Ohio becomes first in nation to implement IDDT in state hospital system

The Integrated Behavioral Healthcare System (IBHS) operated by the Ohio Department of Mental Health (ODMH) has become the first psychiatric hospital system in the United States to adapt the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model for use in an inpatient setting. IDDT was originally designed for community-based systems of care to reduce gaps in service to persons with co-occurring substance abuse and mental health disorders by incorporating substance abuse services within mental health systems. Twenty-one community-based agencies throughout Ohio have implemented, or are in the process of implementing, IDDT. The state hospital initiative will help create an integrated system of inpatient and community-based care in Ohio that will provide consumers with a seamless treatment experience as they transition from one setting to another. ODMH estimates that between 40 to 70 percent of the consumers who utilize state hospitals have co-occurring disorders.

The Ohio SAMI CCOE has been providing technical assistance to ODMH since the planning process for the state hospital project began in April 2002 and has been coordinating implementation since that process began last autumn. Within ODMH’s IBHS, there are five Behavioral Healthcare Organizations (BHOs) that operate nine hospital campuses (see page 2). Each site is introducing IDDT-based substance abuse and mental illness (SAMI) services. The CCOE is also providing program consultation, clinical consultation, research and evaluation, and education and training services to all nine hospital campuses.

New fidelity scale being piloted
According to Patrick Boyle, MSSA, LISW, CCDC III-E, Director of Clinical Training at the Ohio SAMI CCOE, the CCOE helped the BHOs initiate their adaptation of the community-based IDDT model to the inpatient setting by modifying the IDDT Fidelity Scale, a standardized instrument that community mental health agencies use to implement the model and to evaluate the implementation process. The community-based...
IDDT model and its Fidelity Scale were originally developed by Robert E. Drake, M.D., Ph.D., and his colleagues at Dartmouth College and the New Hampshire-Dartmouth Psychiatric Research Center in Lebanon, New Hampshire. The most recent version of the Fidelity Scale contains 26 items. Each item represents an organizational (administrative) or treatment (service) component of the IDDT model. The CCOE uses the Fidelity Scale in its consultations with Ohio community mental health agencies. The CCOE and the agencies use the Fidelity Scale in partnership to conduct fidelity assessments, which evaluate the degree to which the agencies’ IDDT programs adhere to the IDDT model. Research has shown that programs produce positive consumer and administrative outcomes when they work to maintain fidelity to the model. Boyle describes the Fidelity Scale as the blueprint for IDDT-based SAMI programs.

“I cannot stress enough the importance of the Fidelity Scale,” he says. “It’s a set of standards developed from well over a decade of research studies. If an organization wants to implement IDDT, it will implement it according to the Fidelity Scale. Anything short of this will likely compromise outcomes. We are eagerly piloting the new Inpatient IDDT Fidelity Scale to set new standards for hospital care.”

Boyle has been working closely with ODMH’s Intensive Specialized Services (ISS) Committee, which oversees the hospital-implementation project, to adapt the community-based IDDT Fidelity Scale for the inpatient setting. He has also been working with Barbara Wieder, Ph.D., Director of Evidence-Based Practices Implementation Project Research at the CCOE, and the Inpatient Fidelity Scale development team (see page 3), which has reduced the community-based Scale to 23 items. The team has also modified some fidelity items because there are components of the community-based IDDT model that will not work in hospitals. For instance, the IDDT model requires community-based agencies to provide treatment that is long term and time unlimited, with no termination dates. Because hospital stays are typically short term, this fidelity item was changed to a required discharge plan that involves a case manager from a community-based IDDT program. The discharge plan will help consumers transition from the IDDT program in the hospital to a time-unlimited IDDT program in the community.

According to Wilma J. Lutz, Ph.D., RN, Research Administrator at ODMH’s Office of Program Evaluation and Research and co-author of the Fidelity Scale, although the team changed items on the community-based Fidelity Scale, the underlying principles of IDDT have remained the same.

“We were excited to discover how relevant the IDDT model is to the inpatient setting,” Dr. Lutz says.

The Fidelity Scale team conducted a pilot test of the new Inpatient Fidelity Scale at ODMH’s Twin Valley BHO in Columbus in October and at Summit BHO in Cincinnati in January. According to Dr. Wieder, these trials will help the team evaluate and revise the Fidelity Scale where needed. ODMH plans to implement the adapted inpatient IDDT model at all of its BHO campuses.

“This instrument will continue to evolve,” Dr. Wieder says. “The more we use it in real-world applications, the more we will understand its usefulness. This process of evaluation will help us improve what we are doing.”

**Inpatient IDDT creates continuity of care**

According to Lenore A. Kola, Ph.D., and Robert J. Ronis, M.D., MPH, Co-Directors of the Ohio SAMI CCOE, the implementation of IDDT in the inpatient setting is preparing Ohio’s mental health system for a significant change.

