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CENTER FOR EVIDENCE-BASED PRACTICES

A partnership between the Mandel School of Applied Social Sciences & Department of Psychiatry at the School of Medicine

CASE WESTERN RESERVE UNIVERSITY EST. 1826

A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services

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Service innovations for people with mental illness, substance use disorders

- **SAMI** — SUBSTANCE ABUSE & MENTAL ILLNESS — *strategies for co-occurring disorders*
  - **IDDT** — INTEGRATED DUAL DISORDER TREATMENT — *the evidence-based practice*
  - **DDCAT** — DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT — *an organizational assessment & planning tool*
  - **DDCMHT** — DUAL DIAGNOSIS CAPABILITY IN MENTAL-HEALTH TREATMENT — *an organizational assessment & planning tool*
- **ACT** — ASSERTIVE COMMUNITY TREATMENT — *the evidence-based practice*
- **SE/IPS** — SUPPORTED EMPLOYMENT/ INDIVIDUAL PLACEMENT & SUPPORT — *the evidence-based practice*
- **IPBH** — INTEGRATED PRIMARY & BEHAVIORAL HEALTHCARE
- **MI** — MOTIVATIONAL INTERVIEWING — *the evidence-based treatment*
- **$** — BENEFITS ADVOCACY & PLANNING — *relationships supporting recovery*
- **TRAC** — TOBACCO: RECOVERY ACROSS THE CONTINUUM — *a stage-based motivational model*

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What are Co-occurring Disorders (COD)?

- Mental illness and substance abuse occurring together in one person

Why focus on COD?

Co-occurring disorders are:

- Common
- Interdependent
- Leading to worse outcomes and higher cost when not effectively treated

Co-occurring Disorders are Common

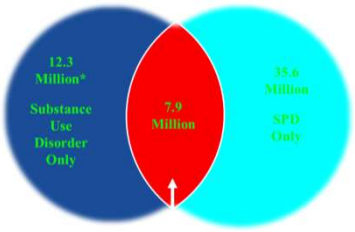
- Over 50% of people with schizophrenia, bipolar disorder and other severe mood disorders have a substance use disorder at some time in their life
- About one third of people with anxiety and depressive disorders have a substance use disorder at some time in their life
- According to SAMHSA's 2014 National Survey on Drug Use and Health, approximately 7.9 million adults had co-occurring disorders in 2014.

Co-occurring Disorders are Common

- 73% of persons in the criminal justice system with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime
- In substance abuse settings, very common to see:
  - Major Depressive Disorder (and other mood disorders)
  - Post-Traumatic Stress Disorder

SOURCE: "The Epidemiology of Co-Occurring Substance Use and Mental Disorders." COCE Overview Paper 8. DHHS Publication No. (SMA)07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Co-Occurrence of Serious Psychological Distress and Substance Use Disorders among Adults Aged 18 or Older



* NSDUH 2016

Prevalence and Incidence of COD

- Epidemiologic Catchment Area Study
  - Presence of a mental disorder triples the risk of having a co-occurring substance use disorder
  - Presence of addictive disorder quadruples the risk of having a co-occurring mental disorder
- National Co-morbidity Study
  - 83.5% of time, mental disorder precedes the addictive disorder
- National Survey of Drug Use and Health
  - Uses a uniform definition mental illness to identify 7.9 million Americans with Severe Mental Illness (SMI) and a co-occurring substance use disorder (SUD)

- Substance Abuse and Mental Health Services Administration. (2005). *Overview of the findings from National Household Survey on Drug Use and Health.* (Office of Applied Studies, NSDUH Series H-27, DHHS Publication No. 05-4061). Rockville, MD.

Course of Co-Occurring Disorders

Symptoms related to intoxication and withdrawal:

- Mask
- Mimic
- Initiate
- Exacerbate psychiatric symptoms

Interactive Complexity of COD

DEPRESSION	MANIA	ANXIETY	PSYCHOTIC	ORGANIC
ETOH Intox	ETOH Intox			ETOH Intox
	Amphetamine Intox	Amphetamine Intox	Amphetamine Intox	Amphetamine Intox
Cannabis Intox	Cannabis Intox	Cannabis Intox	Cannabis Intox	Cannabis Intox
Opioid Intox	Cocaine Intox	Cocaine Intox	Cocaine Intox	Cocaine Intox
Hallucinogen Intox	Opioid Intox	Hallucinogen Intox	Hallucinogen Intox	Hallucinogen Intox
Cocaine Withdrawal			PCP Intox	PCP Intox
Opioid Withdrawal		ETOH Withdrawal	ETOH Withdrawal	ETOH Withdrawal
Amphetamine Withdrawal		Cannabis Withdrawal		
Sedative-Hypnotic Withdrawal		Sedative-Hypnotic Withdrawal	Sedative Hypnotic Withdrawal	Sedative-Hypnotic Withdrawal

Quadrant Model for COD

I	II
Mild to moderate SUD Mild to moderate MH	Mild to moderate SUD Severe MH
III	**IV**
Severe SUD Mild to moderate MH	Severe SUD Severe MH

