CENTER FOR EVIDENCE-BASED PRACTICES

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

www.centerforebp.case.edu
A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services
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 practice
- **TRAC**: Tobacco: Recovery Across the Continuum, a stage-based motivational model
Workshop objectives – *participant needs*

- Participants will be able to:
  1. Describe 7 core components of the DDCAT/DDCMHT tools.
  2. Understand programmatic core competencies essential in the treatment of co-occurring disorders.
  3. Identify the application of these instruments to their treatment settings.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Unaware or uninterested</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Information gathering</td>
</tr>
<tr>
<td>Preparation</td>
<td>Motivating change processes</td>
</tr>
<tr>
<td>Action</td>
<td>Implementing the model/services</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Sustaining change</td>
</tr>
<tr>
<td>Relapse</td>
<td>Help organization learn from “relapse” and recycle through stages of contemplation, preparation, and action</td>
</tr>
</tbody>
</table>
Substance abuse is common in people with mental illness

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.
Additional Information from SAMHSA

73% of persons 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

Prevalence of Tobacco Use: General Population vs. other Dx

Percentage of Tobacco Users

- Gen Pop
- Schizophrenia
- Bipolar
- ETOH Dep
- Depression
- Panic D/O

(SAMI Matters, Fall 2007)
Quadrant Model for Co-Occurring Disorders

I
Mild to moderate SUD
Mild to moderate MH

II
Mild to moderate SUD
Severe MH

III
Severe SUD
Mild to moderate MH

IV
Severe SUD
Severe MH
Traditional Treatment

- Treat each disorder separately
  May be parallel or sequential

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

Sequential
- Treating the disorders one at a time
Traditional Treatment

- People with MI often lack genuine access to AOD programs
  - Not admitted
  - Prematurely discharged

- People with AOD issues lack genuine access to MH programs
  - Not screened, assessed or diagnosed properly

- Implication that the consumer fails, not the treatment

- Separate treatment is less effective
Problems With Separate Mental Illness And Substance Abuse Treatments

- Different eligibility requirements
- Trouble accessing both services
- Primary/secondary distinction
- Different treatment approaches
- Variable clinical expertise and focus
- Lack of integration
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
Dual Diagnosis Capability
Index Development

Practical program level policy, practice and workforce benchmarks
   Based on scientific literature and expert consensus

Observational methodology
   Staff interviews; milieu observation; Document review (clinical record, policies, curricula)

Iterative process of measure refinement
   Field testing and psychometric analyses

Materials
   Index, manual, toolkit & Excel workbook for scoring and graphic profiles
Exploring Program Capability

What client needs are important for organizations and systems to address over the next 1-5 years in order to become co-occurring capable?

What outcomes do you want to improve?

Challenges, barriers, facilitators, resources, processes?
DDCAT/MHT Specific Objectives

1. To objectively determine the dual diagnosis capability of addiction treatment and/or mental health services.

2. To develop practical operational benchmarks or guidelines for enhancing dual diagnosis capability.

3. To provide a useful quality improvement tool for organizational change pertinent to co-occurring disorders (COD).
DDCAT/CMHT Index

- 7 domains
  - Subdivided into 35 Program elements

- Utilizes taxonomy of Patient Placement Criteria Second Edition Revised outlined by American Society of Addiction Medicine (ASAM)
DDCAT/CMHT Index Measures

- Presence or absence of benchmark
- Relative frequency
  - Variable vs. Routine, systematic and standardized
  - “Percentage of…”
Continuum of Co-occurring Capability

1. Addiction Only Services/Mental Health Only Services
2. Dual Diagnosis Capable
3. Dual Diagnosis Enhanced
Addiction Only Services (AOS)  
Mental Health Only Services (MHOS)

**AOS** reflects programs whose mission and treatment focus are primarily services to individuals with substance-related disorders.

**MHOS** reflects programs whose mission and treatment focus are primarily services to individuals with mental health-related disorders.
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.
Dual Diagnosis Enhanced (DDE)

Programs that:

• Are capable of providing services to any individual with substance-related and mental health-related disorders.

• Can be responsive to both types of disorders fully and equally.
Dual Diagnosis Capability
Index Domains

I. Program Structure
II. Program Milieu
III. Clinical Process: Assessment
IV. Clinical Process: Treatment
V. Continuity of Care
VI. Staffing
VII. Training
### DDCAT/DDCMHT content

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

A. Mission statement

Programs that offer treatment for individuals with co-occurring disorders (COD) should have this philosophy reflected in their Mission Statement.

