

Clinical issues related to the integration of Providence Portland Medical Center Adult Outpatient Services and Chemical Dependency Services

Capstone Project for the Addictions Counseling Curriculum
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Introduction

The Behavioral Health System (BHS) at Providence is changing. The integration of mental health and chemical dependency services is no longer considered an optional and perhaps problematic notion; but rather, as a necessary and proactive effort to respond to an environment of changing characteristics. Current challenges facing local behavioral health programs include the ongoing, complex, and possibly increasing needs of patients with co-occurring disorders. Also evident are differing staff beliefs about how to provide more effective and time limited Behavioral Health Services. And thirdly, challenging business concerns related to significant changes in funding sources and how various resources are being allocated pose difficulties that must be dealt with. The need for change appears certain, imminent, and necessary. In order to help illustrate potential barriers to be resolved and to identify clinical staff expertise necessary for a successful integration process, a survey was developed and used to gather pertinent information. The survey itself along the survey data / results can be found at the end of this paper under Appendix A and B.

Method

The survey was a 30-item questionnaire given to BHS clinical staff in Building B. at Providence Portland Medical Center (PPMC). The questionnaire itself focused on questions about staff skill sets and clinical issues related to the integration of both PPMC Adult Outpatient Services (AOS) and Chemical Dependency Services (CD). Clinical staff were asked to participate on a voluntary and anonymous basis with efforts made to keep individual survey results confidential and safe from peer or supervisory review. All clinical staff from four distinct yet separate and interrelated behavioral health programs or departments were invited to participate.

The four groups consisted of:

- Group 1: Inpatient Chemical Dependency (Inpt. CD)
- Group 2: Outpatient Chemical Dependency (OP CD)
- Group 3: Access Triage Phones (ATP)
- Group 4: Adult Outpatient Services (AOS)

Results

Overall, staff response to the survey was approximately 40%. By individual groups, the total clinical staff response rate was 35%, 67%, 47%, and 100% respectively. This shows a significant difference in responses for example from Inpatient CD vs. AOS groups.

Inpt. CD staff reported having the most time worked in CD services, but the least time worked with co-occurring patients and the least time worked in their current positions. By contrast, AOS had the least experience working in CD services, and the most time in their current positions, which may suggest a certain level of program stability. And OP CD had by far the most time working in MH services (21 years) and working with co-occurring patients (16 years), which suggests a very high level of clinical expertise.

Staff in all groups, for the most part, that they considered themselves capable and competent to work in both CD and MH programs, although only Inpt. CD and OP CD identified themselves as having been cross-trained to work in both settings.

Staff responses from OP CD, ATP and AOS groups also indicated that treatment knowledge (defined here by years of academic training) was both significant and highly developed. The majority of those staff (about 74%) have graduate degrees in social science and (including group 1) have an overall average of 22 years apiece of direct clinical experience. Only one group, AOS, clearly showed evidence of a multi-disciplinary team. Team members of AOS were comprised of Occupational Therapists, Mental Health Therapists (social workers and counselors), a nurse and a physician!

62% of all staff felt competent and capable to work with co-occurring patients, while 72% indicated the desire for further treatment specific training. Most responses, 91.5%, favor the notion of integrating treatment services. However, certain groups of staff have concerns about mixing together patients with different treatment issues in the same group. Also quite notable was that approximately 50% of all staff think they have inadequate supervision, and 22% find their workload hardly ever manageable.

The Inpt. and OP CD groups feel very competent to work in both CD and MH fields, with the AOS group less confident with CD patients. CD groups also report more cross training the MH group, but both CD and MH staff are willing to work in both areas. All groups agree that more training would be helpful, particularly in the area of assessments and treatment planning. And, 72% of all groups indicate a preference for working together as part of a team. Staff responses in these cases, show clear intent, willingness and flexibility to work together in an integrated program.

Another finding, common to both CD and MH fields, is that the CD group has more experience-based training than the MH group that is more academically trained. Survey results from the Inpt. group, for example, indicates no respondents have graduate degrees. And while MH staff report more need for dual diagnosis training than either CD group, other responses from some CD staff suggest those individuals may have difficulty applying their clinical experience.

