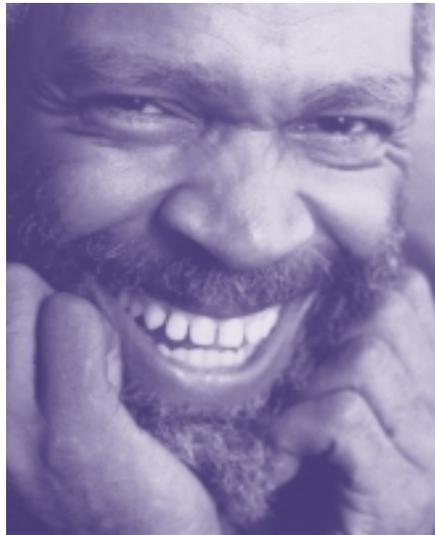


The SAMI CCOE is a partnership between the **Mandel School of Applied Social Sciences** at Case Western Reserve University (CWRU) and the **Department of Psychiatry at the CWRU School of Medicine**. The partnership is in collaboration with the **Ohio Department of Mental Health**.

# SAMI Matters

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

## National EBP implementation project arrives in Ohio



This summer, the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) began to support the Implementing Evidence-Based Practices (EBP) Project, a national dissemination effort coordinated by the New Hampshire-Dartmouth Psychiatric Research Center (PRC) of Lebanon, New Hampshire. EBPs are service delivery models for persons with severe mental illness that research has shown to generate positive consumer outcomes. EBPs are designed to help mental health consumers pursue their personal recovery goals with the support of service professionals and their families and other caregivers. The pilot implementation is taking place for two years. A national demonstration project has also been proposed to follow this initial eight-state initiative.

The national EBP Project is testing the implementation process and training manuals for six EBPs at selected agencies in eight states with the help of implementation institutes in each of those states. In Ohio, the SAMI CCOE of Case Western Reserve University is disseminating the Integrated Dual Disorder Treatment (IDDT) model, and the Ohio Coordinating Center of Excellence for Illness Management and Recovery (Ohio CCOE-IMR) of the Medical College of Ohio in Toledo is disseminating the IMR model (see page 6). There are four implementation sites in Ohio (see adjacent illustration).

Trainers from the two Ohio CCOEs joined trainers from implementation insti-

*Continued on page 2*

### IMPLEMENTATION SITES



- 1 Wood County**  
Behavioral Connections  
Bowling Green
- 2 Cuyahoga County**  
Recovery Resources  
Cleveland
- 3 Delaware/Morrow County**  
Central Ohio Mental Health Services  
Delaware
- 4 Fairfield County**  
New Horizons  
Lancaster

**In this issue**

**3** Activities Update

**4** National News

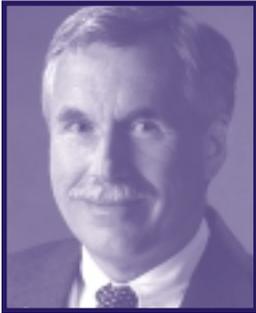
**8** Agency Profile

**14** Clinical Tip

## National EBP implementation project arrives in Ohio

# EBP

(from page 1)



Michael Hogan, Ph.D.

tutes throughout the country this past spring for training seminars that taught them how to help the agencies implement and sustain their EBPs. The four Ohio implementation sites will receive program consultation and training from Ric Kruszynski, MSSA, LISW, CCDC III-E, Assistant Director of Clinical Training at the Ohio SAMI CCOE. Mr. Kruszynski joined the SAMI CCOE this past summer (see page 3).

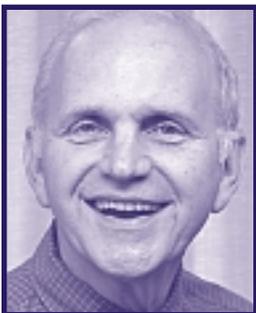
### EBPs

Patrick Boyle, MSSA, LISW, CCDC III-E, CEAP, Director of Clinical Training at the Ohio SAMI CCOE, explains that each EBP provides different services with different approaches but that each EBP contains four basic components: education, program consultation, training, and research and evaluation. The implementation institutes are providing these four service components for each EBP with the help of implementation kits that have been developed for each EBP. Implementation kits contain educational materials—brochures, workbooks, videos, etc.—that teach policy makers, service providers, consumers, and caregivers about the EBP (see page 4).

Mr. Boyle adds that the State of Ohio was identified to participate in the EBP Project because of its commitment to service innovation and demonstration. He explains that Michael Hogan, Ph.D., Director of ODMH, Dale P. Svendsen, M.D., Medical Director of ODMH, and Lon Herman, M.A., Program Director of Residency, Training, and Learning Initiatives at ODMH, have been instrumental in establishing and promoting Ohio's CCOEs for this national project.

Since its inception in December 2000, the Ohio SAMI CCOE has been providing program consultation, clinical consultation, education and training, and research and evaluation services to nine agencies in the State of Ohio. These agencies were funded by ODMH and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) to demonstrate the IDDT model. Since then, eleven additional agencies have begun to seek the services of the SAMI CCOE. Mr. Boyle explains that the CCOE's support of service agencies and the agencies' support of the CCOE have been instrumental in facilitating an efficient implementation of the IDDT model. The CCOE's hands-on approach, he adds, has elicited enthusiasm among providers. They report dramatic changes in consumer functioning over time as a result of IDDT.

