The Health Foundation of Greater Cincinnati is on a mission to transform attitudes toward and services for people with mental disorders and substance use disorders, and it is demonstrating leadership by investing financial and human resources in the effort. The Health Foundation's target for change is diverse—it includes policy makers, tax payers, charitable foundations, and everyone involved with planning, delivering, and using the services—yet its method is precise. Since it was founded in 1998, the Health Foundation has awarded $27.4 million in grants to implement evidence-based practices (EBPs) and emerging best practices for people with mental illness, substance use disorders, and co-occurring disorders. EBPs are service models that have been proven effective through research: EBPs improve outcomes when they are implemented with fidelity to their original design. Among the EBPs funded by the Health Foundation are the Integrated Dual Disorder Treatment (IDDT) model and the Supported Employment (SE) model. The Ohio SAMI
COMMUNITY CHANGE

continued

CCOE provides technical assistance for IDDT implementation. The Ohio SE CCOE provides technical assistance for SE implementation. Both CCOEs are programs of the Center for EBPs at Case Western Reserve University and work collaboratively.

IDDT, SE, and other EBPs facilitate service systems change, organizational change, and clinical change simultaneously. Therefore, EBPs require a commitment to innovation by everyone involved, including policymakers, administrators, service providers, community stakeholders, consumers, and their families. This is how the Health Foundation is inspiring transformation among so many people.

“We invest in EBPs because they lead to better health and better access to healthcare,” says Ann Perrin, MSW, LISW, CCDCIII, program officer for the Foundation’s substance use disorders focus area. “It was a bold move by this foundation to address mental illness and substance use disorders. Many foundations do not look at these as true health issues. But, these are very important health issues, and we promote this message whenever we have the chance.”

CONFRONT STIGMA

Stigma is the act of marking people as outcasts. It brands them as unworthy of participating in the community and unworthy of benefiting from social systems, especially protective ones like health and human services. Stigma originates as a belief and is a barrier to change because it discourages the enactment of proactive public policies for those who have been stigmatized. Stigma also discourages financial investment in proactive services.

Janice Bogner, MSW, LISW, program officer of the Health Foundation’s severe mental illness focus area, explains that public leaders and board members of many foundations are often reluctant to fund innovative services for mental illnesses and substance use disorders because of public pressure. In many communities, there is a misguided belief that individuals with mental and substance use disorders choose their lifestyles and, thus, have the power to change on their own simply by “saying no” or by “pulling themselves up by their bootstraps.” The Health Foundation is different, because it does not give in to misguided public opinions. Instead, it uses research to inform its decisions and its actions.

“The President’s New Freedom Commission on Mental Health reported that it takes ten to twenty years to get evidence into practice,” Bogner says. “That’s unacceptable. We are determined to speed that up.”

PROMOTE OUTCOMES, INSPIRE SUSTAINABLE CHANGE

The Health Foundation is systematic and proactive about change. It issues requests for proposals (RFPs) for planning grants and for implementation grants. It also provides consultation, training, and other forms of technical assistance throughout the application and program development processes. Perrin, Bogner, and their colleagues offer applicants and grantees practical assistance with proposal writing,
program planning, program evaluation, outcomes, and communications. They also help grantees address organizational barriers to change, when needed, by facilitating conversations among administrators and service providers. They also promote intra-system and intersystem collaboration by facilitating discussions among service organizations and county and state boards and agencies.

Planning grants typically provide one year of funding to an organization that enables it to hire (or designate) a staff member or consultant to coordinate a community-planning process. The planning committee is comprised of community stakeholders who conduct a comprehensive assessment of service needs in their community. The committee then develops a plan for enhancing access to services and improving outcomes. An organization that is awarded a planning grant may then apply for an implementation grant by responding to another RFP. The Scioto Paint Valley Mental Health Center (SPVMHC) in Chillicothe, Ohio is an example of a service organization that has participated in and benefited from this entire process (see Agency Profile on page 4).

Implementation grants provide approximately three years of funding, with the amount of financial support being reduced each year. Therefore, the Foundation structures its RFPs like a business plan to encourage organizations to think immediately about long-term sustainability. The RFPs require organizations to outline a plan to build and sustain internal capacity for collecting, analyzing, and reporting the outcomes. Organizations must choose several outcomes that are most important to them and their communities.

“We help them break down outcomes into manageable amounts,” Perrin says. “This enables them to work with the data all the time in real time and to communicate results regularly inside the organization with staff and outside the organization with stakeholders. The communication process improves the quality of programming and the quality of relationships.” Bogner adds that the results make the process worth the effort: 80 to 90 percent of the programs funded by the Health Foundation are sustained by grantees through billable services and other forms of financial support after the grants end.

“In the beginning, some organizations were reluctant to develop outcomes plans,” she says. “In the end, though, service staffs and administrators like it because they can see that they are making a difference, and they can demonstrate it to the community.”

**ACT LOCALLY, SHARE THE RESULTS NATIONALLY**

The Health Foundation is demonstrating leadership in Greater Cincinnati not only by financing innovation and providing technical assistance but also by sharing the lessons learned to local, regional, and national audiences. The Foundation uses a variety of methods. It hosts regular networking meetings for its grantees, which enables them to learn from each other's struggles and successes. In addition, the Foundation makes presentations about its grantees and their outcomes at conferences and provides financial support to grantees to present their own results at these venues as well. In July 2005, the Foundation co-hosted an outcomes conference with the Ohio SAMI CCOE and the Ohio Department of Mental Health. The conference was designed as a first step toward helping EBP programs improve their ability to gather, analyze, report, and utilize outcomes for service improvement (see page 14). The Foundation is currently in the early stages of planning a public policy initiative to take its message systematically to lawmakers.

Bogner and Perrin see a new era of creativity emerging in health and human services, one defined by increasing collaboration among service systems and among the for-profit, nonprofit, and government sectors of society. They are proud that the Health Foundation has been at the forefront of this movement and are pleased to report that other foundations are beginning to catch up.

“It takes ten to twenty years to get evidence into practice. That’s unacceptable. We are determined to speed that up.”

– Janice Bogner

Paul M. Kubek, MA, is director of communications at the Ohio SAMI CCOE.

Resources

The Health Foundation of Greater Cincinnati provides workshops in grant writing, program planning, program evaluation and outcomes, and communications that are open to anyone who works for a nonprofit or government organization. Consult the Foundation’s web site.

