

The SAMI CCOE is a partnership between the **Cuyahoga County Community Mental Health Research Institute** at the Mandel School of Applied Social Sciences, Case Western Reserve University (CWRU) and the **Department of Psychiatry at the School of Medicine, CWRU**. The partnership is in collaboration with the **Ohio Department of Mental Health**.

SAMI Matters

A NEWSLETTER OF THE OHIO SUBSTANCE ABUSE AND MENTAL ILLNESS COORDINATING CENTER OF EXCELLENCE (SAMI CCOE)

ODMH creates SAMI CCOE to support integrated services for dual disorders

The Ohio Department of Mental Health (ODMH) has awarded funds to the Cuyahoga County Community Mental Health Research Institute (CCCMHRI) at the Mandel School of Applied Social Sciences, Case Western Reserve University (CWRU) and the Department of Psychiatry at the School of Medicine, CWRU to establish a new training and research center that is dedicated to enhancing services to persons with dual disorders of severe mental illness and substance abuse addiction.

ODMH has funded the new CWRU-based *Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE)* as part of a larger state-wide initiative to improve the quality of services to mental health consumers. ODMH wants to enhance services to individuals with co-occurring disorders because these consumers are more likely to experience a psychiatric episode, hospitalization, and other negative outcomes than persons with mental illness who do not have a co-occurring disorder.

The SAMI CCOE is helping improve consumer outcomes by supporting the implementation of the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model at agencies throughout Ohio that have shown interest in the model. DDIT reduces gaps in service by incorporating substance abuse services within mental health systems (see page 12).

Service Efficiency

The Co-Directors of the SAMI CCOE are Lenore A. Kola, Ph.D., Associate Professor of Social Work at the Mandel School of Applied Social Sciences (MSASS) and Robert Ronis, M.D., MPH, Associate Professor of Psychiatry at the School of Medicine. Both Dr. Kola and Dr. Ronis have extensive experience in the development of training programs for providers of substance abuse and mental illness services. Under their joint leadership, the SAMI CCOE will combine evidence-based practices from both disciplines to support innovative, integrated biopsychosocial service models. These models will include teams of professionals from a variety of fields, including social work, medicine, nursing,

In Ohio, as in most states, the mental health and substance systems are separate. ODMH has funded the SAMI CCOE as a way to help agencies work together to address dual disorders effectively.

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Activities Update

Site visits reveal need for continuous training, networks of professional support



Patrick E. Boyle,
MSSA, LISW,
CCDCIII-E, CEAP

SAMI Training

As Director of Clinical Training, Mr. Boyle will oversee the CCOE's training initiative. He will provide clinical training and facilitate clinical consultation with professional staff in the State of Ohio's mental health and substance abuse service systems. He will conduct ongoing needs assessments with service providers through onsite visits. He will review research and training literature, attend conferences, and consult with practice experts in other parts of the country where DDIT is being implemented. With this information, Mr. Boyle will develop and deliver training programs and facilitate collaborative relationships with other trainers.



Providers of substance abuse and mental illness (SAMI) services who are implementing the Dual Disorder Integrated Treatment (DDIT) model in the State of Ohio have identified the need for continuous training in program development, clinical treatment, and team building as three necessary components for a successful SAMI Program.

These findings are the result of a needs assessment conducted by Patrick Boyle, MSSA, LISW, CCDCIII-E, CEAP, Director of Clinical Training at the Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE). Mr. Boyle traveled the State in January and February interviewing SAMI Program directors, team leaders, and staff who are utilizing the New Hampshire-Dartmouth DDIT (see page 12). He also interviewed representatives from county-level mental health and substance abuse services Boards in those counties where DDIT is being utilized.

According to Mr. Boyle, the SAMI Program directors and team leaders have specifically asked for "how to" tips for designing, implementing, and maintaining a DDIT SAMI Program. They have asked for the most recent clinical knowledge available to help them work more effectively with consumers. And, in the area of team building, they have asked for more information about how to recruit, retain, and encourage interaction among team members. Continuous training will help SAMI Programs maintain DDIT fidelity and team cohesiveness, Mr. Boyle explains, especially during transitional periods when new staff members join a treatment team. Research has shown that fidelity to DDIT is an important predictor of the long-term success of a SAMI Program.

"The CCOE's research team will give us a more accurate picture about what successful SAMI Programs in Ohio do to get started, to keep themselves going strong, and to help consumers identify and achieve their goals," Mr. Boyle says. "But the message from the service providers so far has been very clear. There

is a lot to learn and a lot to remember about how to integrate the many components of this model into practice. In order for it to work, everyone involved in providing care has to understand each other's role and strengths. Frequent and ongoing communication between team members is important to understanding consumer and staff needs."

Encourage Interaction

To respond to the training needs of service providers, the SAMI CCOE is developing a comprehensive delivery system that will incorporate the latest information from both research and practice. The CCOE will sponsor conferences, workshops, video conferencing, and consultations that will take place at agencies and via teleconferencing. These dissemination activities will be complemented with print and electronic communications, including this newsletter and a Web site that will be designed as a comprehensive training and research information resource for service providers who wish to develop, implement, and sustain a SAMI Program in Ohio.

According to Mr. Boyle, the CCOE has already begun its training initiative but will commence its formal training activities in June by hosting a two-day conference that will focus on the lessons that have been learned about DDIT in Ohio. (see *Conference* on page 16).

"The keywords for this conference are 'network' and 'professional social supports,'" Mr. Boyle says. "When I was meeting with the providers during my needs assessment visits, their eyes would light up and they would start taking notes whenever I would talk about the activities in other programs I had visited. They wanted to know who was doing what, how they did it, and if those people were willing to meet or have a conversation to share what they've learned. So we decided to make this the focus of our first conference. We want to encourage them to interact."