“As we look into the future, we can see a culture of continuity of care beginning to emerge in the system with the use of IDDT,” Dr. Kola says. “We have a lot of work to do to get there, but we are building the foundation. Research has shown...
that IDDT accelerates recovery. As consumers enter inpatient care, there will be SAMI teams available to help them develop or recover their independent living skills as quickly as they are capable. If they are then discharged to a SAMI team in the community, there will be a continuity of care that is likely to produce excellent outcomes for consumers and the system."

Dr. Ronis adds that the discharge plan required by the hospital-based Fidelity Scale will not only increase continuity of care and consumer satisfaction but will also facilitate new partnerships between inpatient facilities and community agencies.

“Currently, there is no mechanism for collaboration,” he says. “The professional service providers at both types of facilities have operated, more or less, in their own subsystems without any knowledge of each other. We have already begun to see an increase in communication among professionals in these systems and, therefore, an increase in the sharing of lessons learned through practice. This will definitely make SAMI programs in the hospitals and in the community much more capable of meeting consumer needs.”

Dale P. Svendsen, M.D., Medical Director of ODMH, explains that the presence of IDDT in state hospitals located in communities that do not have IDDT-based SAMI programs may influence agencies in those communities to develop such programs. He adds that state hospitals with IDDT will also influence the training of professional service providers.

“Most BHOs have medical students and residents and other professional mental health students,” he says. “They will learn this model and hopefully take it into practice.”

The state hospital initiative will help create an integrated system of inpatient and community-based care in Ohio that will provide consumers with a seamless treatment experience as they transition from one setting to another.

Inpatient Fidelity-Scale Development Team

- Barbara Wieder, Ph.D., Director of Evidence-Based Practices Implementation Project Research, Ohio SAMI CCOE
- Patrick Boyle, MSSA, LISW, CCDC III-E, Director of Clinical Training, Ohio SAMI CCOE
- Wilma J. Lutz, Ph.D., RN, Research Administrator, Office of Program Evaluation and Research, Ohio Department of Mental Health
- Georgeann Neuzil, RN, Coordinator of SAMI Services, Twin Valley Behavioral Healthcare--Columbus
- Mark Hurst, M.D., Assistant CCO, Addiction Psychiatry, Twin Valley Behavioral Healthcare--Columbus
- Bill Krenek, MEd, Rehab Counselor and SAMI Coordinator, Northcoast Behavioral Healthcare--South Campus
- Gilho Cho, Ph.D., Psychologist, Northcoast Behavioral Healthcare--South Campus
- Deborah Vorst, OTR/L, Assistant Director of Occupational Therapy/Clinical Standards Coordinator, Summit Behavioral Healthcare

Resources

For more information about the Ohio Department of Mental Health’s Integrated Behavioral Healthcare System (IBHS), visit this web site: http://www.mh.state.oh.us/offices/ibhs/website/ibhs.home.html

To learn more about the IDDT Fidelity Scale and the Ohio SAMI CCOE’s research and evaluation services, visit this web page: http://www.ohiosamiccoe.cwru.edu/research/research.html
Wilma J. Lutz, Ph.D., RN, Research Administrator at the Ohio Department of Mental Health’s (ODMH’s) Office of Program Evaluation and Research, has been providing leadership for the research and evaluation components of the State’s implementation of the New Hampshire-Dartmouth IDDT model. Her contributions have been numerous and significant. She has participated in planning and oversight committees and fidelity review teams. She has developed data-collection instruments, conducted numerous analyses, disseminated research results and resource information, and worked with agencies and trainers to educate service professionals about the importance of fidelity reviews and evaluations of evidence-based practices. She also served as a member of the Ohio SAMI CCOE Advisory Committee.

Dr. Lutz’s contributions to IDDT implementation date back to the planning processes that occurred in 1999. She helped write the original Request for Proposals for the two-year pilot program that was funded by ODMH and the Ohio Department of Alcohol and Drug Addiction Services. Nine community agencies were awarded funds for the pilot program, which ended in June 2002. She helped write the proposal review criteria, design the site review process, and develop a summary report that provides agencies with feedback from the fidelity visits. All of the instruments that she has helped create continue to be used. Dr. Lutz conducted much of her early work on IDDT in collaboration with Paul Schreur.

Dr. Lutz is currently the State Evaluator for Ohio’s participation in the National Implementing Evidence-Based Practices Project (see page 5). She is working with Barbara Wieder, Ph.D., of the Ohio SAMI CCOE, to analyze fidelity and consumer outcomes data from Ohio agencies that are implementing the IDDT model and the Illness Management and Recovery model. Dr. Lutz is also a member of the team overseeing the implementation of IDDT in ODMH’s state hospital system and is a co-author of the Inpatient IDDT Fidelity Scale (see page 1). Dr. Lutz has worked at ODMH since 1997.