“Other states around the country have initially taken a more systemic approach to dissemination by developing large-scale, top-down system changes,” Mr. Boyle says. “While this is also a valid approach, Ohio's implementation of IDDT has sparked considerable enthusiasm among providers. In some ways, we're a couple of steps ahead of other states in learning how to disseminate an evidence-based practice,” Mr. Boyle adds. “However, there is so much more to learn. We keep learning from the Ohio providers, the research that is coming out of New Hampshire, from other colleagues at similar educational and training institutes across the country, and from our own experiences and research.”



Dale P. Svendsen, M.D.



Lon Herman, MA



Patrick E. Boyle, MSSA, LISW, CCDC III-E, CEAP



## Resources

For more information about evidence-based practices, visit this section of our web site: <http://www.ohiosamiccoe.cwru.edu/disorders/disorders.html>

# Activities Update

## Kruszynski joins SAMI CCOE

Ric Kruszynski, MSSA, LISW, CCDC III-E, has joined the Ohio SAMI CCOE as Assistant Director of Clinical Training. In this newly created position, Mr. Kruszynski will provide program consultation and training to Ohio service agencies that are implementing the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model. He will devote half of his time to the four Ohio agencies that are participating in the national Implementing Evidence-Based Practices Project (see page 1) and half of his time to other DDIT training initiatives.

Mr. Kruszynski brings over 17 years of clinical, supervisory, and training expertise in dual disorders to his work at the SAMI CCOE. Prior to joining the CCOE, he was the Manager of Family Services at the Center for Families and Children (CFC) in Cleveland. During his 10 years there, he served as a CSP to a large caseload of consumers with dual disorders. He also supervised a CSP staff and managed several MH programs. Prior to this, he worked as a chemical dependency assessment and treatment counselor for adolescents at the Parmadale Residential CD Program in Parma, Ohio. He also served individuals and families at the Addiction Recovery Services Intensive Outpatient Program at St. Luke's Hospital in Cleveland.

Mr. Kruszynski graduated with an MSSA from the Mandel School of Applied Social Sciences at Case Western Reserve University in 1993. In March 2000, he contributed to the preparation and delivery of the "Instructional Material for Dual-Diagnosis Training for Mental Health and Addiction Practitioners," a training manual produced by Ohio SAMI CCOE Co-Director Lenore Kola, Ph.D.



## Wieder conducts national research through SAMI CCOE

Barbara Wieder, Ph.D., former Associate Director of Research and Evaluation at the Ohio SAMI CCOE, has accepted a new role at the Ohio SAMI CCOE. She is now Director of Evidence-Based Practices Implementation Project Research. David E. Biegel, Ph.D., of the Mandel School of Applied Social Sciences continues to serve as the CCOE's Director of Research and Evaluation.

In her new full-time position with the SAMI CCOE, Dr. Wieder is serving as the Ohio Implementation Monitor for the national Evidence-Based Practices (EBP) Implementation Project. Ohio is one of eight states participating in the project, which is examining the factors that either block or promote successful implementation of EBPs for persons with severe mental illness (see page 1).

As part of the national project, selected community mental health agencies in Ohio will implement either the Integrated Dual Disorder Treatment model or the Illness Management and Recovery model. Dr. Wieder will be observing the process of implementation at the agencies. She will be evaluating the readiness of each agency to implement the EBP, the degree to which the agency maintains fidelity to the EBP, and the barriers to and strategies for successful implementation that the agencies experience.

"An important part of successful implementation is creating an information system that will track key consumer outcomes," Dr. Wieder says. "Like other implementation monitors in other states that are participating in the national implementation project, I will examine whether agencies were able to put in place some method of tracking key outcomes and whether these outcomes were used to reinforce and sustain the practice."



Ric Kruszynski,  
MSSA, LISW, CCDC  
III-E



Barbara L. Wieder, Ph.D.

# National News

## National EBP Project implements culturally responsive services



### 6 EVIDENCE-BASED PRACTICES (EBPs)

1. Medication Management Approaches in Psychiatry (MedMAP)
2. Assertive Community Treatment (ACT)
3. Family Psychoeducation (FPE)
4. Supported Employment (SE)
5. Illness Management Recovery (IMR)
6. Integrated Dual Disorder Treatment (IDDT)

### 8 STATES

1. Vermont (FPE,IMR)
2. New Hampshire (FPE,IMR) & Vermont (FPE,IMR)
3. New York (ACT,IMR)
4. Maryland (SE, FPE)
5. Ohio (IDDT, IMR)
6. Indiana (ACT,IDDT)
7. Kansas (SE,IDDT)
8. Oregon (SE)

In January 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) at the National Institute of Mental Health chose the New Hampshire-Dartmouth Psychiatric Research Center (PRC) to coordinate the Implementing Evidence-Based Practices (EBP) Project. The EBP Project is a national effort to help mental health consumers throughout the country gain access to those services that research has shown to generate good outcomes.

The EBP Project will have a quality improvement component that will evaluate the facilitators and barriers to implementing and sustaining six EBPs in different regions throughout the country. The pilot test of the EBPs that began this summer (see page 1) is taking place in urban and rural regions that have different social, cultural, and economic characteristics.

According to David Lynde, LICSW, MSW, Training Manager for the West Institute at the New Hampshire-Dartmouth PRC, the success of EBP implementation will depend upon a number of variables, including effective alignment of financing mechanisms and how well each state and each agency involves the six stakeholder groups that the EBPs affect. The stakeholder groups include policy makers (state authorities and county boards), service providers (agency administrators, program leaders, practitioners), consumers, and supporters (typically family and friends).

Mr. Lynde explains that the PRC recruited representatives from each stakeholder group from around the country to participate on development teams, con-

sensus teams, and review panels for each EBP. These teams ensured that the EBP Project developed implementation strategies and communications that emphasize the recovery-approach to service delivery, as well as cultural relevance. Each stakeholder group, Mr. Lynde explains, has its own important cultural perspective.