Janice Bogner, MSW, LISW

<table>
<thead>
<tr>
<th>Resources</th>
<th><a href="http://www.healthfoundation.org">www.healthfoundation.org</a></th>
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</tbody>
</table>
Lynn Goff spent 33 years in an Ohio prison and never quite understood what it was like to leave. There were many times she would be walking the halls inside the prison or across the compound when one of the inmates would toss a wave in her direction and give voice to the emotions that were motoring his feet toward the main gate. “Ms. Goff,” he would say, “I’m gettin’ out.” “That’s great,” she would reply with genuine enthusiasm. “Do you have a job?”

Lynn Goff is an upbeat person with a positive outlook who understands why policy makers in federal, state, and county government are so interested in outcomes of the services they fund. She also understands why administrators in service organizations, researchers in universities, and tax payers in cities, towns, and villages throughout the state are interested in outcomes. People want to know if their money is being spent wisely. For her, though, outcomes are less statistical and more personal—let’s say, individual.

On many occasions in her previous life as assistant to the warden in the Chillicothe Correctional Institution, Goff stood in front of a room full of men who had just arrived from the courts, prepared to give them an orientation to the rules and regulations of the prison. She would begin her presentation with a simple yet poignant survey:

“How many of you have been here before?”

The answer was usually just as simple and poignant: it was a show of hands—from more than half the men in the room. This was the only data that Goff needed to know...
that the social and economic systems in the heart of the heart of the wealthiest nation on earth were not working.

REFLECT UPON THE SELF
It is difficult to come out of retirement to face the same dismal circumstances that you intentionally left behind. So in the summer of 2002, when an old friend and colleague asked Goff to come back to work, she did not say, “Yes.” Instead, she asked for some time to think about the question and everything else they had talked about. Actually, the word think is a bit of an understatement. It was more like pray.

Here are some details that she considered. The Scioto Paint Valley Mental Health Center (SPVMHC) in Chillicothe had applied for and received a one-year planning grant from The Health Foundation of Greater Cincinnati to assemble a group of stakeholders from the communities it serves to devise a plan to address the needs of people with mental and substance use disorders involved with the criminal justice system. She was being asked to co-chair the initiative. The stakeholder group would include a number of colleagues from police and sheriff’s departments, the courts, jails, probation, and parole. It would also include service providers from local mental health and substance abuse programs, as well as representatives of the Ohio Department of Mental Health, the Ohio Department of Youth Services, and the Ohio Department of Rehabilitation and Corrections. The committee’s work would take place outside the prison, not inside, so it would be an opportunity to contribute her knowledge and experience, but it would also be an opportunity to learn something new.

INTEGRATE NEW IDEAS
The planning meetings were a bit of an eye-opener for Goff. The committee conducted a comprehensive needs assessment and uncovered some startling facts about its community. She learned that, upon release, most inmates have no place to live, little or no money to spend, no healthcare for medication and doctor’s appointments, and no prospects for work because many employers refuse to hire felons, which is permissible by law. She also learned that most inmates do not have relationships with family members because they have broken trust (or “burned bridges”) with them. As a result, when the imprisoned are set free, they typically get help from the people who influenced their criminal past—drug dealers, substance abusers, and the like. For most, a return to the old lifestyle means a return to prison.

Goff also learned that people with co-occurring mental and substance use disorders experience a higher rate of arrest, incarceration, and re-incarceration (recidivism) than others. Their symptoms put them at risk for experiencing impaired judgment; therefore, they are likely to engage in behavior that is or appears to be potentially harmful to themselves or to others, which often results in arrest.

“I never knew how hard it was to succeed on the outside,” she says.

MAKE INFORMED CHOICES
At first, Goff thought the stakeholder group would recommend a prevention program or a crisis intervention team. Instead, it chose the Integrated Dual Disorder Treatment (IDDT) model and formed the Criminal Justice SAMI Re-entry Program to implement it (SAMI is an acronym for substance abuse and mental illness).

“When we looked at all the needs of the people coming out of jail, including the treatment needs, IDDT made the most sense,” Goff says. “I don’t think we were on to something new. It just made sense to do it this way.”

The re-entry program applied for and was awarded an implementation grant from the Health Foundation for a program to serve 17- to 30-year-olds re-entering Fayette and Highland Counties from secure confinement. Goff has been the Criminal Justice SAMI Re-entry Team Coordinator ever since and maintains a small client caseload. The program started taking referrals and providing assertive outreach in prisons and in the community in October 2003. One year later it was serving 19 clients: 72 percent of the clients had not returned to jail (see “Outcomes” sidebar). The program is now in its second year. It is currently serving 23 clients.

FIND THE RIGHT PEOPLE
Goff attributes much of the program’s success to the planning grant, to IDDT training, and to the program’s core components (see sidebar on page 4), especially the wraparound funds, some of which are used for transitional housing. The housing gives former inmates a safe place to stay and, thus, encourages them to use the re-entry team for social support. When asked to describe the single most important contribution to success, Goff does not hesitate to cite the team effort and to praise the commitment of both past and present team members (see sidebar on page 6).

Continued on page 6
“Picking the right people,” she says, “The people are the success. They must be willing to accept the model and perhaps change their philosophies, especially about chemical dependency. Most of all, they must have hope that people can recover.”

Goff is noticeably uncomfortable if you try to highlight her influence upon the program. In fact, she would rather this story be told from other perspectives, not just her own. However, her story is important, because it illustrates the process of personal change that accounts for the success of so many IDDT programs throughout Ohio. IDDT is implemented to reinvent service systems, organizations, and clinical practices simultaneously. Therefore, an implementation effort needs synergy from many people, including policymakers, administrators, community stakeholders, and service providers from many professional disciplines. Change must occur internally within each individual if it is going to occur externally in groups, committees, teams, and communities.

**ACQUIRE TRAINING AND USE IT DAILY**
There can be something unnerving about sitting in the living room of a person whose judgment has, in the past, been impaired by severe symptoms of mental illness, substance abuse, and criminal intent. Most clients of the re-entry program pose no threat to members of the service team who engage in assertive outreach. Yet, Goff understands the unpredictable and impulsive nature of human beings. Therefore, her first priority is the safety of her team members. She reminds them to notice subtleties in the environment and to trust their instincts.

“I tell my team to pay attention,” Goff says. “For instance, if you have a sense that the person doesn’t want you there, that he or she is being hyper-alert and looking around more than usual, these are clues. It may be best for you to leave.”

If this happens, the entire team reviews the incident at their weekly meeting and develops a new outreach plan for that client.