Cheek brings IDDT and Recovery to Northcoast BHO

Northcoast Behavioral Health is a Behavioral Healthcare Organization (BHO) that is part of the Ohio Department of Mental Health’s (ODMH’s) Integrated Behavioral Healthcare System (IBHS). There are five BHOs in the State system, all of which provide inpatient services to persons with severe and persistent mental illness. Northcoast manages three hospital campuses, one in Cleveland, Northfield, and Toledo (see map on page 2). The Northfield campus has been home to the Ohio SAMI CCOE since spring 2000.

According to Tom Cheek, MBA, Chief Executive Officer, Northcoast is currently involved in an era of innovation. It is participating in ODMH’s initiative to implement the New Hampshire-Dartmouth IDDT model in the state hospital system (see page 1), and it is also implementing ODMH’s recovery model, Emerging Best Practices in Mental Health Recovery. Cheek explains that the recovery model represents a shift in treatment philosophy, because it requires service providers to include consumers as partners in the treatment process.

“Research shows that individuals who determine their own goals are more likely to succeed than if someone else had made those decisions for them,” Cheek says. “In the recovery approach, we engage the patient in the process so they understand it and make the choices that will get them back into the community, in an improved living environment.”

Cheek adds that the implementation of the recovery model and IDDT will be an ongoing process in which staff members will receive continuous training and patients will receive continuous encouragement. Cheek has been CEO of Northcoast since 2001. He began his career in 1971 as a researcher in a clinical lab at ODMH’s Fallsview Psychiatric Hospital in Cuyahoga Falls. He later became director of support services and chief operating officer.
Ohio agencies advance toward EBP implementation

Four Ohio agencies that are participating in the national Implementing Evidence-Based Practices (EBP) Project have begun to establish the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model in their communities with the help of the Ohio SAMI CCOE. In September, the CCOE began to provide three core services, which include program consultation, training in the IDDT model, and consultation to community-based implementation committees. Each SAMI program has a steering committee that oversees implementation. It is comprised of agency staff, county mental health board staff, and a wide range of community stakeholders.

According to SAMI CCOE Assistant Director of Clinical Training Ric Kruszynski, MSSA, LISW, CCDC III-E, the Ohio Department of Mental Health (ODMH) and the CCOE selected the four sites to participate in the national EBP project because of their demonstrated interest and commitment to IDDT. Kruszynski oversees implementation for the EBP sites in Ohio. Barbara Wieder, Ph.D., Director of Evidence-Based Practices Implementation Project Research at the CCOE, is conducting the evaluation of the implementation process.

Wood County

Behavior Connections in Bowling Green is implementing IDDT with its ACT team and has had 10 staff complete the IDDT intensive training. The small group size has facilitated open discussions about IDDT implementation. “Experiential learning is important to this group,” Kruszynski says. “Each training session has brought about clinical and administrative discussions that are based on their own professional experiences. This proves to be a very helpful way to reinforce what is learned in training.”

Franklin County

Southeast, Inc. in Columbus is implementing two SAMI teams—one for consumers in the criminal justice system and another for consumers who are homeless. This makes Southeast, Inc. the largest EBP project in Ohio. “This is an ambitious group,” Kruszynski says. “They are using IDDT to address the needs of two very difficult-to-serve populations. IDDT offers the teams new opportunities to reach out to these folks. That’s the beauty of this model, and this group understands it.”

Delaware/Morrow County

All SAMI team members at Central Ohio Mental Health Services in Delaware have completed the EBP Implementation training, as well as all training events sponsored by the CCOE since the fall of 2002. As a result, each staff member has acquired 50 to 60 hours of training in the last six months. “I commend the staff for making an extraordinary effort to immerse themselves in this model,” Kruszynski says.

Fairfield County

New Horizons in Lancaster was the first of the four Ohio-IDDT sites to complete the EBP intensive training. Administrators, supervisors, and direct service providers attended the training because New Horizons is implementing an integrated-services philosophy for the entire agency. “The administrators and supervisors are the people involved in all aspects of the organization,” Kruszynski says. “Training them ensures that clinical knowledge and skills are cross-pollinated throughout the agency.”

Resources

The Ohio SAMI CCOE provides program consultation to help service agencies and county-level boards implement IDDT-based SAMI programs. For more information, visit this section of the SAMI CCOE web site: http://www.ohiosamiccoe.cwru.edu/program/program.html
In an era when sophisticated technologies continue to reduce opportunities for human interaction, the SAMI PACT program in Summit County demonstrates the importance of relationships. For county and agency administrators, service professionals, and mental health consumers and their caregivers, it is obvious that good relationships do good work. When the SAMI PACT program began to implement the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model in April 2000, it was serving 32 persons with co-occurring substance abuse and mental health disorders. Today, it serves 74. Research data from fidelity assessments and other analyses have revealed consistent improvements in consumer outcomes, including reductions in incarceration, community hospitalization, and use of crisis services. There has also been an increase in abstinence and stable housing. Of the 74 (soon to be 75) consumers in the SAMI PACT program, only three do not live in the community (one is in the county jail, one is in a state hospital, and one is in a respite shelter but will soon move into an apartment).