B. Certification and licensure

Allows for unrestricted service delivery without barriers that have traditionally divided MH/AOD services.
I. Program Structure

C. Coordination/collaboration with MH/AOD services

Staged advances in service systems:

Minimal coordination

Consultation

Collaboration

Integration
I. Program Structure

D. Financial incentives

Programs that accommodate billing strategies for both services have greater capacity to provide integrated services
Next steps

• What might our organization do to improve integration of services?

1. X
2. X
3. X
II. Program Milieu

A. Routine expectation and welcome to treatment for both disorders
   • Program communicates this in policy, protocol, and literature (handouts, curricula, brochures, etc.)
   • Program does not discharge individuals for having the symptoms of their illness

B. Display and distribution of literature and client/family education materials includes content for both MH and AOD
Next steps

• What might our organization do to improve integration of services?

1. X
2. X
3. X
III. Clinical Process: Assessment

A. Screening Methods
   - Routine and systematic for both MH and AOD disorders
   - Standardized, reliable and validated
   - Incorporated into comprehensive evaluation process

B. Assessment
   - Routine and systematic assessment for both disorders
   - Standardized and integrated
   - Essential component in directing an individual’s care
III. Clinical Process: Assessment

C. Psychiatric and Substance Use Diagnoses

- Initial vs. Ongoing: Establishing diagnosis

- Routine, systematic and documented diagnoses are made for both disorders

- Appropriately licensed, trained and supervised clinicians demonstrate core assessment competencies inclusive of both disorders
III. Clinical Process: Assessment

D. Psychiatric and Substance Use history is documented in the medical record
   - Interaction of both disorders is reflected in assessment documentation
   - Routine QI and supervisory review of assessment insures accurate, comprehensive and integrated documentation

E. Program Acceptance – Symptom Acuity
   - Mild, moderate, severe
   - Policy and protocol reflects program parameters
III. Clinical Process: Assessment

F. Program Acceptance – Symptom Severity

- Mild: Few symptoms in excess of those required to diagnose and otherwise minor functional impairment
- Moderate: “Symptoms or functional impairment between Mild and Severe are present”
- Severe: many symptoms in excess of those required to make the diagnosis or several symptoms that are particularly severe are present or marked functional impairment
III. Clinical Process: Assessment

G. Stage-wise Assessment

• Initial and ongoing

• Essential component in directing an individual's care

• Helps assess motivation across identified areas of need

• Helps more strategically and efficiently match the individual to appropriate service intensity
  • Service intensity vs. treatment readiness
Next steps

- What might our organization do to improve integration of services?

1. X
2. X
3. X
IV. Clinical Process: Treatment

A. Treatment Plans (*Recovery Plans*)
   - Both disorders addressed

B. Assess and Monitor Interactive Courses of Disorders
   - Routine client interaction
     - “How does your marijuana use affect your mood?”
   - Curriculum
   - Case consultation
   - Routinely Documented
IV. Clinical Process: Treatment

C. Policies and Procedures for Managing Acute Psychiatric, Withdrawal, and Intoxication Conditions

• Specific clinical guidelines to manage acute symptom exacerbation

• “Oral Tradition” is not a substitute for policy or formal, supervised guidelines

• Issues include: suicidality, acute psychosis, full range of intoxication and/or withdrawal symptoms, medication management, administrative discharge for having the symptoms of the illness, etc.
IV. Clinical Process: Treatment

D. Stage-wise Treatment

• Strategically and efficiently matches the individual to appropriate service content and intensity
  • *Service intensity* vs. *Treatment readiness*

• Ratio: % of services aligned with client readiness for treatment vs. % of clients *actually ready* for treatment
IV. Clinical Process: Treatment

E. Pharmacological Policy and Procedures

- *Medication evaluation*
  - Access to prescriber

- *Medication management*
  - Medication assisted treatment (Suboxone, etc)
  - Avoiding medications with known addictive potential
  - Prescribing medications known to decrease cravings/urges

- *Medication monitoring*
  - Strategies to support medication adherence
  - Adherence vs. Compliance
  - Abuse potential
IV. Clinical Process: Treatment