When choosing team members, Goff looks for individuals who have patience, gentle persistence, a willingness to learn, and a commitment to IDDT principles and skills like motivational interviewing and stages of change. She also looks for individuals who understand the criminal justice culture and its impact upon the mindset of clients. She explains that most clients carry a sense of urgency, an anxious expectation about being arrested again. She adds that a client who experiences a relapse of substance use or mental illness might miss an important appointment, lose a desperately needed job, or be evicted from an apartment. Any of these consequences might be a violation of parole and result in imprisonment.

Goff admits that clients of the re-entry program are among the most difficult to serve and that relapse and recidivism are likely.

“Sometimes we forget this,” she says. “But we go back to the model to remind ourselves.” She adds that team members do not always know if they are making an impact, but when they trust the process of treatment, they eventually see good results.
MEET WEEKLY AND DISCUSS STAGES OF TREATMENT

There is an old house on South Washington Street in Greenfield, Ohio that is SPVMHC’s satellite office in Highland County. It is also the main office of the re-entry program, where the service team meets every Tuesday for three hours to discuss each client’s progress with substance abuse treatment and a number of daily needs, including housing, symptom management, medication management (see page 16), employment, family relationships and other social support, and participation in stage-wise groups (see page 8).

Landa Dorris, LPCC, CCDCIII-E, substance abuse coordinator at SPVMHC and SAMI team clinical supervisor, participates in these weekly meetings. She also consults regularly with Goff and other team members. Dorris has worked with the re-entry program since the beginning: she was a member of the original planning group. Like Goff, Dorris has experienced the implementation process as a journey of transformation. She explains that IDDT has given her (and her colleagues) a new vocabulary that is less judgmental and, therefore, more productive. For example, in the past, she would describe clients who resisted substance abuse treatment as being “in denial.” Now, she simply describes them as being in an early stage of change.

“With this new language, we remove the judgmental language, and we have a client who is more willing to listen,” she says. “If you really take this language and this approach into yourself, you become free to participate in a process. It’s no longer you determining treatment. It’s you and the other person working together.”

The results have been startling in terms of outcomes (see sidebar on page 5) and improved relationships among clients and providers. Many clients in the persuasion stage of treatment and the active-treatment stage actually come to the house on South Washington Street unannounced to ask for help or advice or simply to say, “Hello.” They will also ask to attend team meetings to discuss their needs and concerns.

SUSTAIN FIDELITY AND EXPAND IDDT SERVICES

For Dorris, the re-entry program is a dream that has finally come true. She has wanted to implement IDDT for nearly 10 years. So she is excited about some recent news. In October, SPVMHC received a $202,000 grant from The Health Foundation of Greater Cincinnati to implement IDDT with Assertive Community Treatment (ACT) for people with co-occurring disorders who are not in the criminal justice system. There will be five new teams to serve Highland, Fayette, and three additional counties--Pickaway, Pike, and Ross. In addition, the re-entry program received a grant from the Health Foundation to hire more staff and to expand its target population to age 40.

Dorris is confident about the future, because the small re-entry program created systems change, organizational change, and clinical change that were manageable. She and Goff anticipate there will be growing pains, but there is consensus and commitment from administrators, community stakeholders, and service providers alike. In addition, SPVMHC prepared for this expansion by investing two years ago in IDDT training for 25 of its staff members, even though only five served on the re-entry program. As a result, everybody is ready. They are eager to begin.

Paul M. Kubek, MA is director of communications at the Ohio SAMI CCOE.

The Ohio SAMI CCOE has been providing consultation, training, and other forms of technical assistance to SPVMHC since October 2003.

Resources

Consult our online IDDT Library & Links database and select “criminal justice”:
www.ohiosamiccoe.case.edu/library/

IDDT Overview (The Tri-Fold)
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87

National Gains Center (website)
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=57

www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=26

Jane’s Recovery

Jane is a client of the Scioto Paint Valley Mental Health Center’s IDDT SAMI Re-entry Program. Read her success story online:
The primary goal of the Integrated Dual Disorder Treatment (IDDT) model is to help consumers with co-occurring mental and substance use disorders reach their personal recovery goals by reducing and eliminating their substance use and by managing symptoms of their disorders. Consumers identify, work toward, and achieve their recovery goals in collaboration with service providers. There are four stages of IDDT treatment (see sidebar on page 9). Persuasion is the second. Consumers in this stage . . .

• Have regular contact and a working alliance with service providers;
• Use alcohol and/or other drugs regularly or have reduced the amount for less than one month (i.e., fewer substances, smaller quantities, or both);
• Meet diagnostic criteria for substance abuse or dependence;
• Do not acknowledge the negative consequences of their substance use and are unmotivated to address it.

PARTICIPATION Many consumers with co-occurring disorders who are actively using alcohol and other drugs have been excluded in the past from mental health treatment because of their substance use; they have also been excluded from substance abuse treatment because of their mental health symptoms. Therefore, the persuasion group is designed to address both disorders simultaneously. The group has a no-exclusion policy, which is consistent with all IDDT interventions. This ensures that consumers have access to effective treatment while they are actively using substances. Below is a list of guidelines for attendance in persuasion groups:

• Not compulsory, unless legally mandated (e.g., probation, parole, or inpatient discharge); however, consumer choice of intervention is always encouraged.
• Regular attendance is always encouraged.
• Sporadic attendance is not discouraged.
• Consumers who attend under the influence of alcohol and other drugs are not asked to leave, as long as their behavior is not disruptive (discuss the behavior with the consumer privately, if possible, after the group session ends).
• Consumers with active psychotic symptoms (e.g., hallucinations, delusions) are encouraged to attend. Group leaders should be prepared to respond to symptoms accordingly (see Mueser, p.143).
• Participants may leave during the group at any time if they feel uncomfortable or overwhelmed; though, they should be encouraged to stay.
• Groups are typically brief (i.e., 45 to 60 minutes in length).

PERSONAL STORIES, SOCIAL SUPPORT Substance use and abuse occur in social settings and in isolation. People with co-occurring disorders who use alcohol and other drugs in the company of fellow users receive social support for their behavior. Those who use alcohol and other drugs alone are in need of social support. Therefore, the persuasion group helps consumers transform their reliance upon negative social support or their preference for limited social contact into reliance upon positive social support for life-affirming behavior. The transformation occurs because each consumer is encouraged by group leaders, other group members, and peer mentors to talk openly and honestly about their lives, including their mental health symptoms and their perceptions of the benefits of substance use. Individuals who verbally narrate their own stories make those experiences conscious to themselves and to others. When they listen to their own stories and the interpretations of group leaders and peers, they eventually begin to develop awareness of the following:

• Relationship between their substance use and negative consequences
• Discrepancy between their current behaviors and their recovery goals
• Their own desire for change and, thus, self-motivation
• Fellowship with others—the feeling that they are not alone

OPENNESS NOT CONFRONTATION IDDT persuasion groups are significantly less confrontational than traditional substance-abuse recovery groups. Group
leaders (and other service providers) do not use strong verbal tactics and confrontation with people who have mental disorders. Group leaders also discourage aggressive verbal exchanges among group members. Strong verbal tactics can intensify (or exacerbate) psychiatric symptoms. Group leaders use the stages-of-change approach and motivational-interviewing techniques (see Resources below).