SAMI PACT Supervisor Sveto Popovic, MEd, PCC, CCDC-III-E, attributes the success to synergy among administrators and service professionals. He explains that administrators at Summit County’s Alcohol, Drug Addiction, and Mental Health Services (ADM) Board support the two agencies that collaborate to form PACT (see sidebar) by providing financial resources, research services, and program consultation. In turn, administrators at the agencies support the service professionals by providing time for adequate training in the IDDT model and by insisting that everyone maintain fidelity to it. SAMI team members maintain a low case load (10 to 1) and spend much of their time in the community working with consumers and caregivers.

**Assertive Outreach**

PACT is an acronym for Program of Assertive Community Treatment. It is a team-based approach to providing services. With PACT, each consumer is assigned not to a single case manager but to a team of interdisciplinary professionals, who provide wrap-around services, including case management, medication management, mental health therapy, addictions counseling, and housing services, among others. Team members visit consumers often in their homes to ensure they are able to cook and clean and maintain the property in which they reside. They also work with other community agencies that provide complementary services, such as home health assistance. The team nurse vis-
its consumers regularly to review their medication usage and to monitor other health issues, such as diabetes.

Yet spending time with consumers in the community does not mean that team members are doing most of the work for consumers; they are doing work with consumers, teaching them how to care for themselves. Popovic has been a case manager since 1990. He describes the IDDT-based SAMI approach to case management as “an evolution” of the profession.

“When I started, case managers were doing more for the clients but now we are being a coach,” he says. “We are promoting independence and recovery. The goal is to keep people in the community. We want to help each person develop independence. If we foster dependence and the person’s support system is taken away, they are going to fail in the community. However, if they have independent living skills, they are going to survive. They’ll know how to fill a void in their social network. They’ll know how to get what they need in socially acceptable ways.”

Reducing negative consequences

Popovic attributes the SAMI PACT team’s success to thorough training in the IDDT model as well as to thorough training in both mental health and addictions interventions. The cross-training, he explains, has created a treatment philosophy that combines the goal of incremental reduction of substance use with the long-term goal of abstinence, as well as the goal of developing and maintaining long-term psychiatric stability.

“This enables us to meet the clients where they are in the recovery process, not where we want them to be,” Popovic says. “Many of them find comfort in drinking or taking drugs. It’s unrealistic to tell them that their life will get better if they stop using immediately. It won’t. If you take away their comfort, their level of anxiety increases dramatically. To cope with the anxiety, they often return to drugs and alcohol for comfort.”

The SAMI team encourages consumers to reduce their use of alcohol and other drugs incrementally. First, team members encourage consumers to stop using drugs and alcohol on the street, where they are likely to get arrested for the behavior (this also helps reduce rates of incarceration). Once consumers achieve this initial goal, the team asks them to reduce the amount of alcohol and drugs they are consuming, for instance, from two six-packs of beer per day to one. Once this goal is met, team members help consumers reduce the amount that they use until they achieve abstinence. This process, Popovic explains, helps consumers build a sense of accomplishment and pride and the confidence they need to turn to bigger goals, like employment.

Research guides practice

Program evaluation research conducted by the Summit County ADM Board and the Ohio SAMI CCOE has revealed a growing interest in employment among consumers, as well as the need for an employment specialist to join the SAMI team. An employment specialist is a social work professional who dedicates himself or herself to building and maintaining relationships with employment training programs and potential employers in the community.

Popovic explains that consumer demand for employment services has increased because there are now more consumers in advanced stages of treatment who understand they are capable of finding and maintaining a job.

According to Paula Rabinowitz, RN, MSN, CNS, Planning and Evaluation Nurse at the Summit County ADM Board, the evaluation research has identified other service needs as well. As a result, the SAMI PACT program has submitted an application for a Targeted Capacity Expansion Grant from the Substance Abuse and Mental Health Services Administration. The application includes budget requests for the employment specialist, a half-time peer recovery worker, an additional nurse, additional psychiatry hours, and a van to transport consumers.

Rabinowitz emphasizes the importance of research in identifying service needs and planning for service changes. She explains that the ADM Board takes an assertive approach to research, utilizing as many sources of data as possible, including the IDDT Fidelity Scale and fidelity site visits (see page 8), as well as case management data sheets and audits of case records.

“The outcome data provide an honest evaluation,” Rabinowitz says. “If we didn’t have it available, we’d be at a disadvantage in our planning.”