Another shared understanding among staff is that addiction is perceived as a truly complex disorder, not simply a biological, or sociological, or psychological problem. There was no evidence that any staff considered addiction as immoral conduct, an older notion that while well known is now considered a rather pejorative perspective. And a somewhat interesting yet typical response, CD groups were found less supportive of harm reduction than the MH group.

Notions related to advantages of integrating CD and MH services included themes such as: better treatment for the patients, less duplication of services, improved treatment outcomes, greater and more efficient use of resources, and greater potential for referrals. In effect, advantages centered mostly on the potential for improvement of systems issues rather than on specific benefits for staff.

However, in response to the question about disadvantages of integrating services, responses seemed mixed with staff concerns appearing more evident than system problems. These included mostly ideas such as: increased complexity of staff jobs, poor staff training, confusion with treatment planning, different treatment approaches, overuse of staff, or a lessening of staff expertise by having excessive duties. For more system related disadvantages, these concerns seemed most important: different treatment cultures, billing and insurance problems, CD / MH patients unhappy in the presence of each other, or decreased money for services.

And lastly, the questions about systems issues that might complicate the integration process together with responses from the last survey question about any further comments both had varied responses. These comments, like those listed above as disadvantages, seemed to have more to say about staff anxieties and staff-related issues than about purely system-related difficulties.

Conclusions / Recommendations

The survey was designed and offered to clinical staff with the intent to help identify clinical skill sets as well as staff ideas related to the upcoming integration of CD and MH services. In general, staff response to the survey was considered very good and responses showed significant levels of training and expertise in all groups in Building B. at Providence.

There exists clear interest in and, for the most part, willing attitudes to engage in cross-training and integrating treatment services to meet the demands of patients with co-occurring disorders. However, there also exists at the same time certain anxieties or concerns related to clinical staff perceptions of the ability to successfully integrate services and then to effectively provide those services for a rather diverse population of patients. Given the nature of change, one might easily expect this type of reaction. Thus, further team-building experiences to allay anxieties and remedy this situation could be offered to all staff to enhance and encourage the building of new working relationships. The goal being, to improve the quality of staff interactions and to improve the quality of treatment services. Such an effort is already taking place in part by the recent formation of identified task groups and by the use of some staff to work in related programs outside their usual assigned program. More on-the-job training / cross-training efforts could be increased gradually by allowing more individuals to work in new or different work areas. And certainly, various educational training's, workshops or conferences, either provided by Providence directly or taken outside the Providence environment are other ways of increasing staff efficacy.

Another significant finding is that 72% of all clinical staff identified a need for more specific training, namely, doing assessments. The need for accurate assessments for patients with co-occurring disorders cannot be understated. With more complex patients seeking treatment for various MH and / or CD issues, the assessment instrument and the therapist conducting the assessment process, must both be well-developed. A necessary function to a successful integration process would be to develop a comprehensive assessment instrument. And then, train intake therapists to use such a tool.

Since the integration process as well as the completion of daily work tasks, hinges mostly on staff work performance, efficient, well trained, capable and adequately supervised staff are essential. Unfortunately, an average of 50% of staff surveyed indicated they do not have adequate supervision. This is truly an area that needs further assessment and attention as soon as possible. Also, 56% of all staff who responded rated their workloads as manageable either some of the time or hardly ever. Review of both staff work performance and assigned duties might be helpful to ascertain the reality of this finding.

Lastly, more research needs to be done to more fully understand the characteristics necessary for a successful outcome of this integration process. Many difficult questions remain unanswered. However, other co-occurring disorders programs do exist in the country and more information is likely available at those sources. With ingenuity, persistence and creativity much can be accomplished.

APPENDIX A

INFORMATIONAL AND CLINICAL SKILL SETS SURVEY

Purpose of Survey

This is a 30-question survey of staff skill sets and clinical issues related to the integration of PPMC Adult Outpatient Services (AOS) and Chemical Dependency Services (CD).

As you probably all know by now, staff in Building B., for various reasons, are in a state of transition. Specifically, the Behavioral Health System (BHS) at Providence is changing. With the move of Adult Outpatient Services into Building B. last October, the integration of Mental Health (MH) with Chemical Dependency Services has begun. And, in order to clarify and identify the skill sets of PPMC Behavioral Health Staff as well as your thoughts about the integration, we need your assistance. Hopefully, by asking you for information about work-related topics, we might together use our strengths and skills to make this integration a more successful one. Additionally, this information might also allow for a more informed, thoughtful, and unified approach to the important work we all do. Your participation in this survey would be greatly appreciated. Summary results of the survey will be available for those so interested.