The informal networks that providers develop as the result of the SAMI CCOE's training events, Mr. Boyle explains, will

Ohio SAMI Programs

The Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) have jointly funded nine agencies throughout the State of Ohio to demonstrate the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model. The SAMI CCOE is supporting these funded agencies, as well as other agencies throughout Ohio, in the development, implementation, and ongoing operation of integrated Substance Abuse and Mental Illness (SAMI) Programs.



- 1 Lorain County**
The Nord Center
Lorain, Ohio Recovery Resources
Elyria, Ohio
- 2 Cuyahoga County**
Bridgeway, Inc.
Cleveland, Ohio
- 3 Summit County**
Community Support Services
Akron, Ohio
- 4 Portage County**
Coleman Professional Service
Kent, Ohio Townhall II
Kent, Ohio
- 5 Stark County**
Nova Behavioral Health, Inc.
Canton, Ohio
- 6 Butler County**
Butler County Court
Hamilton, Ohio Horizon
Hamilton, Ohio

- 7 Southern Consortium for Rural Care**
Health Recovery Services
Tri-County Mental Health
and Counseling Services
Athens, Ohio
Washington County
Community Mental
Health Service
Recovery Alternative
Marietta, Ohio Woodland Centers,
Inc.
Pomeroy, Ohio
Shawnee Mental
Health Center
Portsmouth, Ohio
- 8 Four Board Collaborative**
Lutheran Social Services
Lima, Ohio
- 9 Richland County**
Center for Individual and Family Services
Mansfield, Ohio

help accelerate learning and retention of DDIT principles and team-building skills. It will also help spread awareness of “tricks of the trade” (or lessons learned) more quickly. The goal is to get program administrators, team leaders, and staff within each agency to communicate with each other and with their peers at other agencies throughout the State.

“We’ll facilitate the dialogue process with our training events, observe what happens, solicit feedback about what works and what doesn’t work at those events, and design another set of programs that responds to the needs of service providers,” Mr. Boyle says. “This will be an ongoing process that will allow us to continually reinvent the SAMI CCOE so that it is a responsive organization.”

The knowledge that the service providers gain from each other, as well as from other experts in dual disorders, Mr. Boyle concludes, will enable them to adapt to changes in the social, political, economic, clinical, and institutional environments in which their consumers live. It will enable the providers to make DDIT a dynamic model of service delivery that responds efficiently and effectively to the most current needs of consumers in Ohio.



SAMI CCOE Services

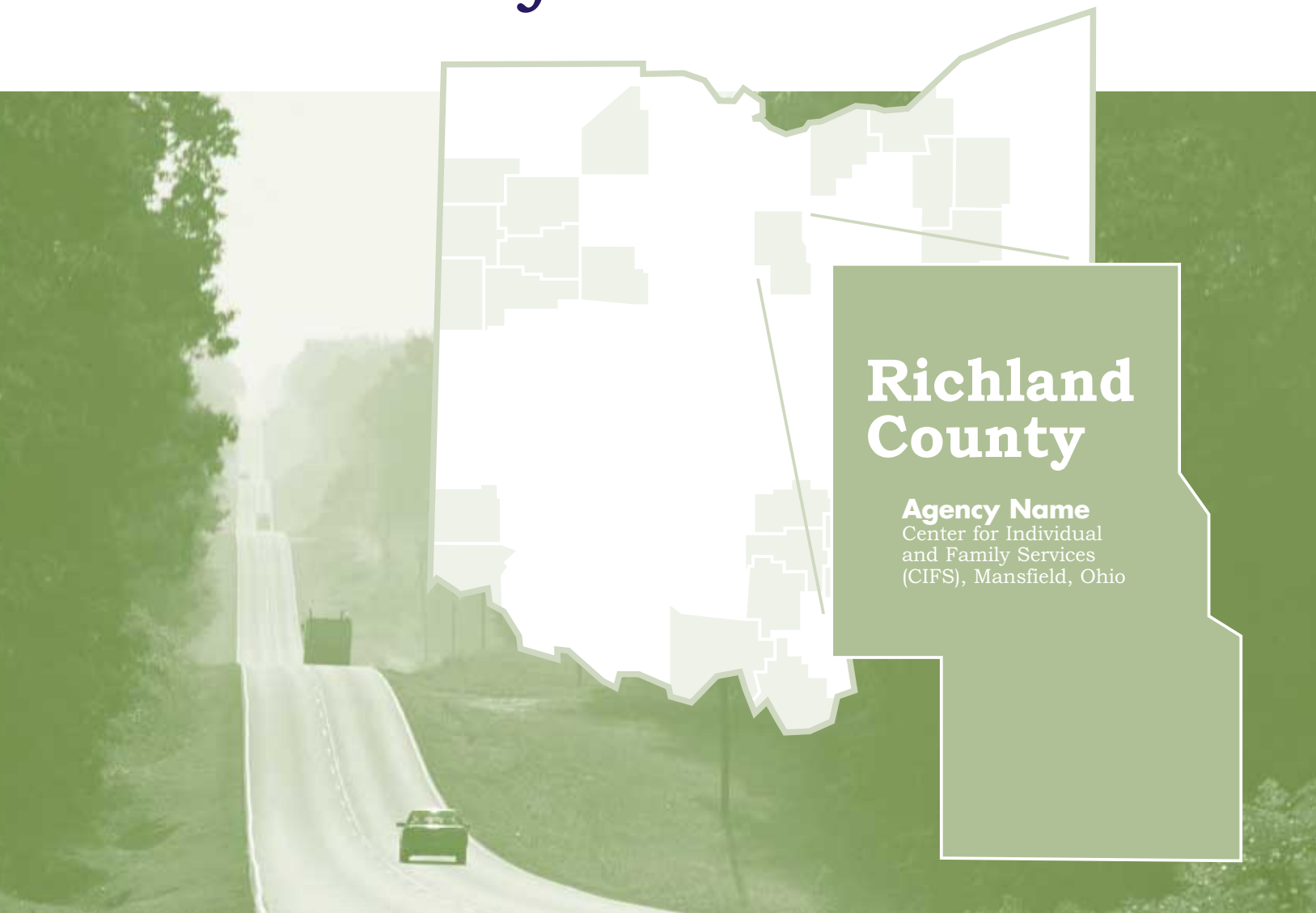
The SAMI CCOE offers a variety of services to providers of dual disorder services who are implementing, or are interested in implementing the New Hampshire-Dartmouth Dual Disorder Integrated Treatment model (DDIT).