—Terrence B. Dalton, MEd, LSW, Chief Operating Officer, Community Support Services

“”

---

Resources

Summit County SAMI PACT, 680 East Market St., Suite 400, Akron, Ohio 44305, 330.315.4410 (phone), 330.315.4414 (fax), pactcm1@aol.com
Community Support Services
www.cssbh.org

Community Health Center
www.commhealthcenter.org

Terry Dalton, MEd, LSW

---
The Ohio SAMI CCOE has been assisting the Ohio Department of Mental Health (ODMH) in creating and facilitating the activities of five Regional Networks that are promoting training, consultation, and advocacy initiatives intended to sustain the implementation of the New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model in Ohio. IDDT is being implemented in community agencies and in ODMH’s inpatient Behavioral Healthcare Organizations (BHOs) (see page 1). The purpose of each Regional Network is to share information about the facilitators and barriers to IDDT implementation and to infuse needed resources within each region.

“We have been developing IDDT-based SAMI programs in Ohio by emphasizing the importance of collaboration among professionals, agencies, and other stakeholders,” says Patrick Boyle, MSSA, LISW, CCDC III-E, Director of Clinical Training at the Ohio SAMI CCOE. “The Regional Networks will provide a formal structure for that collaboration to continue. They will encourage agency professionals to share the lessons that they have learned directly with one another so that they may avoid common pitfalls and capitalize on strategies that work.”

Boyle adds that the information shared in the Regional Networks will also help ODMH and the SAMI CCOE plan for future program consultation, training, and advocacy initiatives.

Each Regional Network is comprised of a Regional Stakeholder Committee. ODMH and the SAMI CCOE recruit members for the Regional Committees from the Implementation Committee at each community agency and each BHO that is implementing IDDT. These local committees are comprised of IDDT program leaders, consumers, family members, and community stakeholders who monitor program development and outcomes. Other community stakeholders may include representatives from housing, employment and vocational rehabilitation, corrections, courts, criminal justice, and community hospitals. ODMH and the SAMI CCOE recruit these individuals to ensure that the Regional Networks will have experience addressing the facilitators and barriers to IDDT implementation. Each committee meets quarterly and is facilitated by chairpersons who have expertise in overseeing the implementation of IDDT and in working with large groups. Chairpersons are also members of the Ohio SAMI CCOE Advisory Council that meets semi-annually.

Each Regional Network has representation from ODMH’s regionally based Area Directors and will have input from the Ohio Department of Alcohol and Drug Addiction Services.
The Ohio SAMI CCOE conducted fidelity self-study training in October for Ohio agencies implementing the New Hampshire-Dartmouth IDDT model. The training equipped agencies with the ability to collect data about their IDDT-based SAMI programs using the IDDT Fidelity Scale, consumer and caregiver interviews, and case-record reviews. The agencies will forward the data to the CCOE, which will generate fidelity scores and reports and provide feedback to the agencies about the degree to which their SAMI programs appear to be maintaining fidelity to the IDDT model. Agencies will use this information as part of their quality improvement process to identify the strengths of and challenges faced by their programs. Research shows that SAMI programs produce the best consumer outcomes and program outcomes when they maintain fidelity to the model. The Fidelity Scale is a research instrument that contains 26 fidelity items. Each item represents an organizational (administrative) or treatment (service) component of the IDDT model. The CCOE uses the Scale as a program development tool. It provides program consultation to the agencies to help them respond to issues and concerns identified in the self-study reviews.

The fidelity self-study is part of a statewide initiative lead by the Ohio SAMI CCOE to provide timely and accurate fidelity assessments. The IDDT model encourages agencies to conduct semi-annual fidelity assessments, especially during the first two years of program implementation. Prior to the self-study training, the CCOE conducted the semi-annual assessments through half-day fidelity site visits at each agency. The site visits began during the two-year pilot implementation of IDDT that was funded by the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Nine Ohio agencies participated in the two-year pilot implementation, which ended in June 2002. Since then, the number of agencies implementing IDDT has increased to 21.

The CCOE and ODMH decided to expedite the fidelity review process by training the agencies to conduct an annual self-study. The CCOE will continue to conduct one in-person site visit at each agency per year. Evaluation teams will be comprised of representatives from ODMH, ODADAS, and the SAMI CCOE. The teams will also include peer evaluators--program administrators and team leaders--from other IDDT programs.

David E. Biegel, Ph.D., Director of Research and Evaluation at the CCOE, Sylvia Leibbrandt, Research Associate, and Patrick Boyle, Director of Clinical Training, coordinated and co-facilitated the self-study training.

Susan Armour, MA, LSW, CCDC-III

“The training opened my eyes to things we don’t do. It’s easy to get off track in daily life, because we get caught up in putting out fires. Staying focused on the SAMI program components is a task that we all have to do. The Fidelity Scale is a very helpful reminder of what a SAMI program is supposed to be. I use it in supervision with my staff, and we use it when we assess clients for treatment readiness.”

—Susan Armour, MA, LSW, CCDC-III, SAMI Program Manager, Allen County Lutheran Social Services of North Western Ohio, Lima, Ohio

Resources
The IDDT Fidelity Scale can be found on the SAMI CCOE web site: http://www.ohiosamiccoe.cwru.edu/research/research.html
Behavioral Family Therapy (BFT) is based upon a stage-wise treatment strategy. There are two types of family interventions for dual disorders, single-family group treatment (SFGT) and multiple-family group treatment (MFGT).