RECOMMENDING THE GROUP TO CONSUMERS
All members of IDDT service teams who have a working alliance with consumers should encourage them to attend persuasion groups even if they are participating in other forms of treatment, such as individual and family psychotherapy and social-skills groups. Service providers should respect a consumer’s decision not to attend and remember that personal change occurs slowly over time through incremental stages; therefore, keep encouraging consumers to attend.

GROUP LEADERSHIP SKILLS
Two service providers typically lead the persuasion group. One person may lead the group. However, group leaders must be equipped with (and, thus, represent) training and experience in mental health therapy and chemical dependency counseling. Group leaders have an expertise in group work. They may be members of IDDT service teams or belong to other service teams in the service organization. Group leaders encourage other service providers to reinforce group principles. Group leaders utilize a variety of skills and techniques to facilitate a social environment that emphasizes and promotes safety and trust. Some of these skills and techniques are listed below.

Social Environment
- Emphasize peer conversation and feedback but do not force group members to talk
- Promote tolerance for cultural and personality differences
- Ensure that group discussions remain focused on the goals of consumers (see Ingersoll)
- Ensure mutual respect among group members
  - Avoid confrontation
  - Notice and correct judgmental language
  - Minimize social censure
  - Minimize disruptive behaviors (e.g., outbursts of anger, “hogging the floor” by talking too much, arguments, preoccupation with hallucinations and other symptoms) (see Mueser, p.143)

Motivational Strategies
- Minimize lecture-styled presentations (short presentations or films may be used to stimulate discussions) (Groups that have an educational format are called psychoeducation groups, which are offered as part of an IDDT program’s menu of services.)
- Listen to individual stories and help participants notice the relationship among their substance use, mental health symptoms, and physical health
- Listen for opportunities to help clients notice the discrepancy between their stated recovery goals and current substance use behavior

Confidentiality
Group leaders emphasize that the information shared in the group must not be shared with non-members. Group leaders promote positive peer pressure by discussing violations of confidentiality with the group.

Attendance at persuasion groups should be noted in the treatment plan and chart of each consumer.

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Stages of IDDT Treatment</th>
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<tbody>
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<td>Engagement</td>
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<tr>
<td>Contemplation</td>
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<td>Action</td>
<td>Active Treatment</td>
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<tr>
<td>Maintenance</td>
<td>Relapse Prevention</td>
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</tbody>
</table>

Resources
Consult our online IDDT Library & Links database and select “groups”:
www.ohiosamiccoe.case.edu/library/


Prescribing psychotropic medication to people who use alcohol and other drugs

—by Christina M. Delos Reyes, M.D.

Many physicians and nurses wonder if they should prescribe psychotropic medication to people with severe mental illness who are actively using alcohol or other drugs. The short answer is yes. This column is the first in a series to explore the Integrated Dual Disorder Treatment (IDDT) model’s approach to medication management for co-occurring mental and substance use disorders.

MULTIDISCIPLINARY TREATMENT TEAM

IDDT views all activities of life as part of the treatment and recovery process. Therefore, a variety of service providers help clients with daily activities. A psychiatrist (or other licensed prescriber) is a core member of the service team and works closely with case managers and others. All team members provide their observations of each client’s symptoms and reactions to medication. They also provide consistent messages about medication management to clients and their families (see chart on page 11).

TWO DISORDERS, ONE PERSON

Co-occurring disorders are two distinct yet interacting diseases. Therefore, simultaneous treatment of both helps clients sort out, manage, and master all of their symptoms. In my practice, I prescribe medication to help clients minimize severe symptoms of mental illness such as disorganized thoughts, severe moods, and hallucinations so they can engage in therapeutic conversations about reducing and eliminating their substance use.

STAGES OF TREATMENT

The IDDT model demonstrates that clients experience successes incrementally over time through stages of treatment. As a result, big changes like sobriety are built upon a series of small and incremental changes in thinking and behavior. Medication helps clients begin and maintain this process of personal transformation.

Engagement stage

In this stage, clients are ambivalent about service providers and about changing their substance abuse behaviors. Therefore, you should not push them to change. Instead, stabilize their psychiatric symptoms and create a therapeutic alliance. Here are some tips:

• Remain open and non-judgmental
• Refrain from expressing disappointment, for example: “I cannot believe you are still drinking and smoking crack.” Instead, be more inquisitive: “How did it go with the drinking last month? Tell me about your use of crack recently.”
• Acknowledge their reasons for substance use but also warn them of the potential dangers: “Alcohol and other drugs can, in fact, ease the pain of your anxious feelings and your depression. However, the relief is temporary and potentially dangerous. In the long run, drinking and using make the symptoms of mental illness worse.”

LIABILITY & PRECAUTIONS

Some medical professionals are uncomfortable prescribing psychotropic meds to active substance users and cite liability as their biggest concern. Here are a few steps I take to address liability that might be helpful to you:

• Educate clients about the potential effects of mixing medications with alcohol and other drugs
• Inform them that substances can make medications less effective
• Document each patient’s informed consent to take meds while using alcohol and other drugs
• Ask team members to monitor each patient’s progress with medication and dispense once per day or once per week if necessary
• Consult with colleagues about difficult situations

Christina M. Delos Reyes, M.D. is medical consultant at the Ohio SAMI CCOE. She is board certified in adult and addiction psychiatry and ASAM certified (American Society of Addiction Medicine). She maintains a clinical practice in Cleveland and teaches at the School of Medicine, Case Western Reserve University.