The SAMI CCOE

- encourages formal and informal networks of support among service providers who are utilizing DDIT
- offers DDIT program-development consultation, clinical consultation, and clinical training to service providers;
- provides research and evaluation services to assist integrated Substance Abuse and Mental Illness (SAMI) Programs with the measurement of program fidelity and consumer outcomes (see *Research* on page 15); and
- disseminates evidence-based research and interventions through its training initiatives, as well as through a unique communications delivery system that includes print, electronic, and video communications.



Agency Profile



Richland County

Agency Name

Center for Individual and Family Services (CIFS), Mansfield, Ohio

Agency Director

Veronica L. Groff, LSW, CCDCCIII-E,
President and Chief Executive Officer

SAMI Team Leader

David Ross, MEd, PCC, CCDC I

SAMI Staff

- 3 full-time case managers
- 1 full-time outreach worker
- 1 full-time counselor
- 1 half-time counselor
- 1 full-time nurse
- 1 full-time residential manager
- 1 half-time psychiatrist

Consultants to SAMI Program

- vocational services
- mobile crisis services
- crisis stabilization unit (8 beds) with a 24/7 help line
- hospital utilization monitoring team

Total Number of Dual Disorder Clients

- 60

Case Load

- Each case manager is assigned a maximum of 15 dual disorder cases.

Agency Services

- case management
- psychiatric services
- nursing services
- individual counseling
- family counseling
- group counseling
- addiction counseling
- prevention services
- integrated substance abuse and mental illness services
- crisis counseling
- hotline services
- mobile triage services (for children, adolescents, and adults)
- housing services for adults

Contact Information

- 419-756-1717

SAMI Program Components

Outreach

A full-time outreach worker remains in contact with individuals who are not convinced that they can benefit from SAMI services. The outreach worker engages consumers in continuous dialogue as a way to build a trusting relationship that will hopefully lead to treatment.

Drop-In Center/Clubhouse

The drop-in center is staffed and operated by consumers. It provides a safe space and a support network for consumers by offering meals, recreational activities, social activities, and basic living-skills training. Consumers teach each other how to shop, cook, clean, manage money, utilize public transportation, prepare for a general education diploma (GED), and improve social skills, among others.

Multiple Family Psychoeducational Support Group

Not to be confused with group therapy. This group is for family and friends of persons with dual disorders. The multiple family group encourages caregivers to teach each other skills that will help them manage their stress while they help their family members or friends manage their mental illnesses and substance abuse addictions.

- meets once per month
- encourages caregivers to develop informal networks of support
- attendance fluctuates between 2 to 15 caregivers

Group Home

This facility is open to men and women who do not have the option of staying with family or friends. It is for individuals who want or need more structure in their lives than independent living can offer. The group home enables consumers to relearn life-management skills before returning to independent living or to the home of family and friends.

- 8 beds
- temporary facility
- average stay of 6 months

Individual/Group Counseling

The unique interplay between mental health and substance abuse issues are addressed in a manner consistent with guidelines from the New Hampshire-Dartmouth Psychiatric Research Center, where DDIT was developed.

- time unlimited
- solution-focused and strength-based
- persuasion groups
- active treatment groups
- relapse prevention groups
- intensive outpatient services

Case Management

These services are provided via the strength-based perspective. Case managers are active in the community. They spend most of their workday in community locations where consumers live and work.

- skill groups (7 per week)
- activities of daily living (ADL) support
- linking to and coordinating of services as appropriate
- payee support



The unique interplay between mental health and substance abuse issues are addressed in a manner consistent with guidelines from the New Hampshire-Dartmouth Psychiatric Research Center, where DDIT was developed.



Richland County produces results with patience and persistence

The team's dedication, the sound training, and administrative support have all contributed to the successes [of the SAMI Program]

— Veronica L. Groff, LSW, CCDCIII-E, President and Chief Executive Officer of CIFS

The news from Richland County's SAMI Program is that the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model works in Ohio. Because of DDIT, consumers in Richland County who have co-occurring disorders of substance abuse and mental illness are remaining out of hospitals, functioning in social settings, being reunited with their families, and finding and maintaining jobs. Richland County's SAMI Team Leader David Ross, MEd, PCC, attributes his program's success directly to DDIT.

When Richland's SAMI Program began in July 1999, only 35 consumers expressed interest in its integrated services. The number has since increased to 60. The program will not add any more cases unless it can acquire funds to add more staff. Effective DDIT insists that service teams maintain a small caseload so they can deliver intensive, individualized services. Ross limits his staff to a maximum of 15 consumers.

Success appears to have come slowly to the Richland County SAMI Program, Ross says, because it has taken two years for the team to see any significant results. The reason for this, he explains, is that it can take consumers up to two years to progress through the first two stages of treatment and into the third stage, where positive outcomes occur more consistently (see *Model* on page 12). He advises other agencies that are implementing, or wish to implement, the DDIT to be patient about

outcomes and to be persistent about maintaining fidelity to DDIT.