**Facts about families**
- Many consumers with co-occurring substance abuse and mental health (dual) disorders have regular contact with their relatives and often live at home.
- Consumers tend to have limited social networks and rely on relatives.
- Families often know little about dual disorders and may unintentionally enable consumers to use alcohol and other drugs.

**Challenges for families**
- Caring for a person with severe mental illness (SMI) is associated with high levels of stress.
- Caregiver stress weakens family support to the consumer, who, as a result, may experience housing instability and homelessness.

**Benefits for families**
- Family interventions reduce stress on family members, enabling them to continue their support of the consumer.
- Research indicates that family interventions for consumers with SMI reduce relapse and hospitalization by 25 to 75 percent.
- Research shows that family therapy is more effective than individual therapy, peer group therapy, or family psychoeducation for improving substance abuse outcomes.

**Goals of BFT**
- Legitimize psychiatric and substance use disorders as medical illnesses
- Lower stress and burden on all family members through improved communication skills
- Help families learn problem-solving skills

**Components of BFT**
- Psychoeducation (e.g., facts about the disorder(s); stress-vulnerability model; role of medications; role of family and social support network; facts about medications; use of alcohol and other drugs)
- Communication-skills training (e.g. conflict management, expressing unpleasant feelings and positive feelings, making positive requests, compromise and negotiation)
- Problem-solving training
- Builds upon family strengths
- Structured yet flexible step-by-step approach
- Stage-wise treatment approach

**Stage-Wise Treatment**
- Recovery takes place over a series of stages and the goals and treatment strategies vary with each stage.
- Consumers and family members may be in different stages of treatment.

<table>
<thead>
<tr>
<th>Component</th>
<th>Phases of Treatment</th>
<th>Number of Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Beginning</td>
<td>1 to 3</td>
</tr>
<tr>
<td>Assessment</td>
<td>Initially and Throughout</td>
<td>1 to 3 (each individual)</td>
</tr>
<tr>
<td>Education</td>
<td>Early to Middle</td>
<td>2 to 4</td>
</tr>
<tr>
<td>Communication Skills Training</td>
<td>Middle to Late</td>
<td>4 to 10</td>
</tr>
<tr>
<td>Problem-Solving Training</td>
<td>Middle to Late</td>
<td>4 to 12</td>
</tr>
<tr>
<td>Special Problems</td>
<td>Late</td>
<td>1 to 5</td>
</tr>
</tbody>
</table>
Single-Family Group Treatment (SFGT)

This time-limited intervention model is based upon the Behavioral Family Therapy model developed for schizophrenia. It utilizes psychoeducation and training to help family members with the following:
- Maintain involvement in the life of the consumer
- Address and reduce the impact of substance abuse upon themselves
- Make progress toward personal and shared goals

Logistics
- Meetings are conducted either in the home of a family member or in the community agency and usually last for one hour.
- Participants in the sessions include the consumer and any relatives and friends who are involved in the consumer's life (e.g., parents, siblings, spouses, children, clergy, etc.).

Phases of SFGT

<table>
<thead>
<tr>
<th>Phase</th>
<th># of meetings</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting</td>
<td>3 to 4</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Assessment</td>
<td>1</td>
<td>2 to 3 weeks</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>6</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>10 to 15</td>
<td>9 months</td>
</tr>
<tr>
<td>Termination</td>
<td>1</td>
<td>1 week</td>
</tr>
</tbody>
</table>

Multiple-Family Group Treatment (MFGT)

This time-unlimited intervention is based on the model developed for the Treatment Strategies for Schizophrenia study. Group meetings provide the following:
- Ongoing psychoeducation about the management of dual disorders
- Validation of experiences and social support from other families
- Connection with the treatment team

Logistics
- At least three families participate.
- Maximum group size is 30.
- Both consumers and family members attend.
- Meetings are co-led by professionals from the agency and the treatment team that works with the consumer.

Structure of Group Meetings

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greetings, introductions, caring, and sharing</td>
<td>5 to 10 minutes</td>
</tr>
<tr>
<td>Presentation on educational topic</td>
<td>20 to 35 minutes</td>
</tr>
<tr>
<td>Group discussion</td>
<td>20 to 35 minutes</td>
</tr>
<tr>
<td>Wrap-up, discuss future topics for discussion</td>
<td>5 to 10 minutes</td>
</tr>
</tbody>
</table>

Resources

---This article was composed by excerpting portions of the following with permission:

To learn how to implement Behavioral Family Therapy at your agency, contact Patrick Boyle, Director of Clinical Training at the Ohio SAMI CCOE (see page 15).
The Mandel School of Applied Social Sciences (MSASS) at Case Western Reserve University (CWRU) has created the Center on Substance Abuse and Mental Illness (SAMI Center) to conduct research, disseminate evidence-based practices through training and consultation, and sponsor education initiatives in an effort to improve services to persons with co-occurring mental and substance-use disorders. Evidence-based practices are health and human service programs that research has shown to generate positive outcomes.