Disclaimer

Basically, this is a volunteer and anonymous survey to help determine the strengths, assets and other areas that might require further attention for clinical or administrative staff. The survey is an academic project of Kelsey Broyles related to the completion of his Addictions Counseling classes at Portland State University. The survey is intended to be helpful to PPMC BHS staff as they move closer to integrating services from several related yet historically independent and separate BHS services. All efforts to develop and implement the survey has been initiated and coordinated by Kelsey Broyles without PPMC influences. However, John Molesworth and Sally Featherstone have given their approval to collect the survey information and to complete the survey during your shift.

None of the collected anonymous information will be used in any fashion that might cause negative consequences for any staff member at PPMC. Your responses will be anonymous. Please be free to state your mind, make suggestions or identify problem areas. Your input is truly important and your participation is greatly appreciated. What follows are some sets of questions for your response.

Instructions

Please mark as many of the answers for each question that applies to you. For your additional comments, use the space at the end of the survey. Please complete the survey ASAP and return it in the provided envelope to your Clinical Supervisor who will return them to Kelsey Broyles. Supervisors will not review your responses. Thank you for your help.

Survey Questions

1. How long have you worked in your current position? _____ Years
2. How long have you worked in the field of CD services? _____ Years
3. How long have you worked in the field of MH services? _____ Years
4. How long have you worked with co-occurring patients? _____ Years

5. Do you consider yourself capable and competent to work in both CD and MH programs?
 Yes Somewhat No
6. Have you been cross-trained to work in both CD and MH settings?
 Yes Somewhat No
7. Are you trained to work in both CD and MH settings? Yes No
 Are you licensed to work in both CD and MH settings? Yes No
 Are you certified to work in both CD and MH settings? Yes No
8. Are you willing to work in both CD and MH services at Providence?
 Yes Not sure No
9. How did you gain your CD treatment experience? Mark all that apply.
 Personal recovery experiences
 On the job or agency training
 Academic training
 Continuing Ed.
 Other _____
10. How did you gain your MH treatment experience? Mark all that apply.
 Personal recovery experiences
 On the job or agency training
 Academic training
 Continuing Ed.
 Other _____
11. What type of academic degree(s) do you have?
 None
 AA/AS
 BA/BS
 MA/MS
 NP/MD
 OT
 BA or MS in Nursing
 Other _____
12. What type of state, national, or professional certification(s) do you have?
 None
 CADDC I or II
 NCC
 MAC
 Other _____
13. What type of state license(s) do you have?
 None
 LCSW
 LMFT
 LPC
 OTA/L

- OTR/L
- NP/MD
- RN
- Other _____

14. Do you feel or think your skills and expertise are most effective in

- CD
- MH
- Both

15. Do you feel or think you need more training to work effectively with patients with co-occurring disorders? Yes No

16. If you were to seek more training to work with people with co-occurring disorders, what area(s) might you choose? Mark all that apply.

- Assessment
- Treatment Planning
- Referral
- Service Coordination
- Individual Counseling
- Group Counseling
- Client, Family, and Community Education
- Documentation
- Professional and Ethical Responsibilities
- Other _____

17. Do you define addiction as (mark all that apply)

- A medical disease
- Genetic Disorder
- Biological Disorder
- Sociological Problem
- Psychological Problem
- Immoral conduct
- Maladaptive behavior
- Other _____

18. What do you believe is the desired outcome of CD treatment?

- Abstinence
- Controlled use
- Harm reduction
- Other

19. What do you believe is the desired outcome of MH treatment?

- Crisis intervention
- Medication management
- Stabilization
- Symptom reduction
- Avoiding hospitalization
- Brief Therapy
- Long-term insight-oriented therapy

20. Do you find it better to work autonomously or as a member of a team? Or _____

21. Do you consider yourself a life-long learner? () Yes () No
22. Do you think you have adequate clinical supervision? () Yes () No
23. Is your workload manageable?
 () All of the time
 () Most of the time
 () Some of the time
 () Hardly ever
 () Not at all
24. Would you consider a change in work schedule (e.g. 10 hr. days, weekends)?
 () Yes () No () Uncertain
25. Do you think you are fairly compensated for the work you do? () Yes () No
26. If you were to become cross-trained in addictions and mental health, would your current wage be satisfactory? ()Yes () No
27. What do you see as advantages to integrating CD and MH services?
28. What do you see as disadvantages to integrating CD and MH services?
29. What systems issues might complicate the integration process?
30. Please include any further comments you want to mention.