"The first two years are the most expensive because you are focusing on the first two stages of treatment, which are the most time consuming and, therefore, the most expensive," Ross says. "You will see the savings, but you've got to hang in there. It takes time to reduce hospital stays, return folks to employment, and stabilize individuals in appropriate housing."

Agency & Board Commitment

The Richland County SAMI Program is housed at the Center for Individual and Family Services (CIFS) in Mansfield, the county seat. Ross credits the proactive philosophy of CIFS and the Mental Health and Recovery Services Board (MHR SB) of Richland County for planting and cultivating the seeds of change in Richland County. MHR SB is a combined Board. That is, it provides funds for and oversees the administration of mental health and substance abuse services from one county-level administrative entity. Many counties in Ohio have two separate Boards.

For years, Ross explains, CIFS has provided a comprehensive set of services under one roof and has delivered those services with a team approach. In addition, CIFS began to use DDIT even before the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services awarded them



funds to demonstrate the model.

According to Veronica L. Groff, LSW, CCDCIII-E, President and Chief Executive Officer of CIFS, the agency has committed itself to DDIT because it understands the value of integrated services.

“It has always been my philosophy to do what works and SAMI treatment works,” Groff says. “It is a rational approach to a consumer’s multiple needs. The team’s dedication, the sound training, and administrative support have all contributed to the successes [of the SAMI Program].”

According to the MHR SB’s Associate Director Steve Stone, MA, LPCC, CCDCIII-E, Richland County began to pursue DDIT in the mid 1990s and connected with Robert Drake, M.D., one of the originators of the model during the Fall 1997 Research Forum of the Cuyahoga County Community Mental Health Research Institute (www.cwru.edu/affil/cccmhri).

“Momentum has been building since that time,” Stone says. “The SAMI

Program is providing our system with an opportunity to bring about a significant change in the culture of the service delivery system. The tensions and ideological differences of the mental health field and the [substance abuse] field are invited out into the open. These issues can be discussed and debated in a more meaningful way. Integrated services will remain a high priority for this Board.”

Stone concludes that the systemic changes, although important, are not the most impressive. The most significant advances are occurring in lives of consumers.

“I cannot emphasize how important this is,” he says. “These are the people who have been the most difficult to engage. These are the people who have suffered in the past, not only as outcasts in society but as misfits in our systems. I am very pleased that this is all beginning to change.”



Team Building

Richland county thrives on consistent communication

Discussion is the key to conflict resolution. Conflict should not be hidden. I encourage frank discussion because I don't want my team members to think they can't disagree.

— David Ross, SAMI Team Leader, Richland County

David Ross, MEd, PCC, CCDC I, does not mind when his staff disagrees with him or with each other. In fact, he expects it.

As the Team Leader of the SAMI Program at the Center for Individual and Family Services (CIFS) in Richland County, Ohio, Ross works with clinicians from a variety of professional backgrounds on a daily basis. The different points of view, different vocabularies, and different philosophies of these disciplines often create a cacophony of conflicting opinions. As Team Leader, it is Ross' job to turn that noise into music.

"The challenge for me is to validate what somebody knows and to teach them that there are different ways to look at things and alternative strategies to doing things," Ross says. "I have to be delicate yet assertive. I am constantly trying to find new ways to tell people 'I want your experience; how can we tailor it to this specific model?'"

Ross agrees that his role is similar to the role of a good bandleader because he must channel individual talent into a unified cause—a symphony of sorts. How does he do it? Simple.

"Talk. Talk. Talk. Talk," he says. "Discussion is the key to conflict resolution. Conflict should not be hidden. I encourage frank discussion because I don't want my team members to think they can't disagree. We have a process. The process is similar to Hegelian Dialectics. There is thesis, antithesis, and synthesis. We also have rules for achieving synthesis. You can't put another person down, and you can't be afraid to put your beliefs on the line and defend them."

Outreach Worker Greg Burks confirms what Ross describes as the secret to his team's success. "David is our synthesis man," he says. "He's done a great job of balancing opinions. He allows us to put all of our frustrations on the table and to redirect us in a constructive way."

Adult Case Manager Kim Romoser agrees. She explains that Ross has been able to encourage an atmosphere of respect and trust in the workplace mainly because he has included himself as a member of the team.

"A lot of my bosses at my previous jobs had the attitude of 'I'm your supervisor and you will do what I say,'" Romoser says. "David doesn't have that attitude. He doesn't yell and scream but he does bring mistakes to our attention. If there is a problem between staff, he encourages us to try to solve it by ourselves first. If we can't, then he'll invite us into his office."

Assembling the Team

The willingness to cooperate and to work together toward resolution is a personality trait that Ross looks for when recruiting team members. When interviewing applicants, he looks for previous team experiences, especially from organized sports and the military.

"Team members have to know how to rely on someone else to help get a job done," Ross says. "They need to be able to demonstrate this skill, not just talk about it. If you are going to work with dual disorder clients, you have to rely on your peers for their opinions and help. These [consumers] are too complicated. You cannot do everything yourself. You'll burn out."

The second and equally important trait that Ross looks for is a commitment to DDIT. If there is one person on the team who rejects the model or is not in agreement with it, he explains, the entire SAMI Program will struggle. If all team members are committed to DDIT, though, the model becomes the common ground upon which differences are resolved. It becomes the unifying principal. Ross uses a sports analogy to illustrate his point.

"The way I see it, everyone on this team is from different parts of the neighborhood and we're all getting together to play baseball," he says. "We've lost some team members in the past because they did not like [DDIT]. They were committed to another model. It's like they wanted to play soccer because they're good at playing soccer. I recognize that. Those skills are good if we are playing soccer. But the game we're playing is baseball."

