Transformation Continues

Fidelity to general organizational index (GOI) of IDDT creates environment that supports clinical innovations for co-occurring disorders
—by Paul M. Kubek and Matthew K. Weiland

It has been almost seven years since the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) began investing in Integrated Dual Disorder Treatment (IDDT), the evidence-based practice that improves outcomes for people with co-

Continued on page 2
occurring severe mental and substance use disorders. The initiative began with nine community-based organizations piloting IDDT services and the Ohio SAMI CCOE providing consultation, training, fidelity-review evaluations, and other forms of technical assistance to the organizations. Today, the CCOE is working with multiple IDDT teams at 60-plus community-based organizations and nine state hospitals in Ohio. In addition, representatives of state- and county-level boards and service organizations in 21 states and four countries have sought the advice and technical assistance of the CCOE (see page 6), as it continues to develop its practice- and research-based implementation expertise to advance the art and science of successful IDDT implementation.

**FIDELITY SCALE IMPROVES ORGANIZATIONAL FOCUS**

According to Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services at the Ohio SAMI CCOE, much of the success in systems change in Ohio can be attributed to the commitment of ODMH and its Integrated Behavioral Healthcare System (state hospitals), ODADAS, and county boards, which serve the state’s 88 counties. Success can also be attributed to each service organization’s commitment to the organizational change and clinical change processes, which are outlined in and guided by the IDDT fidelity scale, a research-informed implementation instrument. The fidelity scale consists of two separate yet related and equally important parts: the 12 organizational characteristics (components)—also known as the general organizational index (GOI); and the 14 treatment characteristics (components) (see fidelity scale sidebar).

“Organizations that have successfully implemented IDDT have committed themselves to implementing all components of the model,” Boyle says. “They have resisted the temptation to pick and choose and turn the fidelity scale into an a la carte menu of disconnected services. IDDT was designed as one complete package with multiple components, and it is this structure that has been proven effective. If an organization simply implements pieces and parts of IDDT, they are not implementing the evidence-based practice.” Boyle adds that fidelity reviews are essential for successful implementation, because if fidelity is not assessed, then the organization will not be able to verify if their IDDT services are evidence-based.

Throughout the history of Ohio’s IDDT initiative, the Ohio SAMI CCOE has consistently reflected upon challenges and successes of implementation in an effort to promote methods that work to up-and-coming programs. All along, the consultants and trainers have noticed that there must be an effective organizational structure (GOI) in place to support the treatment characteristics. Successful organizations that achieve high fidelity and improved outcomes demonstrate this. Therefore, the Ohio SAMI CCOE is taking this opportunity to reexamine the role of the GOI, so organizations that are new to the implementation process may avoid past pitfalls and replicate the successes of their peers more efficiently and effectively.

**ORGANIZATIONAL CHANGE SUPPORTS AND PROMOTES CLINICAL CHANGE**

To help organizations understand the seamless relationship between organizational characteristics and treatment characteristics of IDDT, the Ohio SAMI CCOE’s Director of Consultation and Training Ric Kruszynski, MSSA, LISW, LICDC, regularly uses a metaphor in his consultations with organizations. To him, the treatment components are like the ingredients of a recipe. “You need eggs, flour, and sugar to make a cake,” Kruszynski says. “Just like you need integrated substance abuse counseling and mental health counseling, stages of treatment, motivational interviewing, medication management, psychoeducational groups, and family education, among other treatment components to make Integrated Dual Disorder Treatment.”

However, he emphasizes, to make that cake recipe come out right, you also need the right tools. “You need measuring cups, spoons, mixing bowls, a
cake pan, an oven, and the correct timing,” he says. “Without the tools, you don’t have a cake. You have separate ingredients. Likewise, in IDDT services, you need the organizational components to blend the separate treatment ingredients into IDDT. The components of the GOI are the tools that make the treatment recipe work.” Kruszynski explains that this includes a system of screening and assessment for both disorders, a system for determining eligibility, and a system for treatment planning, consumer choice, process monitoring, supervision, and all other components of the GOI (see sidebar).

**ORGANIZATIONAL SELF-ANALYSIS**

Another way to think about the organizational characteristics (GOI) of the fidelity scale is that they provide a structure for organizational self-analysis and improvement. The GOI helps an organization look at itself critically as it rolls out IDDT services, making sure, for instance, that the organization’s philosophy changes to accommodate updated methods of delivering integrated services. It is not always an easy task, for it invites scrutiny and sometimes criticism of otherwise well-intentioned efforts from the past.