Resources

Consult our online IDDT Library & Links database and select “pharmacological treatment”:

www.ohiosamiccoe.case.edu/library/


www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=44
<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Stage of IDDT Treatment</th>
<th>Definition</th>
<th>Treatment goals</th>
<th>Psychosocial interventions</th>
<th>Pharmacological interventions</th>
<th>Treatment-team collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Contemplation Engagement</td>
<td></td>
<td>Has no contact or irregular contact with service providers</td>
<td>Has working alliance with providers</td>
<td>Establish a working alliance with consumers</td>
<td>Assertive outreach, provide practical assistance for daily living (e.g., food, clothing, shelter, medicine)</td>
<td>Reduce acute symptoms of mental disorders, minimize impairment of insight and judgment, improve cognitive functioning, facilitate therapeutic alliance</td>
</tr>
<tr>
<td>Contemplation and Preparation Persuasion</td>
<td></td>
<td>Has regular contact with service providers; is unmotivated to address substance use; does not acknowledge negative consequences of substance use</td>
<td>Continued with the same amount or reduces amount for less than one month (i.e., fewer substances, smaller quantities, or both)</td>
<td>Meets criteria for substance abuse or dependence</td>
<td>Use motivational interviewing/interventions, assure consumers that ambivalence to change is normal</td>
<td>Stabilize and decrease psychiatric symptoms to improve cognitive functioning and enhance insight about negative effects of substance use</td>
</tr>
<tr>
<td>Action Active Treatment</td>
<td></td>
<td>Has regular contact with service providers; is motivated to reduce substance use</td>
<td>May relapse or slip-back to substance use</td>
<td>Meets criteria for substance abuse or dependence (early active treatment)</td>
<td>Help consumer reduce substance use or attain abstinence, help consumer acquire skills and support for managing symptoms of both disorders and for pursuing personal goals</td>
<td>Stabilize and manage psychiatric symptoms, create opportunities for participation in counseling and enhanced social relationships, provide detox treatment</td>
</tr>
<tr>
<td>Maintenance Relapse Prevention</td>
<td></td>
<td>Experiences no negative consequences of substance use for 6 months (or is abstinent)</td>
<td>Does not meet criteria for substance abuse or dependence for the past 6 to 12 months</td>
<td>Help consumer maintain awareness that relapse can occur</td>
<td>Develop a relapse-prevention plan with consumer</td>
<td>Help consumer take more responsibility for coordinating his/her medications, teach consumer skills to monitor, log, and report symptoms and to negotiate with medical provider for changes to prescriptions</td>
</tr>
</tbody>
</table>

**Frequency of Use**
- Continued with the same amount or reduces amount for less than one month (i.e., fewer substances, smaller quantities, or both)
- May meet criteria for substance abuse or dependence (early active treatment)
- Does not meet criteria for substance abuse or dependence for the past 6 to 12 months

**Rx**
- Treat psychiatric illness, which may have secondary effect on cravings/adiction (e.g., selective serotonin reuptake inhibitors, atypical antipsychotics, buspirone)
- Avoid (or judiciously prescribe) meds that may be addictive (e.g., benzodiazepines, amphetamines, antiparkinson agents)

**Dx**
- Meets criteria for substance abuse or dependence

- Does not meet criteria for substance abuse or dependence for the past 6 to 12 months

**IDDT STAGE-WISE MEDICATION MANAGEMENT**

Created by Paul M. Kubek, Patrick E. Boyle, and Ric Kruzyzynsk, Ohio SAMI CCOE with reference to these sources:

www.ohiosamiccoe.case.edu | SAMI MATTERS - Fall 2005
Cleveland agency implements integrated treatment in homeless shelters

—by Christine Couture, MSSA, LISW

Mental Health Services for Homeless Persons, Inc. (MHS) is Cuyahoga County’s leading provider of services to homeless men and women with disabilities. MHS has 200 staff members. Our services include assertive outreach, community psychiatric supportive treatment (CPST), two homeless shelters (one for men and one for women and their children), a drop-in center, and residential programs which provide both transitional and permanent supported housing. MHS also operates the county’s mobile mental health crisis teams, as well as the Children Who Witness Violence program. There are approximately 2,200 homeless people in Cuyahoga County: approximately 1,400 have substance-use disorders and almost 600 have mental health disorders.

In January 2005, MHS began implementing the Integrated Dual Disorder Treatment (IDDT) model in both of its homeless shelters and its residential program. The initiative is made possible with funding from the United Way and the Cuyahoga County Community Mental Health Board. MHS currently has two IDDT teams, which take a stage-wise approach to treatment by helping clients make small, incremental changes that prepare them for more permanent housing in our residential program. One team consists of staff from our homeless shelters, our drop-in center, and CPST: this team has seven team members who serve 30 clients with assertive outreach, community psychiatric support, pharmacological management, and shelter services. The second IDDT team is located at our residential program. This team has 11 team members who serve 60 clients with community psychiatric support, pharmacological management, and vocational services. Currently, both teams meet weekly for clinical supervision and to stage clients. Group-based CPST services began in September. We are currently training a second group of staff to supplement existing teams and to expand outreach and nursing services.

The biggest challenge during implementation has been the restructuring of services to provide for integrated treatment. While the integration of our assertive outreach services, homeless shelters, drop-in center, CPST, and residential program is still being refined, the feedback from staff has been unanimous. Services have improved. Of the 60 clients in our residential program, most have come directly from our homeless shelters. As of October, all of them remain in residential placements.

One of the most significant changes that has occurred as a result of IDDT has been a shift in clinical style. We engage clients differently now. We use the stages-of-change and stage-wise treatment approaches, which have been transformative. Our clients report they can now be more honest with staff about their substance use without feeling judged.

The best advice that we can give to other organizations is this: “Anything that’s worth having is worth working for.” The ability to implement the IDDT model requires initial enthusiasm, as well as the determination to maintain that passion over time.

Christine Couture, MSSA, LISW, is SAMI program manager at Mental Health Services for Homeless Persons, Inc. in Cleveland.

The Ohio SAMI CCOE provides ongoing program consultation, clinical consultation, training, and other forms of technical assistance to help MHS implement and sustain its IDDT program.

Resources

Consult this resource from our online IDDT Library & Links database:

Post your questions about IDDT housing initiatives in the “housing specialist” section of our free online message board:
www.ohiosamiccoe.case.edu/training/messageboard_fr.html
SAMI CCOE reorganizes, creates Center for EBPs at Case Western Reserve University

The Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE) has reorganized and created an additional CCOE and a new umbrella organization. The Ohio SAMI CCOE will continue to provide technical assistance for the evidence-based Integrated Dual Disorder Treatment (IDDT) model. The Ohio Supported Employment CCOE will provide technical assistance for the evidence-based Supported Employment (SE) model. And the Center for Evidence-Based Practices (EBPs) at Case Western Reserve University will function as the parent organization for both CCOEs.