“The development and consensus teams have created the content for our communications,” Mr. Lynde says. “The multiple perspectives will help to ensure the effectiveness of our materials in providing information to each of the stakeholder groups about the practice of each EBP. Additionally, we are confident that the sites who will be piloting these EBPs will work actively with each stakeholder group in implementing the practices.”

Mr. Lynde concludes that the collaboration between all of the stakeholder groups in this project provides a unique and exciting opportunity to develop culturally responsive evidence-based services to consumers and their families in their communities.

### FUNDING OF THE EBP PROJECT

- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, National Institute of Mental Health
- Robert Wood Johnson Foundation
- National Institute of Mental Health (NIMH)
- McArthur Foundation
- West Foundation
- Johnson & Johnson



# COMPONENTS OF EBP IMPLEMENTATION



## Education/ Implementation Resource Kit

Each EBP has an *implementation resource kit* of educational materials about the EBP. The materials include brochures, videos, workbooks, etc. These materials, in combination with the consulting and training, comprise the *implementation package*.

- The implementation resource kit materials help all audiences (or stakeholder groups) understand, advocate for, and utilize the EBPs. The materials also help facilitate program consultation, training, and research and evaluation. The implementation kits have been consistently organized, graphically designed, and written to make them easily understood by all stakeholder groups. A team of individuals who represent each of the groups has developed each implementation kit. The team members were recruited from various regions throughout the United States. A cultural-competence committee was also recruited to review and contribute to the development of the materials.



## Program Consultation

Program consultations take place in-person at agencies and/or through teleconferencing and video-conferencing. There are two types of program consultations:

- *State policy consultations* are conducted by representatives from the National Research Institute at the National Association of State Mental Health Program Directors (NASMHPD). These consultations take place with state authorities and boards, such as the Ohio Department of Mental Health. The consultations focus on financing policies, regulatory policies, and contracting mechanisms that support the implementation of EBPs.
- *Agency consultations* are conducted by the implementation institutes that have been established in each state. These consultations help county

board administrators, agency directors, program directors, and team leaders plan and support each EBP with effective organizational structures, financing strategies, medical record-keeping procedures, training, supervision, and service delivery.



## Training

Training activities are coordinated and/or conducted by staff of the implementation institutes. Training activities will include an overview of each EBP for all stakeholder groups, as well as training for the service professionals within each agency who will be utilizing the EBPs. The training institutes will conduct the training programs at each agency participating in the EBP pilot test.



## Evaluation and Quality Improvement

Quality improvement investigation and evaluation will be coordinated through the New Hampshire-Dartmouth PRC in collaboration with each of the implementation institutes. There are two types of evaluation activities:

- *Fidelity measures* evaluate the degree to which agencies adhere to the EBP models. Research has shown that agencies achieve the best programmatic and consumer outcomes when they maintain faithfulness to the EBP models. The fidelity outcomes will be used to identify the facilitators and barriers to successful implementation of the EBPs.
- *Implementation Kit Evaluation*. Implementation monitors will use a variety of methods to gather information about the effectiveness of the components of the implementation kits, including qualitative measures. This information will be used to improve the effectiveness of the kit components and the consultation and training services.



David Lynde,  
LICSW, MSW

*The pilot test of the EBPs is taking place in urban and rural regions that have different social, cultural, and economic characteristics.*

# News



## New CCOE disseminates techniques for illness management and recovery



Mary Kay Smith M.D.,  
Director of the  
CCOE—IMR



Mary Jo Swartzberg,  
MLS, Program Director  
of Public and  
Community Psychiatry

This spring, the Ohio Department of Mental Health (ODMH) funded the Medical College of Ohio in Toledo to create the Ohio Coordinating Center of Excellence for Illness Management and Recovery (Ohio CCOE-IMR). The CCOE will pilot test and evaluate the consensus-based IMR service model to agencies that serve persons with mental illness in the State of Ohio. IMR utilizes several service and treatment strategies that are designed to help consumers develop personalized strategies to take care of themselves, manage their symptoms, and learn how to reduce their susceptibility to symptoms (see page 7).

The strategies include the following:

- Psychoeducation
- Cognitive-behavioral methods for medication management
- Relapse prevention
- Coping skills training

This summer, the Ohio CCOE-IMR began to pilot test the implementation of the IMR model at Ohio agencies as part of the Implementing Evidence-Based Practices (EBP) Project, a national dissemination effort coordinated by the New Hampshire-Dartmouth Psychiatric Research Center (PRC) of Lebanon, New Hampshire (see page 1). The CCOE-IMR will be providing the following services to Ohio agencies: program consultation, clinical consultation, education and training, and research and evaluation. The training services will be coordinated by Alice Claggett, PsyD, Clinical Researcher. The research and evaluation services will be coordinated by Barbara Wieder, Ph.D., Director of Evidence-Based Practices Implementation Project Research at the SAMI CCOE.

According to Mary Kay Smith, M.D., Director of the Ohio CCOE-IMR and

Assistant Professor of Psychiatry at the Medical College of Ohio, the IMR model serves the same population of individuals as the IDDT model but with different, complementary approaches. IDDT casts a large net over substance abuse and mental health services by promoting the integration of systems, as well as the integration of professional services. IDDT incorporates the IMR model and other models as well. IMR provides service professionals with specific techniques for interacting with consumers in an integrated-services environment that is consumer focused.