For instance, an organization might have a decade’s old zero-tolerance philosophy that will force people out of treatment if they continue to use alcohol or other drugs or relapse. However, the GOI ensures that this tenet (see “#1 program philosophy” in fidelity scale sidebar) is updated accordingly to accommodate and encourage IDDT’s stages-of-change and stages-of-treatment approaches, which emphasize that big changes like sobriety and abstinence occur gradually over time through a series of small yet significant changes, such as a reduction in use and management of symptoms of both disorders.

**PROCESS MONITORING: THE CORNERSTONE OF THE GOI & EFFECTIVE IMPLEMENTATION**

When convening consultants and trainers from the Ohio SAMI CCOE and asking which organizational characteristic is most vital in the overall hierarchy of the GOI, the discussion soon grows into quite a debate. One component is so vital to carrying out the others that it becomes a chicken-or-the-egg analysis of what should come first and thereafter. Eventually, though, process monitoring (see “#9” in sidebar) emerges as the answer. The consultants agree that it is the cornerstone of effective program development, a way of keeping everyone on the same page—on task and accountable. Below is a brief outline of important components for process monitoring.

**WHAT?**

By definition, process monitoring involves keeping an eye on the process of implementing IDDT. It convenes an organization’s implementation team around several important big-picture questions:

- How effectively is implementation proceeding?
- What is going well that we can do more of?
- What barriers are we encountering?
- What solutions do we need to employ to overcome the barriers?
- How do we extend this process and our successes to other parts of the organization that would benefit? How do we extend this to other parts of the community (e.g., other service systems) that would benefit?

Process monitoring also involves some very specific questions about the organizational characteristics and treatment characteristics of the fidelity scale. A few examples include the following:

- Do our decisions fit the philosophy of IDDT?

*Continued on page 4*
The State of Ohio’s commitment to IDDT and other evidence-based practices (EBPs) in behavioral health care began under the leadership of former Director Michael Hogan, Ph.D., who is now Director of the State of Ohio’s School of Mental Health. The state’s commitment to EBPs continues under the leadership of former Director Michael Hogan, Ph.D., who is now Director of ODMH and revised by Sandra Stephenson, MSW, LISW, and recently appointed Director of ODADAS Angela Cornelius (see page 13).

The IDDT fidelity scale is currently in review and revision, a project which is being undertaken by the Psychiatric Research Center (PRC) at Dartmouth Medical School. Robert Drake, M.D., and his colleagues at the PRC were among the first in the country to disseminate IDDT and have conducted much of the research that has demonstrated its efficacy.

• Are we offering our services to all consumers who are eligible (i.e., those who have been diagnosed with co-occurring severe mental and substance use disorders)?
• Are we making the effort to conduct assertive outreach to those consumers who are among the most difficult to engage in treatment?
• Do we have individualized treatment plans for each consumer and are we documenting those plans clearly in the consumer’s medical record?
• Are we monitoring outcomes and developing or enhancing a quality-improvement process?

WHO?
Process monitoring asks that members of each organization’s implementation team check-in periodically with each other to assess progress. Implementation team members should include the following:
• Direct-service providers
• Team leader(s)
• Program manager
• Upper management of the organization
• Other stakeholders

WHEN?
The Ohio SAMI CCOE recommends that organizations convene for process monitoring with a frequency that matches their stages of implementation. For instance, organizations that are early in the process typically meet more frequently than those who have established IDDT services. However, each organization finds its own time interval, which might include the following:
• Weekly
• Quarterly
• Monthly
• Every six months

HOW?
Process monitoring is an ongoing internal organizational method that is often conducted formally. Ideally, it is a way of raising or enhancing awareness among the implementation team about the day-to-day methods of managing and delivering services. Organizations in Ohio use a variety of instruments and methods for process monitoring, including the following:
• The IDDT fidelity scale
• An implementation plan, which typically precedes the first (baseline) fidelity review and fidelity action plan (see “Implementing IDDT” page 21 in Resources)
• A fidelity action plan, based upon objective fidelity assessment recommendations (complete with tasks, goals, person(s) responsible, and deadlines) (see “Implementing IDDT” page 24 in Resources)
• Grant-funding guidelines/criteria (for organizations that have received dedicated funding for planning and implementation)
• Organization’s quality-improvement protocol

WHY?
Process-monitoring questions are those that should be asked regularly as a routine of inquiry and that hopefully translate into a rhythm of critical thinking, of programmatic self-examination, of raised consciousness, of attentiveness and responsiveness. In some respects, process monitoring becomes a heightened state of awareness that can become second nature, addressing and assessing how the team does business and how successful the team is. It ideally becomes a natural part of the organization’s quality-improvement process.

Ultimately, process monitoring can (and should) provide a foundation for efficacious treatment and delivery of services that is not reliant upon one individual or group of individuals. It ensures that the system of implementation—and process monitoring itself—will endure despite the inevitability of changes in staffing.