SAMI CCOE Co-Directors Lenore A. Kola, Ph.D., of the Mandel School of Applied Social Sciences and Robert J. Ronis, M.D., MPH, of the Department of Psychiatry at the Case School of Medicine will continue to provide leadership as the co-directors of the SAMI CCOE, the SE CCOE, and the Case Center for EBPs. The two CCOEs will also share staff and other resources, such as office space at Northcoast Behavioral Health in Northfield and at Case in Cleveland (see map).

The reorganization occurred this past summer in response to growing demand for CCOE services. The SAMI CCOE began providing technical assistance for IDDT to service systems, organizations, and providers in 2000 with a grant from the Ohio Department of Mental Health (ODMH). It began serving nine community-based programs; it currently serves 51 community-based and inpatient programs. The SAMI CCOE also began providing technical assistance for SE in 2003 with a grant from the Substance Abuse and Mental Health Services Administration, which was awarded to ODMH. This project began serving four SE programs; that number has grown to 10.

“Those of us in health and human services associate the word SAMI with co-occurring mental and substance use disorders,” says Dr. Ronis. “So there was some confusion about Supported Employment when it was being disseminated by the SAMI CCOE. Some providers thought SE was just for co-occurring disorders. It’s not. It’s for anyone with severe mental illness who may or may not have a co-occurring substance use disorder. It made sense to give SE its own identity.”

Dr. Kola explains that ODMH endorsed the creation of the Ohio SE CCOE this summer. ODMH supports a number of CCOEs: each disseminates a different EBP. She adds that the new Center for EBPs provides a fiscal and academic infrastructure for both the SE CCOE and the SAMI CCOE which benefits the customers of both.

“Service systems and organizations that implement different EBPs experience similar facilitators and barriers to implementation,” she says. “Our trainers and consultants see each other regularly, so they talk to one another about what their customers are experiencing. Some organizations are implementing both IDDT and SE, so we’re able to brainstorm, troubleshoot, and plan strategies that benefit both. It’s an efficient process.”

Patrick E. Boyle, MSSA, LISW, LICDC, is now director of implementation services at the Case Center for EBPs, the Ohio SAMI CCOE, and the Ohio SE CCOE. Ric Kruszynski, MSSA, LISW, CCDC III-E, is now director of consultation and training at the Ohio SAMI CCOE. Sarah Swanson, LSW, CRC is director of consultation and training at the Ohio SE CCOE.

The Case Center for EBPs and its two CCOEs are a partnership between the Mandel School of Applied Social Sciences at Case and the Department of Psychiatry at the Case School of Medicine (see page 15).

Resources
Consult our online Library & Links database for IDDT and SE resources:
www.ohiosamiccoe.case.edu/library/

IDDT Overview (The Trifold)
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87

SE Overview
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=88
CCOEs plan technical assistance for outcomes, quality improvement

This past summer the Ohio SAMI CCOE and the Ohio Supported Employment CCOE began an initiative to explore how they will support Integrated Dual Disorder Treatment (IDDT) programs and Supported Employment (SE) programs in Ohio in their efforts to identify, collect, analyze, and report consumer outcomes. IDDT and SE are evidence-based practices (EBPs) that research shows will improve outcomes when they are implemented with fidelity to their original designs. IDDT and SE facilitate systems change, organizational change, and clinical change simultaneously and, thus, improve outcomes for consumers, organizations, and systems alike.

The Ohio SAMI CCOE and the Ohio SE CCOE provide technical assistance to service systems and organizations to help them implement and sustain IDDT and SE respectively. Thus far, the research-and-evaluation services of both CCOEs have focused primarily but not exclusively upon the fidelity review process. As IDDT and SE programs achieve and sustain moderate to high fidelity to the models, they report the need for assistance with outcomes.

According to Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services at the SAMI CCOE and the SE CCOE, not all IDDT and SE programs in Ohio have the same capacity to collect and utilize outcomes. Some programs have more financial and human resources than others to devote to the effort.

“There is a consistent theme throughout Ohio of programs needing continued financial support,” Boyle says. “Outcomes will help these programs demonstrate to foundations, county boards, other funders, and people in local communities who vote for tax levies that IDDT, SE, and other EBPs are smart human and business investments.”

Lon Herman, MA, program director of clinical best practices at the Ohio Department of Mental Health (ODMH), agrees with Boyle and emphasizes the need to demonstrate positive change in consumer quality of life and cost effectiveness of EBPs across systems of care. For example, research shows that IDDT supports recovery for persons affected by mental illness by increasing employment and reducing costly inpatient psychiatric hospitalizations and involvement with the criminal justice system, among other positive results.

“The State of Ohio will have a new governor soon. There may be new leadership throughout the administration,” Herman says. “We must effectively share our success and demonstrate that support for EBPs and the CCOEs are cost effective approaches to help persons with mental illness achieve their recovery goals.”

According to Barbara L. Wieder, Ph.D., director of research and evaluation at the SAMI CCOE and SE CCOE, the outcomes initiative began last July when both CCOEs co-sponsored a conference with ODMH and The Health Foundation of Greater Cincinnati (see sidebar). The one-day event included an overview of the components of successful quality improvement processes as well as a panel discussion with service providers that are currently collecting, analyzing, and reporting outcomes. An afternoon discussion focused on next steps and needs for IDDT and SE programs.

The Ohio SAMI CCOE and the Ohio Supported Employment (SE) CCOE are programs of the Center for Evidence-Based Practices at Case Western Reserve University (see page 13 & 15).

Resources
Consult our online Library & Links database and select “fidelity and outcomes”: www.ohiosamiccoe.case.edu/library/
IDDT Overview (The Trifold)
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87
SE Overview
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=88
ABOUT US

The Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE) is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices for the treatment and recovery of people with mental and substance use disorders. The SAMI CCOE helps service systems, organizations, and providers implement and sustain the Integrated Dual Disorder Treatment (IDDT) model, maintain fidelity to the model, and develop collaborations within local communities that enhance the quality of life for consumers and their families. The SAMI CCOE provides these services:

- Service systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Research and evaluation

CONSULTING & TRAINING

Our consultants and trainers are experienced administrators, service providers, and researchers who offer personal attention and customized training and consultation throughout the EBP implementation process.

PARTNERSHIP

The Ohio SAMI CCOE is a program of the Center for Evidence-Based Practices (EBPs) at Case Western Reserve University, which is a partnership between the Mandel School of Applied Social Sciences at Case and the Department of Psychiatry at the Case School of Medicine. The partnership is in collaboration with and supported by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. The Ohio SAMI CCOE works cooperatively with the Ohio Supported Employment CCOE, which is also a program of the Center for EBPs at Case.