Richland County's SAMI Team has not lost a team member since April 2000.



“There is something magical about doing direct work, about sitting down with folks and working with them through their journeys. I had to fight to keep a small caseload, but it was worth fighting for.”

— David Ross, SAMI Team Leader,
Richland County

RICHLAND

Talk techniques

SAMI Team Meetings

- twice per week for one hour
- team members discuss consumer activities
- physicians discuss possible effects caused by the mixing of medication with drugs and/or alcohol

Clinical Meetings

- once per week for one hour
- discuss and role-play clinical skills, such as reflective listening and motivational interviewing, etc.

Systems Meetings

- once per week for one hour
- review paperwork and other administrative issues

One-On-One Meetings

- every day
- team leader talks with each team member
- discuss consumer experiences, especially crises and relapse
- discuss clinician's reactions to and experiences with consumers to sort out confusion, clarify

questions, identify solutions, manage stress, and maximize the clinician's response to consumer needs

- identify team issues, system issues, and/or clinical issues that need to be addressed

Team leader survival

RICHLAND

David Ross has a technique for staying connected with consumers and team members and for managing his stress. He refuses to recommend his method as a prescription for other SAMI Program Team Leaders. The method just happens to work for him.

- conducts research about advances in clinical methods and leadership skills via the World Wide Web
- renews his knowledge and

sharpens his skills by attending continuing education courses and workshops

- develops peer networks by attending state-wide meetings, conferences, workshops, and continuing education courses
- maintains a small caseload of five to eight clients to stay connected with the consumers and team members: “It’s a mistake to leave all the direct care behind,” he says.

“Administrative work is a whole different ballgame, and you can easily lose touch.”

- engages in activities not related to dual disorder treatment: “I do not eat, drink, and breathe SAMI,” he says. “Church, family, fun, and travel are important to me. I like to interact with people from other cultures. I like to learn how people think.”

Stages of team development

RICHLAND

- write job descriptions/identify staff positions to fill
- identify characteristics of desired team members
- identify background experiences that would have helped a clinician develop the desired characteristics
- recruit clinicians; do not recruit clinicians who say they can do everything
- train clinicians for 30 to 32 days through shadowing
- gradually build case load: assign cases after the training/shadowing period ends; begin with two or three cases and gradually increase to a maximum of 10 to 15 over six months
- foster growth of team members: offer constant and consistent feedback; provide time and financial resources for continuing education courses and licensure exams
- manage stress, minimize burnout: assign low caseloads; provide access to training workshops; encourage clinicians to readjust their views of consumer progress (e.g. if a consumer says that riding the bus by him or herself is progress, then the clinician should view this activity as progress)

For SAMI Team Leaders

Principles of client-centered management

Include clients as active participants in service rather than as passive recipients; include them in agency decisions, operations, and community activities

This is an abbreviated version of Client-Centered Management (CCM). We encourage readers to learn more about CCM by contacting the source listed at the end of this article.

Venerate the People We Call "Clients"

- know clients' names, habits, preferences, and idiosyncrasies
- talk about clients in a respectful, humanistic and positive manner, not as symptoms, diagnoses, and other derogatory labels
- enable clients to determine the location of services in the community
- talk with clients about topics that are of interest to them, not just about their mental illnesses or substance abuses
- include clients as active participants in service rather than as passive recipients; include them in agency decisions, operations, and community activities
- talk about and make case notes about clients' strengths, abilities, and talents

Learn for a Living

- actively seek clients and staff to evaluate the performance of supervisors and the performance of agency programs
- involve clients and staff in meetings and decisions about changes to programs
- encourage a learning environment in an open, inquiring supervisory structure and support continuing education opportunities for staff
- hire curious people who are committed to learning
- incorporate ideas into new approaches and products
- openly discuss mistakes and failures with staff to identify ways to change or improve

Disrespect "The Impossible"

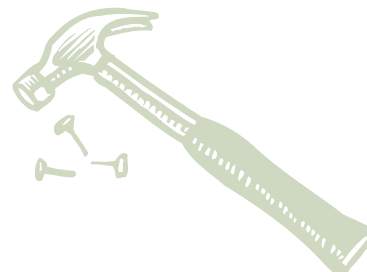
- view problems as opportunities or challenges to improve environments for clients and staff
- develop partnerships with community organizations to maximize opportunities to meet clients' needs
- remove out-dated policies, procedures, and paperwork that inhibit new ideas and service innovations; take responsibility to remove obstacles and barriers
- avoid blaming external obstacles, such as shortages of funding, staff, and supplies
- commend and reward risk-taking
- encourage the organizational culture to embrace doing "whatever it takes" to meet clients' needs

Focus on Client Outcomes

- ask clients to identify desired outcomes of programs and use these as program goals
- discuss client outcomes at every meeting, including group supervision sessions
- celebrate client outcomes as program successes and as connected to program decisions and policies
- reward staff for helping clients achieve outcomes



Source: Linda Carlson, LMSW, Mental Health Project Coordinator, School of Social Welfare, University of Kansas. Contact Ms. Carlson at 785-864-3796. Ask for the "Supervisor's Tool Box".



ODMH creates... Continued from page 1

In Ohio, as in most states, the mental health and substance systems are separate. According to Dr. Kola, ODMH has funded the SAMI CCOE as a way to help agencies work together to address dual disorders effectively.

"Many consumers do not receive the maximum benefits from traditional psychiatric treatment settings or traditional, primary substance abuse treatment programs," Dr. Kola says. "We hope that a new area of professional expertise will emerge that combines the best evidence-based practices of both fields."