An example of a successful processing-monitoring initiative is included on page 5. It is a short profile of a community-based service organization in Lake County, Ohio.

Resources

IDDT Fidelity Scale
www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=107

PROCESS MONITORING

Lake County service organization overcomes uncertainties about implementing IDDT with staff inclusion, buy-in

—by Matthew K. Weiland and Paul M. Kubek

Building consensus and collaboration within an organization for the implementation of the Integrated Dual Disorder Treatment (IDDT) model may be difficult at times. Barriers to innovation can come from any number of areas, such as a perceived lack of funding, a shortage of staffing, not enough training, a lack of physical space for hosting psychoeducational groups, or just good old-fashioned resistance to change from staff members who are accustomed to established administrative routines and clinical approaches. There are, however, a number of methods that Ohio organizations have developed to convert the potential energy of uncertainty into the kinetic energy of innovation that are easily accessible and high-yield.

One such organization is NEIGHBORGING, a community-based provider of mental health, substance abuse, and employment services in Lake and Geauga Counties. NEIGHBORGING began the organizational change process of IDDT implementation in 2002, almost two years before engaging the Ohio SAMI CCOE for technical assistance. Without knowing it, NEIGHBORGING created a version of process monitoring (see “#9” in fidelity scale sidebar on page 3) that inspired, encouraged, and guided the initial organizational change process.

QIT BECOMES IMPLEMENTATION WORK TEAM

According to Dual Diagnosis Program Supervisor Deana Leber-George, MEd, LPCC-S, CCDCI, NEIGHBORGING has a Quality Improvement Team (QIT) that meets regularly to review successes and failures of initiatives throughout the organization. It was the QIT that began reviewing the IDDT implementation process. Chaired by QIT Director Laurie Rider, the team was (and still is) comprised of senior administrative and clinical staff, as well as representatives of various direct services and support departments. The QIT included case managers, supported-employment specialists, therapists, support staff, and nurses.

During the initial stages of IDDT implementation, the QIT engaged in a process of reviewing dual disorder treatment, service use by consumers, and outcomes, enhancing the relationship between administrative and clinical functions.

INVOLVE DIRECT-SERVICE PROVIDERS IN PLANNING, DECISION MAKING, AND ACTION

With the onset of technical assistance from the Ohio SAMI CCOE, NEIGHBORGING developed its initial fidelity action plan under the direction of Chief Operating Officer Ken Gill, MSSA, LISW, LICDC, and then IDDT Supervisor/Team leader Susan Rooney. Gill and Rooney then shared the plan with the IDDT services team, which helped identify issues it wanted to address. Priorities in that first year of implementation were focused on group and family treatment. This process transformed the functions of the QIT into an IDDT implementation work team that engages in process monitoring.

Because the initial fidelity action plan was developed without input from direct-service providers, Leber-George explains, there was some delay with buy-in from staff members who were being charged with delivering services. Some initial reactions to the IDDT approach included skepticism about the stages-of-change approach and time-unlimited services: some staff members perceived these treatment components as a “looser” way of providing services that might “enable” clients to hesitate or delay treatment.

However, the skepticism was short lived, because the IDDT implementation committee included direct-service providers in process-monitoring discussions about the fidelity action plan. It gave them the opportunity to contribute to the decision-making process and to participate in the writing of subsequent action plans. Today, fidelity action plans are generated at the direct-service and supervisory levels. The IDDT team itself sets goals and evidenced-based strategies for achieving them.

“Increased understanding of the model and an increased sense of control over the provision of services seemed to help turn the corner and significantly heighten the commitment of the service team,” Leber-George says. “The skepticism also dissipated as our outcomes started to show significant progress in engagement of clients who have never been able to tolerate being engaged in services. Our team experienced the seeing-is-believing effect.”

Matthew K. Weiland, MA, is senior writer and new-media specialist at the Ohio SAMI CCOE. Paul M. Kubek, MA, is director of communications. The Ohio SAMI CCOE has been providing technical assistance to NEIGHBORGING for IDDT since 2002.

NEIGHBORGING

www.neighboring.org
Lake County
5930 Heisley Rd.
Mentor, Ohio 44060
440-354-9924
Geauga County
115 Wilson Mills Rd.
Chardon, Ohio 44024
440-286-7448

Deana Leber-George, MEd, LPCC-S, CCDCI

“Increased understanding of the model and an increased sense of control over the provision of services seemed to help turn the corner and significantly heighten the commitment of the service team.”