APPENDIX B

Survey Results of Informational and Skill Sets for Clinical Staff at Portland Providence Behavioral Health Services (BHS).

Data and Results

There are a total of 54 full-time equivalent positions with approximately 70 employed staff providing BHS services in Building B. 81 blank questionnaires were handed out and 32 (40%) completed surveys were returned. By individual groups (including clinical staff only), the response rate was 35%, 67%, 47%, and 100% respectively.

Number of actual completed responses were:

Group:	#1	#2	#3	#4	Total
	6	4	8	14	32

Number of possible clinical staff responses:

Group:	#1	#2	#3	#4	Total
	17	17	14		54

1. Average number of years in current position:

Group:	#1	#2	#3	#4	Average
	3.42	5.5	4.94	7.4+	5.3+ yrs.

2. Average length of time worked in CD services:

Group:	#1	#2	#3	#4	Average
	10.33+	9.63+	7.06,	0.6	6.8+ yrs.

3. Average length of time worked in MH services:

Group:	#1	#2	#3	#4	Average
	14.75	21	10.94	14.4	15.3 yrs.

4. Average length of time worked with co-occurring patients:

Group:	#1	#2	#3	#4	Average
	8.33	16	10.94+	12.9+	12+ yrs.

5. Consider yourself capable and competent to work in both CD and MH programs:

Group:	#1	#2	#3	#4	Average
Yes:	66%	100%	62.5%	21%	62%
Somewhat:	17%	0	0	79%	24%
No	17%	0	37.5%	0	14%

6. Been cross-trained to work in both CD and MH settings:

Group:	#1	#2	#3	#4	Average
Yes:	67%	100%	25%	7%	49.8%
Somewhat:	33%	0	75%	57%	41.2%
No:	0	0	0	36%	9%

7a. Trained to work in both CD and MH settings:

Group:	#1	#2	#3	#4	Average
Yes:	67%	100%	75%	36%	68%

No: 33% 0 25% 64% 32%

7b. Licensed to work in both CD and MH settings:

Group:	#1	#2	#3	#4	Average
Yes:	67%	75%	0	36%	44.5%
No:	33%	25%	100%	64%	55.5%

7c. Certified to work in both CD and MH settings:

Group:	#1	#2	#3	#4	Average
Yes:	67%	75%	0	36%	44.5%
No:	33%	25%	100%	64%	55.5%

8. Willing to work in both CD and MH services at Providence:

Group:	#1	#2	#3	#4	Average
Yes:	80%	100%	100%	86%	91.5%
No:	20%	0	0	0	5%
Not Sure:	0	0	0	14%	3.5%

9. Gained CD experience by:

Group:	#1	#2	#3	#4	Average
Personal recovery experiences	50%	25%	25%	21%	30%
On the job or agency training	83%	100%	100%	86%	92%
Academic training	67%	50%	75%	43%	59%
Continuing Ed.	50%	75%	75%	50%	63%
Other _____	0	0	0	0	0

10. Gained MH experience by:

Group:	#1	#2	#3	#4	Average
Personal recovery experiences	33%	75%	0	36%	36%
On the job or agency training	67%	100%	88%	100%	89%
Academic training	50%	100%	100%	100%	88%
Continuing Ed.	33%	100%	75%	93%	75%
Other _____	0	0	13%	7%	0

11. Academic degrees:

Group:	#1	#2	#3	#4	Average
None	1/17%	0	0	0	1
AA/AS	2/33%	1/25%	0	2/14%	5
BA/BS	2/33%	1/25%	0	4/29%	7
MA/MS	0	5/75%	6/75%	8/57%	19
NP/MD	0	0	0	1/7%	1
OT	0	0	0	2/14%	2
BA or MS in Nursing	1/17%	0	0	0	1
MSW	0	1/25%	0	1/7%	2
Other	1/17%	0	1/13%	0	2