“Consumer-focused recovery is an integral part of the IDDT model,” Dr. Smith says. “The Illness Management Recovery model will enable us to intensify the focus on consumers. It’s a natural fit for all four stages of the treatment process. Service providers can use IMR strategies in engagement, persuasion, active treatment, and relapse prevention.”

Dr. Smith adds that the IDDT and IMR models work well together because they both promote better communication between consumers, caregivers, and service providers and better integration of biopsychosocial treatments within service systems. Both models also require that service providers, caregivers, and consumers all share a certain level of awareness and knowledge about biopsychosocial treatment methods.



# Illness Management and Recovery

## Helping consumers become experts in self-care

—This article was written by referencing “Illness Self-Management and Recovery: A Review of the Research” by Kim T. Mueser, Ph.D., et al, which will be published in *Psychiatric Services*.

Illness Management and Recovery (IMR) is a service delivery model that utilizes four service and treatment strategies that are designed to help consumers enhance their abilities to take care of themselves, manage their symptoms, and learn how to reduce their susceptibility to symptoms.

An IMR program typically involves weekly meetings that last approximately three to six months. The meetings may be conducted in individual sessions with consumers or in group settings. In the meetings, consumers work closely with practitioners to set goals for recovery and to develop strategies (or activities) for attaining the goals. The purpose of the activities is to help consumers gain more control over their lives and to pursue their own personal path of recovery.

Below is a brief description of the service and treatment strategies typically used in an IMR program.

### 1. Psychoeducation

Psychoeducational programs provide a wide range of information to consumers and family/community support persons about mental illness, including the effects of stress, symptoms, diagnosis, and treatments.

### 2. Cognitive-behavioral methods for using medication effectively

These interventions help consumers develop and utilize personalized methods for taking medication:

- *Behavioral tailoring* incorporates medication into the consumer’s daily routines and/or simplifies the medication regimen.
- *Motivational interviewing* helps consumers articulate personally meaningful goals and explore how medication may be useful in achieving such goals.

### 3. Relapse prevention

*Relapse prevention* programs teach consumers how to achieve the following:

- Recognize environmental triggers of relapses
- Recognize the early warning signs that symptoms may be worsening
- Know when and how to take steps to avert a crisis
- Increase their ability to manage stress

### 4. Coping Skills

*Coping-skills* interventions teach consumers how to manage stress and persistent symptoms. Throughout the interventions, consumers are encouraged to set and achieve personal goals. The interventions may include the following:

- Exploring the coping skills currently used
- Amplifying the current coping skills and/or teaching new coping strategies
- Behavioral rehearsal of the coping skills
- Evaluating the effectiveness of the coping skills
- Modifying the coping skills as necessary

Research shows that successful illness management techniques improve social relationships and reduce

- relapse,
- rehospitalization,
- symptoms, and
- distress.



## Resources

The recommended research studies listed below support the components of the Illness Management and Recovery (IMR) model. For a list of more studies, refer to the article cited at the top of this page.

#### Psychoeducation

Macpherson, R, Jerrom, B, Hughes, A: A controlled study of education about drug treatment in schizophrenia. *British Journal of Psychiatry* 168:709-717, 1996

#### Behavioral Tailoring

Boczkowski, J, Zeichner, A, DeSanto, N: Neuroleptic compliance among chronic schizophrenic outpatients: An intervention out-

come report. *Journal of Consulting and Clinical Psychology* 53:666-671, 1985

#### Relapse Prevention

Herz, MI, Lamberti, JS, Mintz, J et al: A program for relapse prevention in schizophrenia: A controlled study. *Archives of General Psychiatry* 57:277-283, 2000

#### Coping Skills

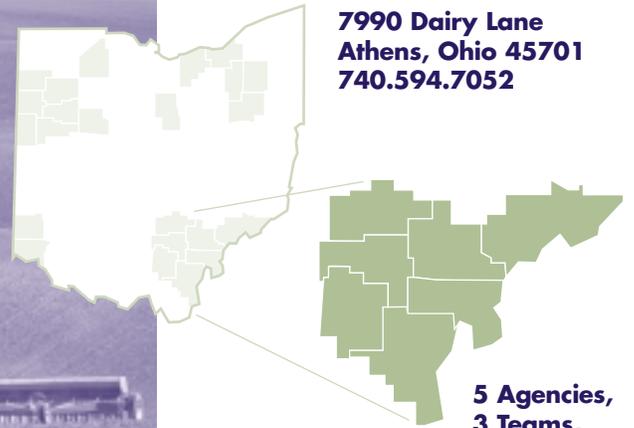
Leclerc, C, Lesage, AD, Ricard, N et al: Assessment of a new rehabilitative coping skills module for persons with schizophrenia. *American Journal of Orthopsychiatry* 70:380-388, 2000

# Agency Profile



## SOUTHERN CONSORTIUM FOR RURAL CARE (SCRC)

7990 Dairy Lane  
Athens, Ohio 45701  
740.594.7052



5 Agencies,  
3 Teams,  
7 of 10 Counties

## SCRC delivers IDDT in Appalachian foothills

*The Southern Consortium for Rural Care (SCRC) is a council of governments of mental health and alcohol-and-other-drug services boards in 10 counties in southern Ohio. The SCRC is made possible through a provision in Ohio law that enables government entities with a similar purpose to form a council of governments. There are three SAMI teams in the SCRC. They are comprised of staff from 5 agencies in seven of the 10 counties in the SCRC service area.*

Persons with co-occurring mental health and substance abuse disorders in rural southern Ohio are finding hope because of the patience and persistence of the SAMI program at the Southern Consortium for Rural Care (SCRC), which is located in the foothills of the Appalachian Mountains near the Ohio River.