—Deana Leber-George, MEd, LPCC-S, CCDCI

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—Deana Leber-George, MEd, LPCC-S, CCDCI

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NORTHWEST REGION

SERVICE PROVIDERS

**Hancock County**
- Century Health, Inc.
  Findlay, OH 45840

**Lucas County**
- Harbor Behavioral Healthcare
  Toledo, OH 43623
  *Northcoast Behavioral Healthcare (BHO)—Toledo Campus
  Toledo, OH 43614

**Wood County**
- Behavioral Connections of Wood County, Inc.
  Bowling Green, OH 43402

**Lucas County cont.**
- Unison
  Toledo, OH 43624

NEW! **LUCAS COUNTY**

Since the beginning of 2007, the ADAMHS Board has supported a county-wide IDDT effort. A steering committee meets monthly to support three organizations and other stakeholders in Greater Toledo that are in the early stages of implementation. The Ohio SAMI CCCE is providing technical assistance to the committee and the organizations:

- Harbor Behavioral
- Unison Behavioral
- Zepf Center

SOUTHWEST REGION

SERVICE PROVIDERS

**Brown County**
- Brown County Recovery Service
  Georgetown, OH 45121

**Butler County**
- Community Behavioral Health | Horizon Services—SAM I Court Program
  Hamilton, OH 45011
  Transitional Living, Inc.
  Hamilton, OH 45011

**Hamilton County**
- Greater Cincinnati Behavioral Health
  Cincinnati, OH 45206
  *Summit Behavioral Healthcare (BHO)
  Cincinnati, OH 45237

NEW! **BROWN COUNTY**

Brown County Recovery Services (BCRS) in Georgetown completed intensive IDDT training from the Ohio SAMI CCCE in early 2007 and continues to engage in consultation. BCRS is a Talbert House organization.

NEW! **HAMILTON COUNTY**

Talbert House in Cincinnati has begun implementing IDDT with two teams. The implementation of IDDT will complement Talbert House’s mission of reaching out to consumers with co-occurring disorders. Additional funding support comes from The Health Foundation of Greater Cincinnati.

CENTRAL REGION

SERVICE PROVIDERS

**Delaware County**
- Central Ohio Mental Health Center
  Delaware, OH 43015

**Fairfield County**
- New Horizons Youth and Family Center
  Lancaster, OH 43130

**Fayette County**
- Scioto Paint Valley Mental Health Center
  Greenfield Clinic
  Greenfield, OH 45123

**Franklin County**
- Southeast, Inc.
  Columbus, OH 43215
  *Twin Valley Behavioral Healthcare (BHO)—Columbus
  Columbus, OH 43223

**Highland County**
- Scioto Paint Valley Mental Health Center
  Greenfield Clinic
  Hillsboro, OH 45133

**Lucas County cont.**
- Unison
  Toledo, OH 43624

NEW! **MARION-CRAWFORD COUNTY**

Marion Area Counseling Center, Inc. in Marion has joined Ohio’s network of IDDT providers by preparing for its baseline fidelity assessment this fall.

*This organization is an inpatient psychiatric hospital operated by the Ohio Department of Mental Health.*

...NATIONALLY

Representatives in various roles from community-based organizations, inpatient hospitals, and state-, regional-, or county-level boards from 21 states have sought the advice and technical assistance of the Ohio SAMI CCCE. We are encouraging and assisting states to develop CCCE-like technical assistance organizations of their own. The states we work with include the following:

- California
- Colorado
- Hawaii
- Illinois
- Indiana
- Kentucky
- Maine
- Maryland
- Michigan
- Minnesota
- Missouri
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Pennsylvania
- Virginia
- Washington
- West Virginia
- Wisconsin

...INTERNATIONALLY

Representatives from community-based organizations, inpatient hospitals, and national and regional authorities from the following 4 countries have sought the advice and technical assistance of the Ohio SAMI CCCE:

- Australia
- Canada
- England
- The Netherlands

Breaking Statewide News: ODMH and ODADAS are working with the Ashland County ADAMHS Board and the Ohio SAMI CCCE to pilot test an IDDT “affiliation code”, which will track county-level aggregate statistics on service use.
The Ohio SAMI CCOE is a technical-assistance organization that helps service systems, organizations, and direct-service 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 the following services:

- Service systems consultation
- Program/organizational consultation
- Clinical consultation
- Training and education
- Fidelity evaluation and research
- Professional peer-networking opportunities

CUSTOMIZED TRAINING AND CONSULTATION

Our consultants and trainers understand that every service system and organization exists within a unique social, political, and economic context. Therefore, we work closely with you to adapt the IDDT model to the unique culture of your community, while maintaining fidelity to the model.