CONTACT US

Service systems and organizations that wish to develop or enhance IDDT programs are encouraged to contact Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services.

Ohio SAMI CCOE

c/o Northcoast Behavioral Healthcare
Cottage 7, Room 304
1756 Sagamore Road
Northfield, OH 44067-1086
330-468-8663 (phone); 330-468-8723 (fax)
patrick.boyle@case.edu
www.ohiosamiccoe.case.edu

NEW STAFF

Terry Jones, MSW, LISW, has joined the SAMI CCOE as a consultant and trainer to support service systems, organizations, and providers with implementing and sustaining IDDT. Mr. Jones brings to the CCOE 19 years of experience in clinical practice and supervision, as well as administration, program implementation, and training. Before joining the SAMI CCOE, he was clinical director at Southeast, Inc., a large behavioral healthcare organization in Columbus, Ohio that serves approximately 1,500 people with severe mental illness per year. At Southeast, Mr. Jones supervised 16 team leaders and program managers. He also oversaw the implementation of three IDDT service teams (criminal justice, homeless dual diagnosis, and BAT teams).

Suzanne Marquart, EA, has joined the SAMI CCOE as fiscal manager. Mrs. Marquart brings to the CCOE over 15 years of experience in accounting, project management, systems analysis, and programming. Prior to joining the CCOE, she worked as a consultant with companies in Cleveland to enhance their information systems and business processes. Mrs. Marquart will assist the SAMI CCOE, Supported Employment CCOE, and Center for EBPs in developing systems that enhance fiscal management. Mrs. Marquart is an Enrolled Agent, certified to practice before the Internal Revenue Service. She holds an associate’s degree in computer science and a bachelor’s degree in business management.

www.ohiosamiccoe.case.edu | SAMI MATTERS - Fall 2005
## TRAINING EVENTS

**Register online for 2006 training events**

www.ohiosamiccoe.case.edu/events

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### Two new online database resources

**With generous support from the Eva L. and Joseph M. Bruening Foundation of Cleveland**

**EBP Program Locator**

www.ohiosamiccoe.case.edu/ebpprograms/

**Library & Links**

www.ohiosamiccoe.case.edu/library/

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**SAMI Matters**

**Ohio SAMI CCOE**

c/o Northcoast Behavioral Healthcare

Cottage 7, Room 304, PO Box 305

1756 Sagamore Road

Northfield, OH 44067-1086

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Jane feels a bit annoyed whenever she hears fellow classmates at the community college she attends make judgmental comments about people who abuse alcohol and other drugs. After all, she and her classmates are studying to be chemical dependency counselors and social workers. They should be learning how to convey acceptance. It is the foundation of a working alliance—the safe and trusting relationship—that is necessary to support people through recovery. Judgmental language is not safe. It is aggressive. It puts people on the defense and inspires counter-attack or withdrawal or any number of self-protective maneuvers. Jane is sensitive to judgmental language, because this is what she had expected to receive from service providers when she started her own recovery journey in the spring of 2004. However, to her surprise and relief, this is not how she was treated. She received patience, acceptance, and the persistent reminder that a relapse to her substance use was probable but not inevitable and certainly not a reason for termination from treatment—ever. She insists that this disposition saved her life. She has not used alcohol or other drugs for a year and a half.

SELF-REFLECTION
Jane does not react against judgmental language whenever she hears it fired in her direction or ricocheting around a room. First, she reflects upon the words, upon the people from whom the language has emerged, and upon herself—her own thoughts and her own feelings of disappointment. She reminds herself that her classmates may not have firsthand experience with substance abuse and recovery, and that they may, in fact, be struggling to understand it. She reminds herself that her ability to observe and to convey acceptance are the skills that will make her the kind of professional she wishes to become. It is her way of “giving back,” of acknowledging the spirit of the
people who work for the Integrated Dual Disorder Treatment (IDDT) SAMI Re-entry Program at the Scioto Paint Valley Mental Health Center (SPVMHC) in Greenfield, Ohio—the program that helped her save her life.

Jane is twenty-one years old.

***

**ISOLATION: BEFORE RECOVERY**

In the spring of 2004, Jane was arrested and sent to a county jail. She does not describe the behavior that resulted in her arrest, except that it was the result of using drugs. She does not name the drug either: she refers to it only as “her drug of choice.” For this version of her story, there is no need for any more details, because this story is less about what happened before the arrest and more about what has happened since.

However, Jane does share the following information to set the context of her recovery. She started using her drug of choice as a junior in high school. Back then, it did not stop her from being a good student and a reliable friend, but over time, it eroded her ability to concentrate and her ability to maintain trusting relationships with others. After she graduated, she increased her use of the drug. She dropped out of two different colleges because she could not stay focused. She fought constantly with her family, moved in with a friend who also used drugs, and eventually got fired from her job. Then she got arrested. A week later, her parents posted bond.

“When I got out, I realized that I was not where I wanted to be in my life,” Jane says. “I was not living a full life. I was living my life for a drug. When you’re using, you don’t pay attention to details. You’re focused on one thing—getting that drug. You don’t see the clouds in the sky, the season changing, the rainbows. I see all of that stuff now. I see the colors. I pay attention. My life has changed 180 degrees since I have been involved in the SAMI program.”

**ACCEPTANCE & SOCIAL SUPPORT: RECOVERY BEGINS**

In retrospect, Jane’s arrest was an external event that inspired an internal change which aligned her with people in her life and in her community who were willing to help. When she was arrested, her parents placed telephone calls to close friends. One of those friends connected them with an acquaintance at SPVMHC, who connected them with SPVMHC’s IDDT SAMI Re-entry Program office in the town of Greenfield.

After her release from jail, Jane made an appointment with the SAMI Re-entry Program and two weeks later, she went there for an interview—to see if she met the eligibility requirements. The program serves people with co-occurring mental and substance use disorders between the ages of 17- and 30-years old who are involved with the criminal justice system. Jane was diagnosed with depression and substance use disorder.

“I was expecting to go to an office once or twice a week and be shuffled in and out,” Jane recalls. “Instead, they helped me realize I wasn’t the only person going through this. The people at the SAMI program were so accepting. They told me that with my drug of choice, I might relapse. They told me that if I do relapse it does not mean I am done.

“When I realized I could get help and I wasn’t going to be judged or looked down upon—that they would accept me for who I was and that I would be able to see the colors in the world again—I decided to keep going. I wanted to change my path. It relieved me that I did not have to be this way any more.”