Quadrant Model for COD

Quadrant I
Low psychiatric problem severity
Low addiction severity

Quadrant II
High psychiatric problem severity
Low addiction severity

Quadrant III
Low psychiatric problem severity
High addiction severity

Quadrant IV
High psychiatric problem severity
High addiction severity

COD leads to worse outcomes than single disorders

- Relapse of mental illness
- Treatment problems and hospitalization
- Violence, victimization, and suicidal behavior
- Homelessness and Incarceration
- Medical problems, HIV & Hepatitis risk behaviors and infection
- Family problems
- Increase service use and cost

Traditional Treatment for COD

Historically, the approach has been to treat each disorder separately/independently.

- Parallel
  - Treating both disorders at the same time, however in different organizations, departments, or with different clinicians
- Sequential
  - Treating the disorders one at a time

Problems With Separate Mental Illness And Substance Abuse Treatments

- Different eligibility requirements
  - Not eligible or prematurely discharged
- Trouble accessing both services
  - Territorialism or parallel/sequential treatment approaches
- Primary/secondary distinction
  - Billing should not dictate service delivery on recovery based care

Problems With Separate Mental Illness And Substance Abuse Treatments

- Different treatment approaches
  - Harm Reduction versus Abstinence Based
  - Prescriptive versus Stage Wise treatment
- Variable clinical expertise and focus
  - Knowledge, skills, beliefs and attitudes
- Lack of integration
  - Waiting for resolution of one disorder before treating the other perpetuates the chronicity of COD.

Rationale For Integrated Treatment

If COD are more common than not in behavioral healthcare settings...

And, substance abuse worsens most outcomes (hospitalization, incarceration, risk of violence, victimization, homelessness, family disruptions, physical health, etc.)...

And, parallel/sequential treatment is less effective...

Then the real question becomes why ***wouldn't*** you have integrated co-occurring capability?

Integrated Treatment for COD Works

There is a robust body of empirical data which supports superior COD integrated treatment outcomes which now goes back several decades.

- McLellan et al, JAMA (1993)
- Saxon and Calsyn, Am J Drug Alc Abuse (1995)
- Charney et al, J Clin Psych (2001)
- Weisner et al, JAMA (2001)
- Mueser et al., Am J Addict (2003)
- Ziedonis, CNS Spect (2004)
- Mangrum et al, JSAT (2006)
- Van den Bosch and Vereul, Curr Opin Psych (2007)
- Drake et al., JSAT (2008)
- Xie et al., JSAT (2010)
- Baker et al., J Clin Psych (2010)
- Torrens et al., Sub Use & Misuse (2012)
- Kelly and Daley, Soc Wk Pub Health (2013)

Consider this…

- How do "we" (providers/practitioners/system) stigmatize the people we aim to help?
- What are our attitudes toward people with serious mental illness and co-occurring substance use issues?

Overarching Considerations

- Knowledge of Basic Addiction Issues & Integrated Co-occurring (Substance Use/Mental Health) Treatment Interventions
- Motivational and Stage-wise treatment approaches
- Recovery Oriented System of Care
- Trauma Informed Care
- Person-centered treatment planning

Stage of Change	Characteristics - Issues	Strategies
Pre-contemplation *"Unaware"*	"Nothing needs to change"	• RELATIONSHIP • TRUST • BASIC NEEDS
Contemplation *"On the Fence"*	"I am considering change"	• ACKNOWLEDGE MIXED FEELINGS • DEVELOP DISCREPANCY
Preparation *"Testing the Waters"*	"I am figuring out HOW to change"	• BUILD CONFIDENCE • INFO, OPTIONS, ADVICE • CAREFUL - DON'T PUSH…
Action *"Started Moving"*	"I'm working on reaching my goals."	• PLAN REACHABLE GOALS • TEACH RECOVERY SKILLS
Maintenance *"Holding Steady"*	"I've changed, now to just keep it up."	• SUPPORT CHANGE • RELAPSE PRE-PLAN
Relapse Prevention *"Falling off the Wagon" "Revisiting the Past"*	"I've gone back to old behaviors. Have I lost everything I worked for?"	• CAREFUL -AVOID SHAMING • WHAT WENT WRONG?! • TRY AGAIN!!

Integrated Care Strategies

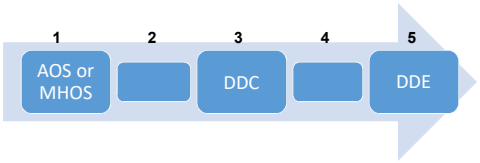
- Dual Disorder Capability for Addiction Treatment
  - DDCAT Index
- Dual Disorder Capability for Mental Health Treatment
  - DDCMHT Index
- Integrated Dual Disorder Treatment/IDDT
  - IDDT Fidelity Scales

DDCAT/CMHT Index

- 7 Domains
  - Subdivided into 35 Program elements
- Utilizes taxonomy outlined by American Society of Addiction Medicine (ASAM)

Continuum of Co-occurring Capability

1. Addiction Only Services/Mental Health Only Services
2. Dual Diagnosis Capable
3. Dual Diagnosis Enhanced



Dual Diagnosis Capable (DDC)

DDCAT

Programs that have some capacity to provide services for both disorders, however there is greater capacity to serve individuals with substance-related disorders.