F. Specialized Interventions

- Routine symptom management groups
- Therapies focused on specific disorders
- Systematic adaptation of Evidence Based treatments

  - Assertive Community Treatment,
  - Cognitive Behavioral Treatment
  - Integrated Dual Disorder Treatment
  - Illness Management & Recovery
  - Motivational Interviewing
  - Psycho-Social Rehabilitation
  - Twelve Step Facilitation
  - Supported Employment
IV. Clinical Process: Treatment

G. Education About Co-occurring Disorders and Their Interactions
   • Specific content for specific disorder co-morbidity
   • (ex: cocaine use and mood disorders, etc.)

H. Family Education and Support
   • Priority on family inclusion in treatment
   • Range of family education and supports available
   • Addresses both MH and AOD concurrently
     • Al-Anon & NAMI
IV. Clinical Process: Treatment

I. Specialized Interventions to Facilitate Peer Support Groups

• Routine and specific group supports

• Orientation to self-help (Meetings 101)

• Close-monitoring and follow-up re: peer supports

• (It’s not ok to just hand someone a meeting schedule and wish them luck…)
J. Availability of Peer Recovery Supports

- Alumni/volunteers/self help liaisons and available onsite

- Facilitated and/or integrated into programming

- Routine and documented individual supports
Next steps

• What might our organization do to improve integration of services?

1. X
2. X
3. X
4. X
5. X
6. X
V. Continuity of Care

A. COD Addressed in Discharge Planning Process

- Both disorders are seen as primary

- Plans ensure both disorders are included and planned for equally
V. Continuity of Care

B. Capacity to Maintain Treatment Continuity
   • Recovery Management
   • (Chronic Illness vs. Acute Care)
   • Optimally same agency or program
     • Continuity of Care considerations...
V. Continuity of Care

• The majority of people completing addiction treatment resume AOD use in the year following treatment (Wilbourne & Miller, 2002).

• Of those who consume alcohol and other drugs following discharge from addiction treatment, 80% do so within 90 days of discharge (Hubbard, Flynn, Craddock, & Fletcher, 2001).

• Most persons treated for substance dependence who achieve a year of stable recovery do so after multiple episodes of treatment over a span of years (Anglin, et al, 1997; Dennis, Scott, & Hristova, 2002).
V. Continuity of Care

C. Focus on Ongoing Recovery Issues for COD

• Both disorders seen as primary

• Both disorders are chronic, relapsing conditions requiring ongoing management of symptoms

• Recovery philosophy (Recovery vs. Symptom Management)
V. Continuity of Care

D. Peer Support Linkage
   • Facilitating
   • Documenting
   • Discharge Planning

E. Medications at Discharge
   • Sufficient Supply & Access
   • Documented Plan
Next steps

• What might our organization do to improve integration of services?

1. X
2. X
3. X
VI. Staffing

A. Prescriber of Medications for COD
   • Medication Assisted Treatment
   • Medication for psychiatric disorders

B. Onsite Staff with COD Licensure and Competency
   • Licensure does not equal competency

C. Access to Supervision or Consultation
   • Routine
   • Clinical vs. Administrative
   • See Also: Section B above
VI. Staffing

D. Systematic Monitoring and Review Procedures for COD
   • Routine Supervision
   • QI
   • UR
   • Outcomes

E. COD Peer/Alumni Supports Routinely Available
   • As previously noted and described
Next steps

• What might our organization do to improve integration of services?

1. X
2. X
3. X
VII. Training

A. COD Basic Training for Direct Care Staff
   • Prevalence
   • Common Signs and Symptoms
   • Screening and Assessment
   • Establish core competencies

B. COD Advanced Training
   • Integrated treatment skills (Groups, etc)
   • Trauma
   • DBT
Next steps

• What might our organization do to improve integration of services?

1. X

2. X

3. X
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

• 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
Resources

1. Manuals for DDCAT and DDCMHT
   http://www.centerforebp.case.edu/resources/tools/ddcat-manual

2. TIP 42 In-service manual
   http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=141&rcID=5

   http://www.centerforebp.case.edu/resources/tools/
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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- News about us and our collaborators.
- Recovery stories told by consumers, family members, service providers, employers.
- Conversations with people who implement service innovations.
Tools | Education & Advocacy

Booklets

Posters

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