IDDT is implemented to reinvent service systems, organizations, and individual clinical practices simultaneously. Therefore, our consultants and trainers work with many individuals, not only from each organization listed on pages 6 and 7, but also from multiple service systems in each community, region, and state where the organization is located, including but not limited to the following:

- State and county authorities (e.g., mental health, substance abuse, criminal justice, housing, health, and vocational rehabilitation, among others)
- Agency and organization administrators
- Clinical directors
- Direct-service providers
- Quality improvement staff
- Steering committee members
- Community stakeholders
- Advocates
- Consumers
Located just down the road from historic Ohio Wesleyan University, the Central Ohio Mental Health Center (COMHC) in Delaware, Ohio has, over the past couple of years, become a destination for education in its own right when it comes to SAMI Integrated Dual Disorder Treatment (IDDT) team training. For providers of mental health and substance abuse services seeking to implement IDDT into their own organizations and communities, COMHC has become a recommended pilgrimage, a “how-to” seminar given by some of the best of the best-practices crowd.

The COMHC SAMI/ACT team began implementing IDDT five years ago. It currently serves 37 consumers who have co-occurring severe substance abuse and mental illness (SAMI) as well as 40 consumers who receive Assertive Community Treatment (ACT), an evidence-based practice designed for individuals who are most at-risk of psychiatric hospitalization. Since implementing IDDT, consumers have experienced some very positive outcomes. The frequency of hospitalizations is down. The frequency of involvement in the criminal justice system is down. And people who were once homeless now have stable housing (see sidebar on page 9).

As one of the premier veteran voices of IDDT, COMHC has achieved and maintained high fidelity scores since its first year of implementation. As a result, the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (Ohio SAMI CCOE)—which provides consultation, training, and other forms of technical assistance like fidelity reviews for IDDT implementation throughout Ohio and beyond—has facilitated site visits from aspiring integrated treatment teams from Ohio, Michigan, and West Virginia. Last year, a team from Southeast Human Service Center in Fargo, North Dakota came for consultation from the SAMI CCOE that included a visit to COMHC.

The team of care providers at COMHC, at once confident and unassuming, has made training others in IDDT a practice that seems almost second nature. Their own process began with five COMHC staffers being trained in the integrated approach to mental health and substance abuse services. Those five, in turn, eventually provided
mentoring to another five who received training and so on, introducing the model and its methods around the organization and communities in Delaware and Morrow counties. Along the way, COMHC has made IDDT ambassadorship and education a part of its day-to-day routine clinical work with consumers.

“It’s an ideal way of doing things,” says Ohio SAMI CCOE Director of Consultation and Training Ric Kruszynski, MSSA, LISW, LICDC. “They extend their knowledge to those inside the organization who are not part of the SAMI team as well as to those outside of the organization who work with the SAMI clientele.”

Kruszynski adds that COMHC’s IDDT services thrive with partnerships among local police departments, probation officers, judges, hospital emergency rooms, and individual doctors. It has also received funding from the Delaware-Morrow Mental Health Recovery Services Board to collaborate with a local housing initiative to provide IDDT to their clients. COMHC has also begun plans to implement a second evidence-based practice, Supported Employment, into their service array for this fall.

**PACKAGING EXISTING STRENGTHS**

For COMHC’s Recovery Services Program Director Stephanie Patrick, MSW, LISW, implementing the IDDT model into everyday practice was an opportunity to maximize the effectiveness of many care-providing principles already present in the organization’s professional routines. For instance, before IDDT, many staff members understood that they needed to approach people with co-occurring severe mental illness and substance use disorders a little differently. So, on their own, they engaged clients with a non-threatening stages-of-change approach, encouraged the extent to which our mental health board was willing to fund IDDT and help us make it happen,” Patrick says. “We’ve had strong support from our ADAMH Board, and they have shown a very strong interest in the effectiveness of IDDT.”

**INTERPERSONAL RAPPORT: BREATHING LIFE INTO THE IDDT MODEL**

It would seem too easy to simply say that it is “the people” who make the SAMI/ACT team at COMHC special, yet while spending time with the group, there’s no denying the fact that on various levels it’s true. Whether it’s the casual atmosphere created by their communal office space, the genial and welcoming nature of the individual team members, or the understated insightfulness about how the IDDT model encourages them to make the most of their clinical skills, you can see right away why their company is sought and valued by other fledgling teams from inside and outside the state. They are humble; they are caring; and they are smart. And, while learning about and becoming well-versed in IDDT can sometimes be a cerebral exercise in treatment philosophies and methodologies (replete, at times, with sentences consisting only of acronyms), being with the COMHC SAMI/ACT team quickly becomes a lesson in real-life experiences, how the importance of self-reflection and the utility of team-based innovations overcome the challenges of helping people with co-occurring disorders—a population often referred to in health care, behavioral health care, and criminal justice circles as among “the most difficult” to engage and sustain in treatment.