Dr. Ronis agrees that the separation of treatment for mental illness and treatment for substance abuse has had negative clinical consequences.

"In the traditional approach, physicians try to determine which disease is primary and ignore the other," he says. "Clinicians have recognized for years, and now the research is supporting the notion, that to be effective in working with these difficult cases one must address both problems at the same time. As a result, the physician has to adjust his treatment expectations and the rigidity of the traditional medical intervention."

Dr. Ronis adds that in order for physicians to be more flexible, they must be informed about which methods produce the best results. Then they have to be trained in the use of those methods. The SAMI CCOE will provide that training.

Training and Research

According to Dale P. Svendsen, M.D., Medical Director of ODMH, the State of Ohio has endorsed the New Hampshire-Dartmouth DDIT as the treatment of

choice for persons with dual disorders throughout the State because the research evidence shows that it improves outcomes. The SAMI CCOE, he explains, will play an important role in helping to improve outcomes through its training, research, and consultation activities.

"We want the SAMI CCOE to be the consultant and the educator to help agencies around the state implement this best practice," Dr. Svendsen says. "This is a very big project that demands a lot of time, resources, and expertise. That's why we think it's a good idea to partner with entities like universities who have the expertise to take on a project of this magnitude and help us produce the desired results."

According to Michael Hogan, Ph.D., Director of ODMH, other states have experimented with the CCOE approach as a way to support clinicians and case managers. Thus far, CCOEs appear to be the best way to make evidence-based practices work, especially in larger states. Dr. Hogan adds that ODMH intends to learn more about the CCOE strategy through collaboration and formal evaluation. CWRU's SAMI CCOE is in collaboration with ODMH.


"In the long run, the proof of the CCOE strategy will be whether practice changes and consumer outcomes improve," Dr. Hogan says. "Thus, we have funded the [SAMI] CCOE as a kind of 'venture capital' strategy. But over the next couple of years, the community mental health marketplace will have to decide if it is willing to invest in quality, and whether CCOEs can provide it."



Lenore A. Kola, Ph.D., Co-Director, SAMI CCOE



Robert Ronis, M.D., MPH, Co-Director, SAMI CCOE

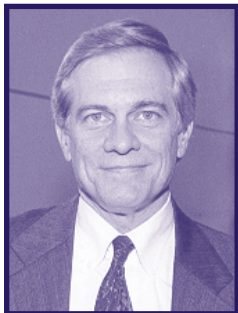


Over 50 percent of the people in the State of Ohio who have been diagnosed with a severe mental illness have also been diagnosed with a co-occurring substance abuse disorder. Persons with a dual disorder are more likely to experience higher rates of

- psychiatric episode
- hospitalization
- violence
- incarceration
- homelessness
- infectious diseases, such as HIV and hepatitis

Dual Disorder Integrated Treatment (DDIT)

The New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model reduces gaps in service to persons with co-occurring disorders of substance abuse and mental illness by incorporating substance abuse services within mental health systems. DDIT utilizes pharmacological, psychological, and social treatments (i.e. biopsychosocial treatments), as well as educational programming (i.e. psychoeducational programs), to address the needs of consumers and their caregivers. DDIT is built on a specific protocol of program development. It is also built on a specific protocol for working with consumers primarily in



Robert E. Drake,
M.D., Ph.D.

communities where they live and work, not just in mental health centers.

The New Hampshire-Dartmouth DDIT was developed at the Dartmouth College Medical School and Psychiatric Research Center by Robert E. Drake, M.D., Ph.D., Andrew Thompson Professor of Psychiatry and Community and Family Medicine, and his colleagues at Dartmouth College. DDIT was developed for the New Hampshire Division of Mental Health and Developmental Services.

Below is a summary of DDIT's core program components.

1 Continuous Treatment Teams

Integrated substance abuse and mental illness (SAMI) services are delivered by a multidisciplinary continuous treatment team, which includes a half-time psychiatrist, at least one full-time nurse/case manager, three primary clinical case managers, and a counselor. These clinicians collaborate to discuss and plan treatment. At least one clinician with chemical dependency treatment experience participates in all discussions. Team members work with consumers and caregivers to help the consumers manage their mental illness and substance abuse. Treatment teams must have small caseloads. Team leaders should limit team members to a maximum of 10 or 15 cases.

2 Assertive Outreach

Team members are available 24-hours per day, seven days per week and meet with consumers primarily in homes and other community locations, not just in mental health centers. Through assertive outreach, consumers gain access to intake and placement, community housing programs, crisis response, brief hospitalization services in local general hospitals, state hospitals, medication maintenance, family psychoeducational programs, formal and informal social supports, and social and vocational rehabilitation.

3 Treatment

DDIT recognizes that consumers with dual disorders typically progress slowly through the treatment process. DDIT has been divided into four stages that enable service providers to work at the consumer's pace, which, therefore, is non-threatening to consumers. The goal of treatment is to prevent symptomatic relapse and hospitalization in all four stages (see page 13).

4 Training

DDIT uses large conferences to stimulate interest in SAMI services among service professionals. The conferences also provide core educational components and create dialogue between service professionals. DDIT uses in-person or video-conference training sessions to engage practitioners in an ongoing training process. Training programs are designed to appeal to all professional disciplines represented on the continuous treatment team.

Stage 1: Engagement

Consumers with co-occurring disorders are often non-compliant with prior treatment recommendations or uninvolved with the mental health system.

- Team members should not give up on consumers who are non-compliant and disinterested in treatment. It is the primary responsibility of team members to make contact with consumers. This will build trust, which will eventually lead to interaction.
- Team members must convince consumers that providers have something they want or need, such as practical information or direction for fulfilling their housing, financial, physical health, social, or vocational needs.
- Legal constraints and involuntary interventions are sometimes necessary.
- Family members, though equally difficult to engage, are an important target for outreach efforts.