Unlike other SAMI programs in Ohio, the SCRC and its services are defined more by place than by political jurisdiction. The agencies, the service teams, the consumers, and the communities all face a similar challenge because of the landscape—distance and separation. It is approximately 190 miles from one end of the service area to the other, with a terrain dominated by thick woodlands, open fields, high hills, deep valleys, and narrow two-lane roads that twist and turn like the creeks and streams that carve this

topography as they meander toward the great river.

The territory is difficult to serve because there is no public transportation network for consumers and caregivers to use. If cars are available, they are often old and unreliable. As a result, the SCRC has committed itself to an intensive outreach program. The staff logs many hours and many miles driving to the small towns and remote communities. The consumers are often hard to track.

According to Larry Burnett, Executive Director of the SCRC, the outreach program has struggled to stay together financially. The seed money from the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) has been divided among and shared by the five collaborating agencies. (Most SAMI programs

are partnerships between two agencies.) In addition, the hours spent conducting outreach cannot be billed to Medicaid because state law does not define outreach as billable hours. Despite these obstacles, the agency staff in the SCRC persists. They know from experience that the kind of communication that must take place between service providers, consumers, and caregivers is not the kind that can be stuffed into a data packet and sent out over the Internet. It must happen in a shared space, a bio-psycho-social environment where body language and emotions often deliver more meaning than words.

The SAMI teams in the SCRC area will tell you not to discount the power of spoken words, though. Telephone calls, they explain, have set the stage for many face-to-face interactions. There is a bit of magic in the crackle and pop of the human voice as it glides across wires and through the airwaves. At first, consumers tend to reject the outreach and hang up. But with each phone call, the time between connect and disconnect gets a few seconds longer and eventually a simple, "Hello," transforms itself into a conversation, and an appointment for a meeting.

Mr. Burnett explains that a phone call is a simple way to let a consumer know that somebody is thinking about him or her. It is like a postcard from a friend, a short moment in time that is filled with significance.

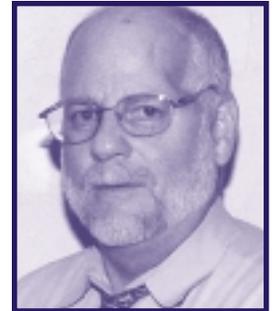
"You don't have to wait for research to tell you this," Mr. Burnett says. "Anybody who's half-awake to what it means to be human knows that you need to acknowledge people, genuinely, to reach them, to engage them. The research is important. I know that. It'll convince the politicians to fund these activities and to change policies so that these consumers can actually get what they need. A good conversation, like a good-anything, takes time. We need

the time to move carefully and cautiously. We have to be gentle. The human spirit is very fragile."

The high cost of outreach and the limited funds, Mr. Burnett explains, has been a barrier to achieving fidelity to the IDDT model in the SCRC service area. Despite this challenge, though, consumers have been achieving good outcomes. They have entered treatment, achieved sobriety, and are experiencing fewer psychiatric episodes (see consumer stories on page 10). They are also staying out of hospital and jails. They are experiencing a higher quality of life.

Mr. Burnett credits much of this success to the staff at local hospitals and to individuals in the criminal justice system, namely judges and probation officers, because some are making an effort to understand the special needs and circumstance of individuals with co-occurring disorders. Mr. Burnett also credits the staff at the agencies that are participating in the SCRC's SAMI program for raising awareness among these professions. Agency staff members converse with colleagues at hospitals and in the criminal justice system an average of once per week. As a result, the hospital staff, probation officers, and judges are more aware of services that are available. They know whom to contact for help.

"We've learned that systemic outreach efforts are just as important to client success as personal outreach from a case manager or nurse," Mr. Burnett says. "Sometimes the hospitals and criminal justice systems have contact with consumers before we do. When they do, they call the SAMI programs because they know who they are and what they do. They help us make the initial contact with consumers. The first interaction is crucial. Once we get the consumer's name and phone number and see their face, we can begin to call on them."

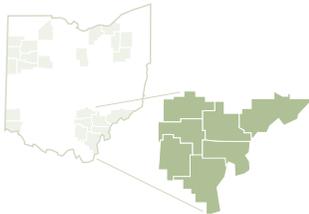


Larry Burnett,  
Executive Director,  
SCRC

*For consumers, their families, and agency staff, these SAMI grants were a godsend. Maybe God can convince the state to continue funding this integrated services model that dramatically helps those Ohio citizens suffering the most from these afflictions.*

—Larry Burnett, Executive Director, SCRC

# Agency Profile *continued*



**SOUTHERN  
CONSORTIUM FOR  
RURAL CARE (SCRC)**



Cassandra Rufat,  
SCRC Consumer  
Council Member



Robin Brigante, SCRC  
Consumer Council  
Member



Treasa Lucas, SCRC  
Consumer Council  
Member

## Consumers take active role in SCRC SAMI program

The SAMI program at the Southern Consortium for Rural Care (SCRC) has not only improved quality of life for consumers with its intensive outreach services, but it has also improved quality of life with programmatic enhancements. The SAMI program has increased the number of Dual Recovery Anonymous (DRA) programs that are available to consumers and has established a consumer council that reviews services and offers insights for enhancements.

According to Larry Burnett, Executive Director of the SCRC, before the start of the SAMI program, there was only one DRA program in the entire 10-county SCRC service area. There are now three. The availability of DRAs is expanding, Mr. Burnett explains, because the SAMI program has made consumers aware of their existence. Most consumers have heard of and are familiar with Alcoholics Anonymous (AA), but they tend to like the DRA better because they feel less inhibited about discussing their mental illnesses in a group of people who understand those illnesses.