DDCMHT

Programs that have some capacity to provide services for both disorders, however there is greater capacity to serve individuals with mental health-related disorders.

DDCAT/DDCMHT content

	Dimension	Content of items
I	Program Structure	Program mission, structure and financing, format for delivery of co-occurring services.
II	Program Milieu	Physical, social (welcoming), and cultural environment for persons with dual conditions.
III	Clinical Process: Assessment	Processes for access/entry into services, screening (acuity/severity), stage-wise assessment & dx.
IV	Clinical Process: Treatment	Processes for tx with interactive plans pharma and stage-wise, psychosocial evidence-based formats.
V	Continuity of Care	Discharge and treatment continuity for both problems and peer recovery supports.
VI	Staffing	Presence, role, integration of staff with co-occurring treatment expertise, supervision process.
VII	Training	Proportion trained and strategy for training.

Integrated Dual Diagnosis Treatment (IDDT) Implementation

- The model focuses on treatment for persons with severe and persistent mental illness and substance use disorder
  - Psychotic disorders
  - Bipolar disorders
  - Other severely disabling disorders

IDDT Fidelity Scale

General Organizational Index

Characteristics aimed at improving program's ability to implement any EBP

➢12 Items – multiple data sources

Treatment Index

Characteristics for IDDT Service Delivery

➢14 Items – multiple data sources

Organizational Characteristics

01: Program Philosophy

02: Eligibility/ Client Identification

03: Penetration

04: Assessment

05: Treatment Plan

06: Treatment

07: Training

08: Supervision

09: Process Monitoring

010: Outcome Monitoring

011: Quality Improvement

012: Client Choice

Treatment Characteristics

T1a: Multidisciplinary Team

T1b: Integrated SA Specialist

T2: Stage-Wise Interventions

T3: Comprehensive Services

T4: Time-unlimited Services

T5: Outreach

T6: Motivational Interventions

T7: Substance Abuse Counseling

T8: Group DD Treatment

T9: Family Psychoeducation on COD

T10: Participation in Self-help Groups

T11: Pharmacological Treatment

T12: Interventions to Promote Health

T13: Secondary Interventions for Treatment Non-Responders

Implementation Strategy

- Assess Readiness & Foster Consensus for Change
  - Identify Organization's Stage of Change
  - Work group/steering committee
- Baseline evaluation (or assessment)
- Action Plan
- Consultation, training and supervision
- Ongoing outcomes monitoring
  - Implementation – program-level
  - Intervention – participant-level

Implementation Lessons Learned

- Best practices and EBPs are preferred because they have strong conceptual support – and/or - empirical support that they work
- Training alone is insufficient to change practice behavior. On-going supervision is essential.
- Change occurs in stages and takes time

Implementation Lessons Learned

- Intellectual buy-in does not necessarily equal changed practice….new behavior is required
- Leaders often underestimate the complexity of implementation
- Using instruments that help you compare your progress across specific structural and clinical domains helps focus an intentional process
- Ongoing attention to process/fidelity/outcomes is critical

Helpful Resources

- CEBP Integrated Dual Disorder Treatment Resources: https://www.centerforebp.case.edu/practices/sami/iddt
- CEBP Dual Diagnosis Capability Resources: https//www.centerforebp.case.edu/practices/sami/ddc
- SAMHSA Co-Occurring Disorders Overview & Resources: https://www.samhsa.gov/disorders/co-occurring
- ASAM Public Policy Statement on **Definition of Addiction**, Adopted: April 12, 2011 http://www.asam.org/docs/publicy-policy-statements/1definition_of_addiction_long_4-11.pdf

Helpful Resources

- Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005
- Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: Building Your Program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
- Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.
- Center for Substance Abuse Treatment. *Clinical Supervision and Professional Development of the Substance Abuse Counselor. Treatment Improvement Protocol (TIP) Series* 52. DHHS Publication No. (SMA) 09-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

Helpful Resources

- National Institute on Drug Abuse. Drug Addiction Treatment: A Research Based Guide, Second Edition. NIH Publication Number 09-4180, 2009.
- White, W. (2008). Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.
- White, W.L. (2012). Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual Disability Services and Northeast Addiction Technology Transfer Center.

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- Stories
- Booklets
- Posters
- Audio
- Manuals
- Fidelity scales
- More

Stories

- News about us and our collaborators.
- Recovery stories told by consumers, family members, service providers, employers.
- Conversations with people who implement service innovations.

Our Mission

The Center for Evidence-Based Practices (CEBP) at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include the following:

- Service-systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Program evaluation (fidelity & outcomes)
- Professional peer-networks
- Research

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