Stage 2: Persuasion

Consumers with co-occurring disorders are typically unmotivated to control their substance abuse.

- Team members must convince consumers to consider the possibility of long-term abstinence-oriented treatment.
- Team members should utilize consumer peer groups to persuade consumers to become and remain sober and compliant with medication prescriptions. Peer groups are often the most effective means of persuading consumers to remain sober and compliant.

Stage 3: Active Treatment

Consumers tend to respond more positively and remain committed to treatment that is tailored to their specific needs.

- Team members should use a variety of medical, behavioral, educational, individual, family, and group interventions to help consumers remain abstinent and sober.
- Clinical assessment is an ongoing process to determine psychiatric severity and type and degree of chemical dependency.
- Community-based support groups are helpful during this stage.

Stage 4: Relapse Prevention

Consumers with dual disorders are prone to relapse, so the retention of consumers in treatment over time is vital.

- Team members should anticipate relapse and plan prevention efforts with consumers and family members.
- Team members should discuss the possibility of relapse with consumers and family caregivers at the onset of treatment.
- Research has identified some common predictors of relapse. They include but are not limited to the following: medication prescription noncompliance, social withdrawal, losses (such as the transfer of case management, the ending of relationships, the death of loved ones), difficult anniversaries, holidays, wavering optimism, and controlled substance use, among others.

Team members are available 24-hours per day, seven days per week and meet with consumers primarily in homes and other community locations, not just in mental health centers.



5

Research & Program Fidelity

The DDIT model assumes that clinical services and research should cross-fertilize each other. Clinicians are included in the research process, and researchers are included in program design and development.

A research team evaluates the treatment process, treatment outcomes, consumer and family caregiver satisfaction, and fidelity to the core components of DDIT. Research has shown that DDIT works best when integrated mental health and substance abuse systems fund programs to adhere closely to the core components of the model. Fidelity measures evaluate how faithful agencies have been to DDIT. Poor consumer outcomes must not be attributed to DDIT if a SAMI Program does not develop, implement, and maintain its program as prescribed by the model.

Source: Robert E. Drake, M.D., Ph.D., Gregory B. Teague, Ph.D., S. Reid Warren, III, MSW, (1990) Dual Diagnosis: The New Hampshire Program, *Addiction and Recovery*, June, 35-39.



Motivational Interviewing

Encouraging behavior change among individuals



Motivational interviewing (MI) is a directive, client-centered counseling style that encourages behavior change among individuals who have substance abuse addiction. It was developed by William R. Miller, Ph.D., and Steve Rollnick, Ph.D. Dr. Miller characterizes MI as a “kinder, gentler confrontation,” though it is more goal directed than non-directive counseling. MI helps individuals identify, explore, and resolve their own ambivalence about changing their behaviors.

“It is inappropriate to think of motivational interviewing as a technique that is applied to or ‘used on’ people,” Drs. Rollnick and Miller write. “Rather, it is an interpersonal style whose use is not restricted to formal settings. . . . If motivational interviewing becomes a trick or a manipulative technique, its essence has been lost.”

MI strategies have been adapted for the co-occurring disorders of substance abuse and severe mental illness, as well as for a number of other behaviors, including risky sexual practices and eating disorders, among others. Below are a few highlights of MI.

- Clinicians elicit the motivation to change from the consumer. Clinicians should not impose the motivation. Unlike other therapeutic techniques,

MI does not emphasize coercion, persuasion, constructive confrontation, and the use of external contingencies (or consequences), such as the threat of job loss.

- It is the consumer’s task to articulate and resolve his or her own ambivalence about changing his or her behavior. It is the clinician’s task to help the consumer express both sides of the ambivalence (i.e. the positive and negative consequences of changing their behavior). It is also the clinician’s task to guide the consumer toward an acceptable resolution that triggers change.
- Direct persuasion is not an effective method for resolving ambivalence. Persuasion tactics generally increase resistance from consumers.
- Clinicians should not interpret resistance from the consumer as a trait of the consumer. Clinicians should view resistance as a response to his or her own behavior. Resistance is typically a signal that the clinician is assuming a greater readiness by the consumer to change than is present. If resistance occurs, the clinician should modify his or her motivational strategies.



Source: <http://www.motivationalinterview.org/clinical/whatis-mi.html>. Stephen Rollnick, Ph.D., & William R. Miller, Ph.D.

RESOURCES:

World Wide Web
<http://www.motivationalinterview.org/>

Books
Miller, W. and Rollnick, S. (1991) *Motivational interviewing: Preparing people to change addictive behavior.*

Protocols
Treatment Improvement Protocols (TIPS) Series. “Enhancing Motivation for Change in Substance Abuse Treatment”. TIP No. 35 (Order No. BKD342) National Clearinghouse for Alcohol and Drug Information (NCADI) 800-729-6686.

Manuals
Miller, William (1993) *Motivational enhancement therapy manual: A clinical guide for therapists treating individuals*

with alcohol abuse and dependence. National Clearinghouse for Alcohol and Drug Information (NCADI) 800-729-6686.

Videos
Motivational Interviewing: A complete professional training videotape series (six tapes). The University of New Mexico, Albuquerque, New Mexico 505-277-2805.

Research & Evaluation

Developing a continuous quality improvement mechanism

Under the leadership of David Biegel, Ph.D., Director of Research and Evaluation, and Barbara Wieder, Ph.D., Assistant Director of Research and Evaluation, the SAMI CCOE will be studying the effectiveness of the implementation of the New Hampshire-Dartmouth Dual Disorder Integrated Treatment (DDIT) model in Ohio. The research will provide agencies with feedback concerning the degree to which their programs have maintained fidelity to the model, as well as with feedback about outcomes obtained from treatment. This information can then be used by agencies as part of their quality improvement process.