And as much as the team members may downplay anything particularly unique about themselves, using tepid words like “flexibility” and “cooperation” to explain their success, the passion with which they approach their work is palpable. When pressed to answer the question that is posed to the group, “What is the crux of your story; what is the unique hook that makes this team so successful,” the collective answer that finally emerges is, “The people . . . and their way of reaching out,” delivered with an almost self-deprecating shrug.

*Stephanie L. Patrick, MSW, LISW, recovery services program director

**SAMPLE OF OUTCOMES**

<table>
<thead>
<tr>
<th>Consumers served by IDDT-based SAMI/ACT Team</th>
<th>2003</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Psychiatric hospitalization rate</td>
<td>23%</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Photo provided by S. Patrick

**INTEGRATED DUAL DISORDER TREATMENT**

IDDT is an evidence-based practice for people with severe co-occurring substance use and mental disorders (e.g., schizophrenia, schizoaffective disorder, bipolar disorder, severe depression or anxiety disorders). Research shows that IDDT improves quality of life for consumers and other outcomes for service organizations and multiple service systems when organizations maintain fidelity to the original design of IDDT.

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It is difficult to tell what exactly that shrug is about. Maybe it’s simple humility. Maybe it’s memories of the not-so-celebrated starts, stops, and stutter-step experiences with clients who have been ambivalent about and down-right resistant to treatment. Maybe the shrug is an unstated clinical astuteness, a defense against feelings of arrogance—the antithesis of being consumer-focused. But for an outsider looking to these service providers to explain what is behind their success, you may need to press a little further.

**TRAINING OCCURS EVERY DAY**

This team will tell you that it values training—a lot. Team members seek formal training opportunities at conferences and workshops and informal training opportunities in one-on-one supervision with their team leader as well as feedback from each other during team meetings. In addition, constructive feedback and support comes from senior managers of the organization via the team leader.

COMHC’s IDDT team meets twice a week, Tuesdays and Thursdays 8:30 to 10:00 a.m., to discuss each client’s progress and to evaluate if the treatments currently being used are in-line with his or her stage of change. Team members problem-solve together, brainstorming until they arrive at the right solution for that consumer given his or her stage of treatment. They also make sure to maximize the efficiency of their travel to and from appointments. For clients on the brink of relapse, someone from the SAMI team is in touch with them every day, nudging them to reconsider unhealthy behavior and to use the treatment as a means of achieving their personal goals for recovery.

“The team approach, being able to work more intensely with clients, is what makes IDDT successful for us,” explains Kelly McCauley, SAMI/ACT therapist. “It also provides for more opportunity to try new things, which translates into more learning opportunities for everyone involved.”

**MEDICAL PROFESSIONALS ARE ACTIVE TEAM MEMBERS**

This working closely with clients becomes especially helpful when dealing with medication management. According to Ann Snyder, M.D., COMH SAMI/ACT team psychiatrist, physicians who prescribe medication generally see consumers every four to six weeks. So maintaining contact with the team helps physicians stay current with a consumer’s daily or weekly condition.

“The feedback of team members is very important since they see individuals daily or throughout the week, in their homes and in social settings,” Dr. Snyder says. “They have a better idea of how these individuals are functioning in regards to their medications. We can make changes in treatment or medication or bring a consumer in for a visit should a medical crisis occur. Through the SAMI team, we’re able to manage clients more closely.”
and thus, hopefully, help them stay out of trouble and out of the hospital."

This team dynamic has made a true believer out of the once-skeptical, says Jerry Driesen, M.D., COMHC SAMI/ACT psychiatric consultant. Having himself been educated in and having practiced what he calls “the old-school” approach, where the emphasis was on getting clients sober before attending to their mental health concerns, Dr. Driesen has found IDDT approaches like motivational interviewing have enabled care providers to focus more on the patient's goals, not merely the doctor's objectives.

“It has changed my view completely,” he says. “It’s true engagement. Being a part of twice-weekly [team] meetings and helping make decisions about clients, then watching clients move forward inch-by-inch and keep moving forward: the success is substantial. People who have been out on the streets for years and years are now functioning members of the community.”

**CONSUMER NEEDS & GOALS DETERMINE EACH THERAPEUTIC MOVE**

Ultimately, though, the team members all agree that it’s the consumers themselves who actually dictate what a team needs to do to support recovery. Team members listen carefully to what each person wants to achieve—whether it’s reducing the amount of alcohol and other drugs he or she uses, staying out of the hospital, reconnecting with family and friends who support recovery, or finding a safe and affordable place to live, while not being evicted for symptom recurrences. For some, the goal is to find a competitive part-time or full-time job.