According to Co-Director Mark Singer, Ph.D., Professor of Social Work at MSASS, the SAMI Center builds upon almost three decades of previous work conducted at the School under the leadership of Lenore A. Kola, Ph.D., Associate Professor of Social Work and Dean of the CWRU School of Graduate Studies. Over one third of MSASS faculty members have an expertise in mental disorders, substance-use disorders, and co-occurring mental and substance-use (dual) disorders. Faculty members also have an expertise in assembling multidisciplinary teams of researchers, trainers, and educators. They have been developing and maintaining collaborative relationships with individuals from various departments and schools within CWRU, community-based service agencies throughout Ohio, and agencies of state and federal government.

“The SAMI Center enables MSASS faculty members to expand their work and to demonstrate their leadership in multidisciplinary projects,” Dr. Singer says. “The Center provides an infrastructure for communication and collaboration. It will position MSASS as a leader in the field by leveraging local, regional, and national expertise.”

Research
At the core of the Center’s research activities is a five-year $1.9 million grant that MSASS received from the National Institute on Drug Abuse (NIDA) last fall. This is among the largest Federal grants in MSASS’ history. Only six schools of social work were chosen for this type of award. The grant will support three pilot research projects that will produce a better understanding of how to diagnose and treat people with co-occurring mental and substance-use disorders and how to provide services to consumers and caregivers. The core research team will include seven faculty members from MSASS and two from the School of Medicine. Two pilot projects will focus on experiences of women with dual diagnoses and one will focus on the experiences of caregivers. Results of these pilot studies will be used in future applications for major research grants from the National Institutes of Health.

Training and Consultation
According to Co-Director David E. Biegel, Ph.D., The Henry L. Zucker Professor of Social Work Practice at MSASS, the new SAMI Center will also disseminate evidence-based practices pertaining to mental and substance-use disorders to health and human service professionals and to policy makers throughout the nation through training programs, consultation services, and other dissemination mechanisms. In Ohio, the dissemination of the Integrated Dual Disorders Treatment (IDDT) model will be undertaken by the Ohio SAMI CCOE, a component of the SAMI Center. Dr. Biegel describes these initiatives as imperative because they translate the research (evidence) into the policies and practices that improve quality of life for consumers.

“You too often there are barriers preventing the use of evidence-based practices by health and human service professionals,” Dr. Biegel says. “The SAMI Center can help address these barriers. This is consistent with the Mandel School’s mission of helping practitioners, agency administrators, and policy makers integrate new knowledge efficiently and effectively into real-world applications.”

Education
The core of the SAMI Center’s education initiative is MSASS’ Dual Diagnosis Clinical Residency Training Program for Social Work Students. The program is designed to prepare master’s degree students for careers in the field of dual disorders (see page 11).

—Jeff Bendix of the CWRU Office of University Communication contributed to this story.
Mandel School among first in nation to offer master's degree in integrated treatment

The Mandel School of Applied Social Sciences (MSASS) at Case Western Reserve University (CWRU) is among the first master’s degree programs in the country to offer a specialized program in dual disorders and integrated treatment. The Dual Diagnosis Clinical Residency Training Program for Social Work Students commenced during the Fall Semester 2000. This innovation in teaching addresses the need to systematically educate social work students about effective interventions for persons with co-occurring mental health and substance abuse disorders. Students who are enrolled in the mental health or the alcohol-and-other-drugs concentration within MSASS’ two-year Master of Science in Social Administration program may apply to the Residency Training Program. The Residency Program incorporates classroom experiences with field placements, field seminars, and professional-training workshops. MSASS is ranked among the top ten professional schools of social work in the nation. The Clinical Residency Training Program is being funded by the Ohio Department of Mental Health.

Lenore A. Kola, Ph.D., Associate Professor of Social Work at MSASS, Dean of the School of Graduate Studies at CWRU, and Co-Director of the Ohio SAMI CCOE, directs the Residency Training Program. She explains that the curriculum teaches interventions from the evidence-based New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model.

“The Dartmouth model integrates substance abuse services and mental health services in the same agency so that consumers can get help for both disorders from the same team of providers,” Dr. Kola says. “In the past, we graduated people from separate concentrations because, in the field, the professions were separate. Until recently, consumers had to find two different agencies to help them with each diagnosis. We now know from research that the knowledge and skills from both disciplines have to be contained within the same person. It makes for better practice.”

Dr. Kola adds that MSASS’ Residency Training Program will not only prepare practitioners who are capable of working effectively with dual disorders, but it will also prepare these professionals to acquire leadership roles in their agencies, especially as more agencies begin to adapt the integrated services model. Needs assessment surveys conducted by the Ohio SAMI CCOE have revealed that few Ohio agencies are currently equipped to implement integrated treatment.