“Fidelity is a crucial issue that comes up time and time again in research that pertains to evidence-based practices,” Dr. Biegel says. “If you are going to implement a model that has generated good outcomes somewhere else, you have to stick to

essential elements of that model. You can’t just pick an element here and choose an element there and avoid the rest. That’s a prescription for failure.”

The research team will also examine how DDIT may need to be altered to adapt successfully to Ohio’s decentralized mental health and substance abuse services systems, as well as to Ohio’s diverse communities. In Ohio, the availability of financial resources for substance abuse and mental health services varies from region to region and community to community.

Dr. Biegel explains that the research will enable the SAMI CCOE to develop a continuous quality improvement mechanism to measure the effectiveness of specific program implementation strategies and training activities that are developed, implemented, and/or coordinated through the SAMI CCOE.



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Director of Research
and Evaluation



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SAMI Matters is produced three times a year by the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE), a partnership between the Cuyahoga County Community Mental Health Research Institute at the Mandel School of Applied Social Sciences, Case Western Reserve University (CWRU) and the Department of Psychiatry at the School of Medicine, CWRU. The partnership is in collaboration with the Ohio Department of Mental Health.

Additional copies of this publication may be obtained by contacting the Ohio SAMI CCOE. We welcome and encourage your comments, questions, and suggestions.

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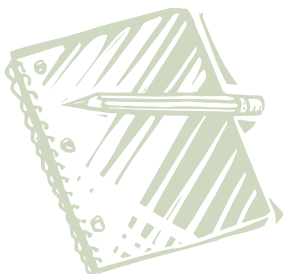
Got a story to tell? Write it down.

We'd like to share program successes from the people who live them.

If you are a member of a SAMI Team in Ohio who has an insight to share with other teams, write the story and send it in. We'll set aside some space in upcoming issues for your columns. Topics might include stories about consumers, new program developments, team building, and successful clinical techniques. If you don't want to write it yourself or don't have the time, don't let

your observations, ideas, and insights go unheard. Success of integrated services in Ohio depends upon you. Give us a call or e-mail us. We can arrange to interview you and write the story ourselves. The choice is yours.

Just keep the communication flowing. Our contact information is listed on page 15.



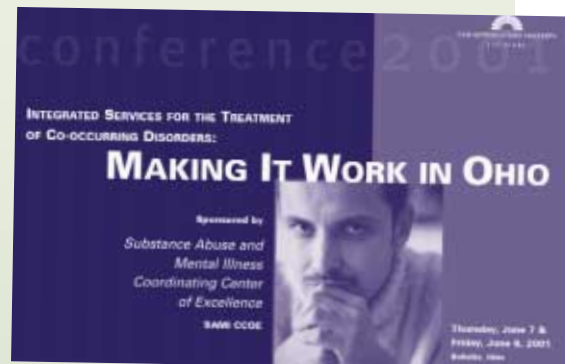
Conference 2001

Integrated Services for the Treatment of Co-occurring Disorders: Making It Work in Ohio

This conference will focus on the lessons that have been learned from the nine agencies in the State of Ohio that have been demonstrating the Dual Disorder Integrated Treatment (DDIT) model. The conference will feature keynote presentations, as well as panel and poster presentations and workshops.

Topics of discussion will range from policy issues to everyday practice concerns. Many presentations will take a "how to" approach. They will focus on program implementation, program evaluation and outcome measures, SAMI team building for team leaders, motivational interviewing, housing and competitive employment for consumers, understanding diagnoses, medication management, and the role of agency liaisons in supporting the growth of community supports for family caregivers and consumers in the recovery process.

This conference will enhance the understanding and the practices of service providers, administrators, and policy makers alike.



DATE

Thursday, June 7 & Friday, June 8, 2001

LOCATION

Der Dutchman restaurant and conference center,
Bellville, Ohio. I-71 at Route 165.

ATTENDANCE IS BY INVITATION ONLY

However, brochures are available at no cost for anyone who wishes to learn more about the content of the SAMI CCOE's Conference 2001. Contact the SAMI CCOE or log on to <http://www.cwru.edu/affil/cccmhri/samiconference.pdf>

Program directors, team leaders, and team members of Ohio SAMI Programs that have been funded by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services should have received a conference brochure via U.S. Mail. If you are one of these people and have not received a brochure, contact the SAMI CCOE.



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Why you received this publication

This newsletter is produced for providers of substance abuse and mental illness (SAMI) services who are implementing, or are interested in implementing, the Dual Disorder Integrated Treatment (DDIT) model



in the State of Ohio. If you are one of these people, you will continue to receive this newsletter. If you are not, we invite you to subscribe. It's free. Our contact information is on page 15.

We have sent this first issue of our newsletter to a number of substance abuse and mental health providers because we wanted as many people as possible to know about the advances being made in the treatment of individuals who have co-occurring disorders of severe mental illness and substance abuse addiction. Feel free to pass this newsletter on to anyone who works in health and human services, or to anyone who is affected by mental illness and/or substance abuse. Invite them to sign up for a free subscription.

We are confident that the information we present about DDIT and SAMI Programs in the State of Ohio will be transferable to other service programs within health and human services, especially those that rely on biopsychosocial educational interventions. These are interventions that combine the use of medication with individual or group counseling and educational programs for consumers and caregivers. Research has shown that integrated treatment programs generate the best outcomes for the person who suffers from the illness(es), as well as for the family and friends who care for them.

Let us know what you think about our newsletter and feel free to offer suggestions that will help us enhance our work.





SAMI *Matters*

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