According to Case Manager Paul Harraman, BA, responding to consumers’ desires for a better life is all about motivational interviewing: What do you want in your life? What steps are you taking to get it? And how can we all work to help you stay the course?

“There’s always this question in the back of your mind,” Harraman says. “Can your clients function successfully without your help? The goal is, after all, for our clients not to need the same intense level of services. And it seems like we’re succeeding as we see our clients becoming more independent.”

**AN UNBREAKABLE ALLIANCE**

Facilitating clinical successes among consumers is not simply about being “touchy-feely”; rather, it is about the ability to engage each consumer on an individual basis, sometimes by whatever means necessary. During the twice-weekly team meetings, consumers at risk of arrest or incarceration are discussed and courses of action determined. If a consumer gets trouble with the law—if, for instance, he or she relapses and fails a urinalysis—the team discusses what might have caused the transgression and, thus, what might be the best course of action for avoiding it in the future. A probation officer and judge will often work with the team to determine the best approach.

If and when jail is determined the best option for a client’s short- and long-term recovery goals, it nonetheless doesn’t rupture the relationship established by the SAMI/ACT team, an important IDDT principle of *time-unlimited services*. With the integrated approach, no one is kicked out of treatment, since recovery frequently consists of a series of starts, stops, relapses, and sometimes just bad decision-making by consumers. The SAMI/ACT team makes every effort to maintain therapeutic alliances through each disruption. It’s a chance to further employ motivational interviewing approaches to help develop consumer discrepancy between his or her stated recovery goals and displayed behavior.

“We go to where clients are incarcerated and still work with them to establish rapport, trust, and respect,” says McCauley. “We help them reevaluate the choices that landed them in jail and help them determine how to do things differently once they’re released.”

*Continued on page 12*
ASSERITIVE OUTREACH: OPENING DOORS
At COMHC, successful implementation, high fidelity to IDDT, and improved outcomes took a few years to achieve. In the beginning, when team members made their first forays out to the homes of potential clients throughout Delaware and Morrow counties, no one knew what to expect. Team members weren’t sure what they were getting into, and consumers weren’t expecting this type of intensive outreach, specifically home visits from care providers.

A lot of people just never bothered opening their doors, says Joanne Haycox, LPN, SAMI/ACT team nurse. “They didn’t know us. They weren’t expecting us. And we weren’t sure what to expect either. But we were attempting to do outreach and we needed to go out to the homes repeatedly in order to engage individuals.”

For the SAMI/ACT team, this gesture to meet consumers on their own ground and invite them on the walk toward recovery often comes to fruition through simple acts of human bonding, of discovering mutual interests on whatever level consumers feel comfortable and best respond. For example, team members often ask clients how they like to spend their free time. This leads to conversations about hobbies, which leads to conversations about other aspects of daily living. Case Manager Harraman is a video gamer, for example, which instantly offers a common bridge of conversation for a lot of younger male clients. Likewise, SAMI/ACT Community Support Provider Jim Little, MA, LSW, is passionate about chess and has found many new clients eager to talk about their love of the game as well.

COMHC also hosts group meetings for clients as a way to establish connections and trust. The groups address a number of life issues. Topics range from the importance of good nutrition and exercise—and how to get healthy doses of each—to medication awareness and management.
Sandra Stephenson named new director of ODMH

Sandra Stephenson, MSW, LISW, was named the new Director of the Ohio Department of Mental Health (ODMH) by Ohio Governor Ted Strickland last May. As director, she is overseeing the primary ODMH responsibilities of increasing access to and ensuring the provision of quality inpatient and community-based mental health services, supporting and monitoring local systems of care, and supporting and promoting inter system collaboration.

Among ODMH’s initiatives is the continuing support of several Coordinating Centers of Excellence (CCOEs), which provide technical assistance to service organizations and systems for the implementation of best practices and evidence-based practices (EBPs). For instance, ODMH began supporting the Ohio SAMI CCOE in December 2000 to provide consultation, training, and fidelity evaluation to organizations and systems implementing Integrated Dual Disorder Treatment (IDDT), an EBP that improves quality of life and other outcomes for people with co-occurring severe mental and substance use disorders.

Before joining ODMH, Stephenson served as executive director of Southeast, Inc., a non-profit behavioral health organization in Columbus. She held that post since 1987, overseeing an annual budget of $27 million and a staff of 350 at several locations. Under her leadership, Southeast, Inc.’s annual budget grew from $4 million annually to the current $27 million. Also under her leadership, the organization began implementing IDDT. It has been providing this evidence-based service to people with co-occurring disorders since January 2003.

As Director of ODMH, Stephenson plans to continue the state’s commitment to disseminating EBPs to communities throughout Ohio.