“Dual Recovery Anonymous eliminates the barrier of stigma,” Mr. Burnett says. “If you’re at an AA meeting, in a room full of people who do not have and, therefore, do not understand mental illness, there’s an invisible wall that goes up around you that prevents you from speaking your truth—your experiences, fears, frustrations, hopes, and dreams. You’re stuck holding everything in. The whole point of

recovery is to get it out, to give it voice. That’s how you start to become aware and begin to make changes.”

### Stigma Busting

Mr. Burnett reports that the SCRC’s consumer council has also made significant contributions to breaking the barrier of stigma in southern Ohio. The consumer council includes representatives from each county in the SCRC service area. The council members meet bimonthly to review services and to offer insights from their experiences. The SCRC uses this information to enhance service delivery.

The consumer council was initiated in July 2000, at the onset of the SCRC’s SAMI program. Since then, council members have made significant contributions to the enhancement of services and to public education. They recently helped rewrite a popular workbook for persons with mental illness, entitled the *Wellness Recovery Action Plan (WRAP)*, so that persons with co-occurring disorders could also use it. The council worked with *WRAP* author, Mary Ellen Copeland, to produce *WRAP* for Dual Diagnosis (see Resources below).

In February 2002, the council commenced a planning initiative for the production of a “Stigma-Busting Video,” which will be used to teach a variety of audiences about co-occurring mental health and substance abuse disorders. The video will feature interviews with consumers who are currently in recovery.

## SUCCESS STORIES

### Chuck

Local police in the Southern Consortium for Rural Care (SCRC) service area routinely arrested Chuck (not his real name), a middle-aged man with mental illness and alcohol dependency, prior to his involvement in the SAMI program. Chuck was typically hospitalized after his arrest for several days or a week each month. The average cost of a hospital stay was \$350 per day, approximately \$29,000 per year.

Two years ago, Chuck enrolled in the SCRC SAMI program. For the last 14 months, he has adhered to his medication prescription and abstained from alcohol with only one minor relapse into drinking. It was Chuck who informed his case manager about the relapse. (This is a clear sign that Chuck is concerned about his own progress in recovery.)

Chuck explains that his life began to change once he started to realize that there was a connection between episodes of hearing voices and his drinking. That's why he quit drinking. Looking back, he explains that he had "hated going to the hospital", though it had appeared to be the only way to manage his illness. He credits the SAMI team for sticking with him during the early days of his treatment when his life was very difficult. It was the SAMI team who connected Chuck with a group of SAMI consumers, and with their help, he began to understand that drinking made his symptoms worse and that medication helped him feel better.

Chuck is very proud of his accomplishments and is grateful to the SAMI team for their help. He recently began to work a few hours per week at his first job in many years. Chuck has not been incarcerated or hospitalized for the last 14 months. The monetary savings to the health care system has been over \$35,000. (The amount of savings for the criminal justice system has not been calculated.)

### Lucy

Lucy (not her real name) has been receiving medication for her mental illness for years but she was taking it inconsistently. She rarely engaged with case managers and other service providers, and, as a result, she was difficult to track. With funding from the SAMI program, Lucy's case manager, Paula, was able to spend more time trying to connect with Lucy. Paula knew that Lucy was taking Benadryl, an over-the-counter (OTC) medication, at a rate of 72 pills a week. She was mixing that medication with six to 12 beers a day.

Concerned about the potentially life-threatening consequences of mixing medication with alcohol, Paula telephoned Lucy every few days to say, "Hello," and to let her know that somebody was thinking about her. For about six months, Lucy would hang up on Paula as soon as she heard Paula's voice. Gradually, Lucy began to talk a little bit, especially when she was intoxicated. Eventually, on occasion, Lucy would call Paula to talk. After several months of these interactions, Lucy agreed to meet for coffee in a neutral location, and gradually the "coffee talks" became more frequent, with Lucy expressing a desire to quit drinking. It was apparent that she was beginning to evaluate the pros and cons of becoming sober.

The deciding moment for Lucy came a few months later during a financial crisis. She called Paula for help and, after being presented with some options, Lucy reluctantly agreed to settle her financial problems through payeeship (she let a third party manage her finances). As part of the agreement, Lucy began to attend individual counseling sessions and group sessions, where she met and conversed with other consumers enrolled in the SAMI program. Three weeks later, Lucy experienced an episode of heavy drinking and serious psychiatric symptoms, but instead of going through the trauma alone, she

*(continued on page 12)*



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Centers, Inc., Meigs  
County



Vicki Burks, PCC,  
CCDC-I, Co-Team  
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PACT, Health  
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Inc., Athens County



Sharon Sheets, MA,  
LSW, CCDC-I, Act  
Team Leader, Tri-  
County Mental  
Health, Athens  
County



## Resources

*Wellness Recovery Action Plan (WRAP) for Dual Diagnosis*, by Mary Ellen Copeland, M.S., M.A., \$10.00

<http://www.mentalhealthrecovery.com/book.html>

# Training Event Conference 2002 In-Review



Kenneth Minkoff, M.D.

Over 275 professional service providers throughout the State of Ohio attended the Ohio SAMI CCOE Conference, which was held Tuesday, May 7 and Wednesday, May 8 at The Holiday Inn in Worthington, Ohio, near Columbus. Those in attendance included direct-service providers, team leaders, program managers, county board members, consumers, family members, and executive administrators.