**Working Alliance & the Interpersonal Environment**

The IDDT model is built upon 14 core components (see sidebar). Two of these components can be detected in Jane’s narrative without her having named them specifically. These are stage-wise interventions (stages of change and treatment) and motivational interviewing. Both of these components help service providers create the interpersonal environment of acceptance to which Jane refers (see Connors, Mueser, and Miller in Resources on page 7d). There are six other components of IDDT that Jane specifically describes as being helpful to her. For instance, in the engagement and persuasion stages of treatment, a case manager at the SAMI Re-entry Program conducted assertive outreach with her and her family by making weekly home visits. She explains that the visits helped her feel understood: the case manager made the effort to come to her and her family and took an interest in her environment. (Although SPVMHC offers family psychoeducation groups—another component of IDDT—her family chose not to attend. They conducted their own research about Jane’s diagnoses as soon as they learned about them.) Jane also participated in group treatment, namely, persuasion groups, which were lead by another service provider at the SAMI Re-entry Program. She describes the group
work as an informal, comfortable atmosphere that helped her address her substance abuse (see Persuasion Groups in Resources on page 7d). She also benefited from access to comprehensive services and substance abuse counseling, namely, by working with the case manager and with a counselor in one-on-one therapy. She describes the counseling as particularly helpful, because it has given her the chance to talk about important, private issues that she is not comfortable sharing with her parents.

Jane currently sees her therapist once every two weeks and will soon be attending a wellness group, which is part of the active treatment and relapse prevention stages of treatment. Her continuing connection with service providers at the Re-entry Program is evidence of the time-unlimited services component of the IDDT model. Jane has also been working with a psychiatrist about medication issues: this is the pharmacological-treatment component of IDDT.

**RE-EMERGENCE**

During the early stages of treatment, Jane dedicated most of her time to individual and group therapy. She did not enroll in the community college until a few months later; however, she applied for her old job and was rehired. She prints promotional t-shirts for a local small business.

“My boss brought me back after I got out of jail,” she says. “He realized that I was in a bad place before but that it did not make me a bad person. It gave me something to do when I got out. It helped me keep my focus off of using.”

Jane currently combines a part-time work schedule with full-time studies. She is currently in her second year at the local community college and will attend a third year to complete an internship in substance abuse counseling. This fall she attended classes four days per week and worked 25 hours per week. Since her release from the county jail, she has been living at home with her parents and her younger brother. She explains that her relationships with them have greatly improved.

“When I was using, I would come home every two to three weeks for two to three hours,” she says. “There was always screaming and yelling. Now, my dad tells me every morning, ‘Remember how great you are doing.’ Even before using, I did not have this kind of relationship, this kind of bond. My parents know it’s been a hard road.”

When asked to explain what makes her feel good about her life right now, Jane does not hesitate to admit that she is enjoying school, work, and her relationships with family and friends. She no longer feels stuck.

“I am working toward my future,” she says. “I am doing things that I was not doing before. When I was using, my life was about here, now, this instant, this drug. Today, I am looking down the road to see what’s coming.”

**CHALLENGES: A CHANGING IDENTITY**

There is a truth about human emotions that is often unstated in day-to-day experience: the truth is that each of us can and does experience many different feelings at the same time. Thus, Jane feels pride and joy about her recovery. Yet, at the same time she also feels some confusion. Her biggest challenge right now, she reports, is self-acceptance.
“I want to stop feeling guilty, to stop being mad at myself,” she says. “I know I have faults. No one is perfect. I sometimes hear other people’s opinions of me, and it’s hard to deal with that, and I sometimes feel what’s the point of being clean [sober]. So I have to accept myself. I have to accept what I’ve done, that I am recovering, that I have the strength to do this. I am trying. What I have done is part of who I am, but it does not make me who I am.”

There is another challenge that confronts her, she explains. It is related to her diagnoses. When she started the Re-entry Program, she was diagnosed with depression. Then, it was changed to bi-polar disorder. Her new psychiatrist is not sure if she experiences symptoms of bi-polar disorder or if her symptoms are the result of her drug of choice or the result of the psychotropic medication that she takes. Her psychiatrist is working with her to sort this out. The first step is to reduce the dosage of her meds.

“Does this mean I don’t have a mental illness or does it mean my body is coping?” she asks. “I haven’t decided where I stand on this. The changing diagnosis confuses me. It’s hard enough accepting the fact that there’s something wrong. It does create confusion. Talking about it is confusing.”

**ADVICE: CREATE OPPORTUNITIES FOR HOPE**

The joys and challenges of Jane’s recovery are evidence of the complexity of the journey. They are also evidence of the power of human relationships to support the process of change. Jane does not hesitate to explain that she needs the continuing support of other people. In other words, she needs time-unlimited access to the acceptance that she first felt in the spring of 2004.

“I need support, definitely,” she says. “I would not be where I am if not for the support of my family and friends and counselors. I know there is a possibility that I could slip back: once an addict always an addict. But this does not mean I will slip back. As long as I remember the pain it caused my family, my friends, and myself, this will help keep me from falling back.”

Jane has advice for service providers in mental health and chemical dependency programs that is based upon her experience. She encourages them not to give up on their clients and their clients’ abilities to recover. She also encourages service providers not to be judgmental.

“I’ve heard horror stories about the way some people have been treated [in other programs],” she says. “It put them in a position of shying away from professional help. A judgmental provider can cause extensive damage. Their clients might wait years to get help again.”

Jane also offers words of encouragement to people who experience mental health and substance abuse symptoms but do not seek treatment.

“Get help,” she says. “You cannot control the addiction yourself. Your brain has made this drug a part of itself. Once you get help, don’t give up. A relapse is just a U-turn. If a relapse occurs, take the step and admit it. Then you can turn yourself around again.”

Paul M. Kubeck, MA, is director of communications at the Ohio SAMI CCOE. The Ohio SAMI CCOE has been providing consultation, training, and other forms of technical assistance to SPVMHC since October 2003.

**Resources**

**IDDT Overview (The Tri-Fold)**
www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=87

www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=44

www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=91

www.ohiosamiccoe.case.edu/library/emailresource.cfm?resourceid=26

**Persuasion Groups promote recovery.**

This story appears as an online addition to the Fall 2005 issue of SAMI Matters. It may be viewed and printed from our web site: www.ohiosamiccoe.case.edu/news/samimatters2005fall.pdf

The entire issue of the newsletter may also be accessed online: www.ohiosamiccoe.case.edu/news/samimatters2005fall.pdf