEKLEMARIAM: Thank you so much, Suzy. And I'm going to try to squeeze in two more. Thank you, Leo for that question.

This one is from Taylor. Taylor asks, would you suggest advising the client to use a less harmful substance or would you just accept that idea if it's something that they bring it up themselves?

>> SUZY LANGEVIN: That's a great question and one that I actually hear most often from difficulties. So we serve from 18 right on up. But I would say that comes out most frequently in that particular age category.

I wouldn't say that I necessarily would say to somebody, hey, you've been shooting heroin. Have you thought about smoke pot?

But if somebody is coming to the table with, I have both of these things that I'm doing. I wouldn't have to say, you know, do you think you can cut back on the heroin use without sort of obliquely addressing the marijuana use? We get there if we get there. My major concern is in the hierarchy, are you using IV? That's the first thing we've got to address. What else are you using that has a high OD risk? That's the next thing we need to address and kind of move down from there.

>> SAMSON TEKLEMARIAM: Great. Great answer. Thank you again, Taylor for that one. Last question, and then we'll close out. We have one minute for this one. Suzy, Eddie asks you from Arizona, is there a reimbursement differential for the co-occurring members in your program?

>> SUZY LANGEVIN: Unfortunately, no. And that is something that we have worked with our funders over the years. And we just have not had the effective advocacy that we needed for that just yet.

There are some projects afoot in Massachusetts to help make that possible through Medicaid. But right now with our funding mechanisms through DMH,

unfortunately we, the same day rate no matter what the presenting issue is. We feel strongly that our staff need these skills anyway.

>> SAMSON TEKLEMARIAM: Awesome. Suzy, thank you so much again for this wonderful guidance on how to implement, how to implement harm reduction. And we'll go ahead and wrap up. You know, for those of you who missed the beginning, I want to remind you that everything you need to know about this particular presentation is on the NAADAC website. You can watch the recording after the live event, download the PowerPoint slides, take the CE quiz and make a payment if you're not a NAADAC member. The webinar address for this webinar again is w□ww.naadac.org/implementing-harm-reduction-webinar. You can go to this page in the future when you need any information regarding this webinar.

And here are the instructions again for receiving CE credits. Just one more time. Please make sure to give us just about an hour to have that CE quiz posted.

How much, while when we're done, when we close out this webinar, there will be a pop-up survey. We would love it if you would take that survey, giving us feedback on the webinar process and NAADAC webinars in general and of course, giving our presenter critical feedback that she needs. We just love any notes or information you guys can share with us.

Again, just one hour or so for the CE quiz to be posted on that website. And make sure to follow these instructions in order to receive your CE certificate.

Here's the schedule for our upcoming webinars. Please tune in if you can. There were some really interesting topics with great presenters just like today.

Also please mark your calendars for this week. Tomorrow starting tomorrow, the northwest regional conference. If you are anywhere in the northwest, please join us for our three-day conference June 13-15 this week at the Portland Marriott Downtown Waterfront in Portland, Oregon for an incredible live event without standing speakers like Carlo De Clemente, addressing the topic of embracing the future.

You can visit our website to learn more information. I will be there. And hope to see you there, too.

Um, the remaining 2019 webinars have been posted. You can bookmark our page w□ww.naadac.org/webinars. Or you can always join NAADAC and get the benefits of all of our free CEs by joining us at□ w□ww.naadac.org/join. The deadline for our 2020 call for webinar presenters is about a month from this week, July 16.

So if you are an expert or specialist on a particular topic, if you are publishing or if you are in the process of a research grant, and you want to publish some research or share some research, this is a wonderful opportunity. So go to our website and click on webinars and you'll see 2020 call for webinar presenters. And give yourself a chance to be reviewed by our review committee and submit your proposal for a webinar for next year. We would love to hear from you.

Of course, there are a lot of benefits for being a NAADAC web. Our webinar series, magazine articles, face-to-face seminars, conferences, certificate programs and independent study courses. You can always connect with us on social media. Everyone, thank you for participating in this webinar. And Suzy, thank you for your valuable expertise. I encourage you all to take some time to browse our website and learn how NAADAC can help you and help others.

Stay connected with us on LinkedIn, Facebook, and Twitter. Have a great day, everyone. >> Yeah.