The conference was designed for those who are providing Integrated Dual Disorder Treatment (IDDT) in partnership with consumers and their support networks and for those seeking more information about how to develop, implement, sustain, and expand treatment programs. The conference featured keynote addresses and workshop sessions. Both days of the conference provided many opportunities for participants to mingle with their peers and to develop professional support networks. A special Physician's Forum was held to kick off a new initiative that creates a peer group for psychiatrists who are interested in learning more about treating co-occurring disorders.

(Interested psychiatrists should contact Dr. Christina M. Delos Reyes at the SAMI CCOE.)

## Keynote Presentations

Kenneth Minkoff, M.D., presented workshops on successful integrated treatment and systems principles. Dr. Minkoff is Medical Director of Choate Health Management Care in Woburn, MA, and Assistant Clinical Professor of Psychiatry at Harvard. He is known nationally as an expert in dual diagnosis and the integration of mental health and substance abuse disorder services.

Tim Hamilton presented workshops on integrating personal recovery and how to start Dual Recovery Anonymous (DRA) meetings. Mr. Hamilton is the Community Resource Director for the Dual Diagnosis Network, a statewide integrated services initiative in Tennessee. It is also a national resource for education and training, self-help, advocacy, and information.



Tim Hamilton

## SAMI PROGRAM

# Agency Profile *continued*



Linda Holley, LSW, CCDC-I, Counselor II, Health Recovery Services, Inc., Athens, County



Margaret Mullins, CCDC-I, Case Manager, Health Recovery Resources, Inc., Athens, Ohio



Sharon Burt, MSW, LSW, Case Manager, Tri-County Mental Health, Athens County

(from page 11)

called Paula and asked to be hospitalized. Paula helped Lucy admit herself, found somebody to take care of Lucy's cat, remained in contact with Lucy and the hospital staff during the hospital stay, and helped Lucy transition back to community living, where she began to attend individual counseling and support group programs again.

Lucy has been in active treatment for seven months. During this time, she has only used alcohol three times. She continues to find help and support in individual counseling and peer group programs.



# News

## Find a computer, we're taking SAMI into the 21st Century.

This summer we hired some database programmers to enhance our web site. While they're busy measuring, sawing, welding, and assembling, we thought we'd let you know why.

### Goodbye fax machine. Hello online registration.

We've been wading through our offices in paper that's piled to our armpits. No kidding. It's the registration forms from our training events. They keep pourin' out of the fax machine. In one respect, that's good. It means we're doing our job. However, we've had enough of the pulp. We've decided to automate. Our first web site enhancement will be an interactive training calendar and online registration. You're gonna love this thing. It will give you an e-mail confirmation of your registration and an e-mail reminder about the event a few days ahead of time. It will also e-mail you a receipt after you've attended.

### News-News-News

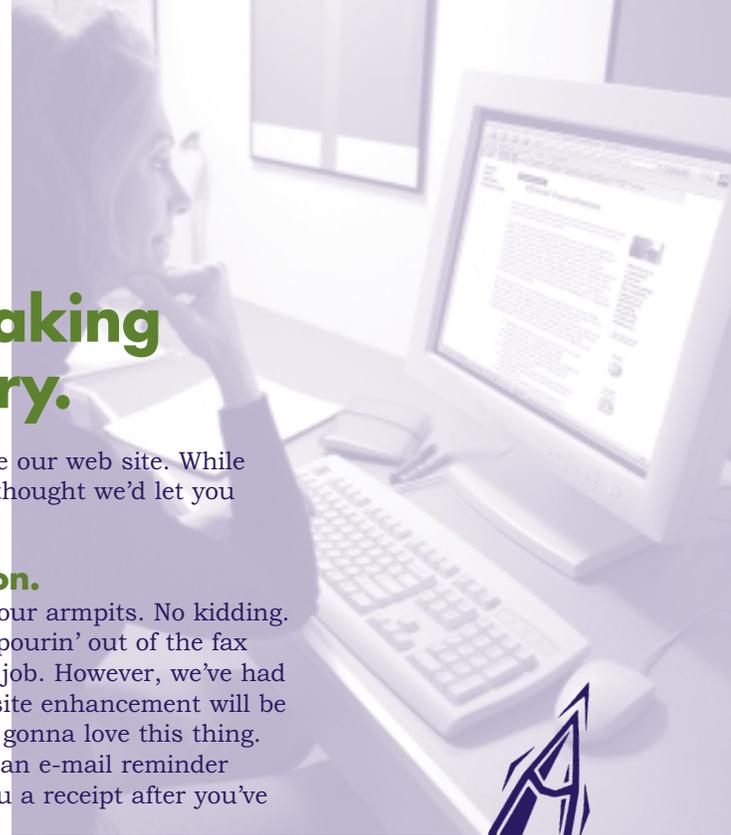
We're adding an e-mail news service that will deliver up-to-date messages from us.

### Chat-Chat-Chat-Chat-Chat

We're also adding a message board/bulletin board that will replace the listserv. The message board will contain sections for each group of individuals typically represented on a SAMI team. You'll be able to post questions and answers and chat with your peers throughout the State of Ohio. You'll also be able to converse across disciplines. Think of the online message board as one big statewide SAMI team meeting.

### More to Come.

We've got other plans, as well. More about this later. Stay tuned.



## Staff

SAMI Matters is produced by the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE), a partnership between the Mandel School of Applied Social Sciences, Case Western Reserve University (CWRU) and the Department of Psychiatry at the CWRU School of Medicine. The partnership is collaborating with the Ohio Department of Mental Health. Additional copies of this publication may be obtained by contacting the Ohio SAMI CCOE or by visiting our web site. We welcome and encourage your comments, questions, and suggestions.