12. Type of state, national, or professional certification(s).

Group:	#1	#2	#3	#4	Average
None	3	4	7	6	5
CADC I or II	0	0	0	0	0
NCC	0	0	0	3	0.75

MAC	0	0	0	0	0
OT	0	0	0	2	0.75
Other_____	1	0	1	4	1.25

13. Type of state license(s).

Group:	#1	#2	#3	#4	Average
None	1	0	4	3	1.75
LCSW	0	2	1	2	1.25
LMFT	0	1	0	0	0.25
LPC	0	1	1	4	1.50
OTA/L	0	0	0	2	0.50
OTR/L	0	0	0	1	0.25
NP/MD	0	0	0	1	0.25
RN	4	0	0	1	1.25
Other_____	0	0	2	0	0.50

14. Feel or think your skills and expertise are most effective in:

Group:	#1	#2	#3	#4	Total
CD	2	1	1	0	4 / 12.5%
MH	1	0	5	11	17 / 53%
Both	2	3	2	3	10 / 31%

15. Feel or think you need more training to work effectively with patients with co-occurring disorders?

Group:	#1	#2	#3	#4	Total
Yes	3	2	5	13	23 / 72%
No	1	0	0	1	2 / 6.30%
?	1	0	0	0	1 / 3.13%

16. If you were to seek more training to work with people with co-occurring disorders, what area(s) might you choose?

Group:	#1	#2	#3	#4	Total
Assessment	2	3	4	14	23 / 72%
Treatment Planning	2	2	4	10	18 / 56%
Referral	2	1	2	6	11 / 34%
Service Coordination	1	1	2	5	9 / 28%
Individual Counseling	1	1	5	7	14 / 44%
Group Counseling	1	1	4	7	13 / 41%
Client, Family, and Community Education	2	1	5	7	15 / 47%
Documentation	2	1	2	5	10 / 31%
Professional and Ethical Responsibilities	1	0	2	5	8 / 25%
Case Management	-	-	1	1	2 / 6.25%
Other	0	0	2	3	5 / 16%
None	1	-	-	-	1 / 3%

17. Define addiction as:

Group:	#1	#2	#3	#4	Total
A medical disease	4	3	6	12	25 / 78%
Genetic Disorder	4	2	5	10	21 / 66%
Biological Disorder	3	2	5	11	21 / 66%
Sociological Problem	4	2	5	11	22 / 69%

Psychological Problem	3	2	5	12	22 / 69%
Immoral conduct	0	0	0	0	-----
Maladaptive behavior	0	3	5	7	15 / 47%
Other_____					

18. Desired outcome of CD treatment:

Group:	#1	#2	#3	#4	Total
Abstinence	4	2	7	7	20 / 62.5%
Controlled use	1	1	0	2	4 / 12.5%
Harm reduction	1	2	3	14	20 / 62.5%
Other					

19. Desired outcome of MH treatment:

Group:	#1	#2	#3	#4	Total
Crisis intervention	1	1	4	8	14 / 44%
Medication management	2	1	4	10	17 / 53%
Stabilization	2	1	6	13	22 / 69%
Symptom reduction	3	2	7	12	24 / 75%
Avoiding hospitalization	1	0	4	11	16 / 50%
Brief Therapy	1	0	3	6	10 / 31%
Long-term insight-oriented therapy	1	0	2	5	8 / 25%

20. Do you find it better to work:

Group:	#1	#2	#3	#4	Total
Autonomously	1	0	1	0	2 / 6.25%
Member of a team	3	3	3	14	23 / 72%
Or __ (both)	1	1	4	0	6 / 19%

21. Do you consider yourself a life-long learner?

Group:	#1	#2	#3	#4	Total
Yes	3	4	8	14	29 / 91%
No	2	0	0	0	2 / 6.25%

22. Do you think you have adequate clinical supervision?

Group:	#1	#2	#3	#4	Total
Yes	3	3	1	9	16 / 50%
No	2	1	7	5	15 / 47%

23. Is your workload manageable?

Group:	#1	#2	#3	#4	Total
All of the time	0	0	0	0	0
Most of the time	2	2	4	7	15 / 47%
Some of the time	2	2	2	5	11 / 34%
Hardly ever	1	2	2	2	7 / 22%
Not at all	0	1	0	0	1 / 3.13%