The new Residency Training Program builds upon over 25 years of research and teaching by MSASS faculty on issues related to mental health and substance abuse services. Much of that experience has been guided by Dr. Kola, who served as chair of MSASS’ alcohol-and-other-drug-abuse concentration from 1976 to 2000. Dr. Kola has developed master’s-level courses and training courses for human service professionals throughout her career. In 1999, she developed the Woodruff Training Program for Addiction Practitioners, which was funded by the Woodruff Foundation and Cuyahoga County’s Community Mental Health Board and Alcohol and Drug Addiction Services Board. In 2000, she developed a master’s course entitled Social Work Interventions in Co-occurring Mental and Substance Use Disorders.
New center addresses co-occurring bi-polar and substance abuse disorders

The Research Institute of University Hospitals of Cleveland (UHC) and the CWRU School of Medicine dedicated a new Center of Excellence for Care and Study of Children and Adults with Bipolar Disorder and Alcohol/Drug Abuse in October.

The dedication included remarks from Pedro Delgado, M.D., The Douglas Bond Professor and Chair of the Department of Psychiatry at the CWRU School of Medicine and U.S. Representatives Marcy Kaptur (D-9th District) and Stephanie Tubbs Jones (D-11th District). Kaptur was instrumental in obtaining a grant of $987,000 from the Health Resources and Services Administration (HRSA), which is part of the U.S. Department of Health and Human Services. UHC will match the grant with $1 million over three years. The Center will work with people of all ages who are suffering from bipolar disorder and will specialize in consultation, treatment, and research. The new funding will allow the Center to build and maintain a network of tertiary care sites across northeast Ohio, including UHC, Louis Stokes Cleveland Veterans Affairs Medical Center, the Cleveland Clinic Foundation, and several community mental health settings. The Center will be co-directed by Joseph Calabrese, M.D., Professor of Psychiatry, and Robert L. Findling, M.D., Associate Professor of Psychiatry.

According to Lenore A. Kola, Ph.D., and Robert J. Ronis, M.D., MPH, Co-Directors of the Ohio SAMI CCOE, the new Bipolar Center will help position CWRU as a national leader in treatment of co-occurring disorders. The Bipolar Center joins the Ohio SAMI CCOE and the SAMI Center (see page 11) as the third expert resource on co-occurring disorders.

“This new Center completes a triad of opportunity for collaboration in dual disorders at CWRU,” Dr. Ronis says. “We are extremely excited by this development and are looking forward to what comes next.”

Dr. Kola adds that the strength of all three centers is that each is dedicated to research and training, which fulfills the University’s mission of creating and disseminating new knowledge.

“At the present time, few, if any, academic institutions have coordinated research, clinical practice, curriculum development, and training agendas in this area of dual disorders,” she says. “CWRU is currently in a unique position to influence the future of clinical services.”

—George Stamatis of CWRU’s Office of University Communication contributed to this story.

Big Thanks!

The following enhancements to the SAMI CCOE website were made possible by the generous support of the Woodruff Foundation of Cleveland.

- Event Calendar and Online Registration
- Mailing List
- Message Board
- Additional enhancements are being funded by the Bruening Foundation, also of Cleveland.

www.ohiosamiccoe.cwru.edu

Join the Chat

Help your colleagues throughout Ohio and around the world get up-to-speed with IDDT.

The Ohio SAMI CCOE has not only been consulting with agencies and county and state boards in Ohio but also with those in Indiana, Kansas, Oregon, England, and Australia. Participate in the creation of worldwide SAMI team meetings online. Ask questions. Get answers. Share the lessons that you’ve learned through practice. Log on today.

www.ohiosamiccoe.cwru.edu/training/messageboard_fr.html
The Ohio SAMI CCOE held its first National Advisory Council Meeting on March 14, 2003. The second meeting will be held September 17, 2003.
And register online to receive a reminder [www.ohiosamiccoe.cwru.edu/contact/contactus.html](http://www.ohiosamiccoe.cwru.edu/contact/contactus.html)

The Ohio SAMI CCOE offers a free online news service that is linked to our online training calendar and online event registration service. Follow the hyperlink above, join our mailing list, and you will receive reminders about upcoming events. Be sure to enter your e-mail address accurately. This will ensure that the news gets to you on time!

**June 25**
10 a.m. to 12 noon
*Substance Abuse Counseling & Relapse Prevention*
This video conference will be broadcasted to video-conference sites throughout Ohio. Locations will appear on the CCOE’s online training calendar.

**August 12 & 13**
*Client-Centered/Outcome-Based Supervision*
This two-day training event will take place at the Worthington Holiday Inn in Columbus.

**September 17, 18 & 19**
*Third Annual Conference*
This three-day training event will take place at the Worthington Holiday Inn in Columbus. Registration will soon be available online.