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# Dual Recovery Anonymous (DRA)

## DRA encourages self-awareness through peer support

— **Patrick E. Boyle**, MSSA, LISW, CCDC III-E, CEAP, Director of Clinical Training, Ohio SAMI CCOE  
This article was written with information obtained from the Dual Recovery Anonymous (DRA) web site (see Resources below).



Tim Hamilton,  
Community Resource  
Director

Dual Recovery Anonymous is an independent Twelve-Step organization that is dedicated to helping men and women through the ongoing process of recovery from co-occurring substance abuse and mental health disorders. DRA consists of men and women who live with dual disorders. It is a non-profit peer-support group that meets regularly in community locations. DRA meetings are free. Newcomers do not need a formal referral from a physician or professional service provider; however, individuals may learn about the location of DRA meetings and connect with a current member by contacting a SAMI program. Service professionals in Ohio may learn about DRA meetings in or near their communities by contacting the Ohio SAMI CCOE (see page 13 for contact information).

### An Adjunct to Treatment

The DRA program is based on the principles of the Twelve Steps of Alcoholics Anonymous and the personal experiences of men and women in dual recovery. Those who attend DRA meetings express an interest in or a desire to stop using alcohol and other intoxicating drugs. They also express an interest in or desire to find strategies to manage their emotional or psychiatric illness in a healthy and constructive environment.

DRA acknowledges that chemical dependence and emotional or psychiatric illness affect individuals physically, psychologically, socially, and spiritually. In this way, DRA functions as an adjunct to formal treatment. It is a biopsychosocial approach to self-help, and it supports the work of formal psychoeducational pro-

grams, which are designed to provide a wide range of information to consumers about mental illness, including information about symptoms, diagnosis, treatments, and the effects of stress.

DRA provides a safe and trusting environment in which individuals with dual disorders feel free to discuss not only their substance abuse but their mental illness as well. In other Twelve Step programs (like AA, Narcotics Anonymous, Cocaine Anonymous), consumers may not feel free to talk about their mental illness because other people in the room who do not have mental illness typically might not understand their struggles. Consumers need an environment in which they can openly discuss their hopes, fears, struggles, and achievements. By hearing other people tell their stories, consumers often begin to tell their own stories. As a result, they begin to open up. Honest self-disclosure in the presence of others who are supportive helps consumers build self-awareness and fellowship, both of which are essential to the recovery process.

### Start a DRA Program

Ohio agencies can promote the development of DRA programs by contacting the Ohio SAMI CCOE, which will coordinate statewide training activities. Agencies should also consult the resource listed at the bottom of this page. If individual agencies arrange for training and consultation from the national DRA program, we ask that you let us know. We'd like to find ways to support your efforts.



## Resources

Tim Hamilton, Community Resource Director  
Dual Recovery Anonymous World Service Central Office  
P.O. Box 218232, Nashville, TN 37221-8232  
877-883-2332

<http://draonline.org/>

# Research & Evaluation



## Strong fidelity scores suggest next steps for SAMI programs

A report completed this spring by the Ohio SAMI CCOE indicates that SAMI programs in Ohio that have been funded to implement the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model are achieving good fidelity to the model. On average, the programs have achieved 82 percent of the total possible points on the IDDT Fidelity Scale, a standardized instrument used to identify the strengths of and challenges faced by the programs (see Resources below). This score places the programs firmly in the moderate range of fidelity.

“Moderate fidelity is a very positive outcome,” says Barbara L. Wieder, Ph.D., Director of Evidence-Based Practices Implementation Project Research at the Ohio SAMI CCOE, and co-author of the report (see page 3). “This indicates that the foundations of these programs are strong, even though not all of the model components have been fully developed. We expect that as the weaker areas of service get developed, scores will move closer to the high fidelity range.”

### Summary of strengths across program sites

Data gathered by site visit teams show that the following IDDT model components have been well developed at the Ohio pilot programs:

- Integration of mental health and substance abuse services
- Time-unlimited services
- Outreach capability
- Integrated mental health and substance abuse group treatment

Assessment teams that visited the programs were particularly impressed with SAMI program staff particularly their dedication, commitment, and knowledge of IDDT model components. Considerable successes were observed with the following:

- Cohesion of SAMI teams
- Enthusiasm for the SAMI program

- and genuine caring about consumers
- Commitment to ongoing training and striving for excellence
- Positive influence upon the culture and clinical approaches of other agency staff

Additional impacts on the larger community were documented, including the following:

- Collaboration between mental health and substance abuse boards
- Collaboration between boards and agencies
- Collaboration among allied community systems (e.g., mental health, substance abuse, and criminal justice)

### Challenges faced by SAMI programs

Most programs experienced challenges with these elements of the IDDT model:

- Crisis plan
- Family intervention

Assessment teams documented a number of barriers to IDDT model fidelity common across programs:

- Insufficient housing, residential treatment, and group homes for SAMI consumers
- Economic disincentives for consumer employment
- Billing challenges for some services, such as community outreach
- Difficulty taking time to attend staff training

### Next steps

The assessment teams observed that identifying challenges leads to growth. The following emerged as immediate priorities:

- Sustain staff training (especially motivational interviewing) by reinforcing it during regular team meetings
- Develop family outreach and interventions
- Develop strategies for program sustainability



## Resources

The IDDT Fidelity Scale can be found on the SAMI CCOE web site:

<http://www.ohiosamiccoe.cwru.edu/research/research.html>



# Your expert knowledge.

If you've developed a successful technique or have a story about engaging and interacting with consumers or consumer support networks that might be beneficial to other service providers in their practice, we'd like to write a story about you (see page 11 for an example). The success of integrated treatment in Ohio depends upon you. Keep up the good work.

Our contact information is on page 3.



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