24. Would you consider a change in work schedule (e.g. 10 hr. days, weekends)?

Group:	#1	#2	#3	#4	Total
Yes	3	2	5	7	17 / 53%
No	1	1	3	3	8 / 25%
Uncertain	1	1	0	5	7 / 22%

25. Do you think you are fairly compensated for the work you do?

	Group:	#1	#2	#3	#4	Total
Yes		3	3	7	14	27 / 84%%
No		1	1	1	0	3 / 9.38%

26. If you were to become cross-trained in addictions and mental health, would your current wage be satisfactory?

	Group:	#1	#2	#3	#4	Total
Yes		2	3	5	12	22 / 69%
No		2	0	2	0	4 / 12.5%

27. What do you see as advantages to integrating CD and MH services?

The disorders are integrated in the patient.
 Better service for the patient. Less duplication of services.
 More holistic, more in tune with reality of needs of patients. Too many to write down.
 Only advantage is working with DDx population Better service to patient. Better use of resources.
 Greater breadth of staff talents. Reduce redundancy with assessments. Coordinating treatment.
 No comment. Yes. More help for the community. More resources. Disorders are often interrelated / intertwined. Longer periods of recovery / abstinence and stability. More tx options.
 Each program may consider patient appropriate for “the other program.”???
 Likely bring insights from CD to the MH arena. Provide another model (in addition to medical).. .
 Be able to treat the “chicken and the egg,” as co-occurring disorders to effect the other one.
 Better team building, utilization and coordination of services. Current trend. Increase referrals.

28. What do you see as disadvantages to integrating CD and MH services?

Decreased money for services. None. Treatment planning could get confusing.
 Different needs and approaches for these two groups. Patients may “slip thru the cracks.”
 Totally different type of service. No comment. None. Confusing except for the DDx patients.
 CD patients are very unhappy when MH clients are on the same floor.
 Combining people who are required to be abstinent with people who are using.
 A great deal of complexity to our jobs. Some staff may not be well trained.
 May have some patients feeling alienated from the extremes of either MH or CD patients.
 Groups could become dominated by issues more related by either CD or MH.
 Different treatment approaches or philosophies in CD vs. MH. Billing and insurance issues.
 Transition with rapid learning curve to bring staff up to speed. Staff could be spread too thin.
 People with separate CD and psychiatric issues are not a good mix. Expertise watered-down.
 Some patients have one or the other disorder, but not both. Different cultures.

29. What systems issues might complicate the integration process?

Egos. Inadequate number of staff to work with and be knowledgeable about different needs, approaches, tx plans, etc. these populations. How the medical system reacts-confusion??
 The needs of CD and MH populations are divergent. Rules, regulations, laws. Payment streams.
 Psych. patients are crazy. CD patients find them scary. Rigidity could be an issue.
 Developing a new team. Who is responsible for what. Difficulty with insurance authorizations.
 Insurance. Billing. Insurance. Billing. Funding streams. (Limited) staff training.
 Many staff and some managers are not integrated even though they think they are.
 Poor collaboration between providers of each field. Poor awareness of other programs.

Having higher amount of relapsing CD patients could “trigger” or effect the stability of others.
Higher instance of on-site substance use / abuse in groups.
Disinterested staff. Older treatment practice vs. newer practice, how treatment “should be.”
Egos, differing philosophical and theoretical approaches. Fears about layoffs.
Lack of team integration. Schedules. Staff reactions in different programs integrating together.
CD is upstairs, and MH is downstairs. Break up the “invisible barrier.”

30. Please include any further comments you want to mention.

Good idea, I look forward to it. I would encourage more training for all BHS staff together.
Psych. pts. Require more individual time. Not attentive in CD groups. Disrupt the whole CD process. Leave large messes in Day Room and Kitchen. Eat off others' trays.
Didn't work when Respite patients and CD patients were put together here.
MH patients with predominately MH issues might feel alienated in CD environment.
We need on-line charting and data base mgmt. Much time wasted on paperwork and duplication of effort and wasting paper.
Use different program staff on the same task force for relationship building.
The role of “expert” doesn't fit well with (CD??) clients.
Important to consider level of dysfunction in grouping patients.
I think the benefits outweigh the difficulties. Treatment team will become stronger.