“Having worked throughout the years with so many consumers who have had substance abuse and mental health problems, I have been very much involved in the whole integrated healthcare movement in Ohio as a provider,” says Stephenson. “Using the integrated approach has helped alleviate the fragmenting of treatment and has helped make recovery more successful. There are often many other issues with dual disorder consumers—homelessness and criminal justice concerns, to name just two—and IDDT gives us a way to deal with even more than just the dual disorders. With the creation of the Ohio SAMI CCOE and the support it provides across the state, it’s an open invitation to providers to get involved and make a significant difference for consumers and their families.”

Angela Cornelius named new director of ODADAS

Angela Cornelius named new director of ODADAS

This past May, Ohio Governor Ted Strickland named Angela Cornelius the new Director of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). With a staff of 106 employees and an annual budget of $195 million, ODADAS plans, initiates, and coordinates an extensive system of services to prevent and treat substance abuse among Ohio’s residents. The Department also coordinates the addiction services of other state departments, the criminal justice system, law enforcement, and the legislature. In January 2003, ODADAS joined ODMH’s support of the Ohio SAMI CCOE in its mission to disseminate the Integrated Dual Disorder Treatment (IDDT) model to community-based organizations that serve Ohio residents who have a co-occurring severe mental and substance use disorder. Research conducted nationally shows that over 60 percent of people with severe mental illness have a co-occurring substance use disorder at some time during their lives. Cornelius plans to continue ODADAS’ commitment to integrated treatment.

“The work the SAMI CCOE has done in implementing the Integrated Dual Disorder Treatment approach has helped propel our field forward in providing treatment services to people who are suffering from mental illness and substance abuse,” Cornelius says. “The SAMI CCOE project continues to educate Ohio’s SAMI providers in evidence-based practices for bringing about a lasting recovery for these clients. The Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services are committed to IDDT and other collaborative efforts designed to increase access and reduce barriers.”

Before joining ODADAS in its chief leadership role, Cornelius was director of Project Linden, Inc., a private, non-profit outpatient alcohol and drug treatment and prevention center in Franklin County, where she served as the executive director as well as the agency’s clinical director prior to that. She has also served as an employment services specialist and a vocational rehabilitation counselor for the Rehabilitation Services Commission in Dayton, Ohio.

(Portions of this story were obtained from the ODMH web site: www.mh.state.oh.us.)
A Research Infrastructure Grant (RIG) awarded to the Center for Evidence-Based Practices (EBPs) at Case Western Reserve University has enabled the Center to expand its capacity to access and analyze fidelity-review data gathered from service organizations that are implementing Integrated Dual Disorder Treatment (IDDT) and/or Supported Employment (SE). Both are EBPs for people with severe and persistent mental illness. The evaluation of this data will help the Center's consultants and trainers disseminate practical knowledge to service providers, helping them improve the outcomes of their work with consumers.

The RIG was awarded in late 2005 to the Center by the Mandel School of Applied Social Sciences—the professional school of social work at Case—to support and promote research that improves behavioral healthcare practices. The Center is a partnership between the Mandel School and the Department of Psychiatry at the Case School of Medicine. Lenore A. Kola, Ph.D., assistant professor of social work at the Mandel School and co-director of the Center for EBPs is the principle investigator.

SIX YEARS OF DATA COLLECTION
According to Deb Hroud, MSSA, LISW, assistant director of research and evaluation at the Center, the RIG Project marks an important step toward understanding facilitators of and challenges to EBP implementation. She explains that there is much published research about the effectiveness of the IDDT and SE models as well as published...
research about the processes of organizational change in general. However, there have been very few research studies that have examined organizational characteristics and other characteristics—from big-picture macro issues like service-system policies to frontline clinical issues such as level of education and training of direct-service staff—that positively and negatively affect IDDT and SE implementation over time.

The Center has been providing evaluation services and other forms of technical assistance for EBP implementation to Ohio organizations since the onset of Ohio’s IDDT initiative in 2000. For instance, the Center assembles teams of implementation experts who conduct annual fidelity reviews of IDDT and SE programs. To date, the Center has conducted over 200 fidelity reviews at 68 outpatient- and inpatient-IDDT programs and 13 SE programs in Ohio. Thus, the Center has collected a wealth of data on the 12 organizational characteristics (components) and 14 treatment characteristics that comprise the IDDT model and its fidelity scale (see sidebar on page 3). The Center has also collected fidelity scores for each fidelity scale item as well as data that describes changes in those scores over time.

“We have acquired a great deal of experience, practical knowledge, and skills, which have led to the creation of a 40-page booklet about how to implement IDDT with success,” Hrouda says, referring to Implementing IDDT: A step-by-step guide to stages of organizational change, published in 2006 (see Resources on page 16). “The RIG Project gives us the opportunity to be more scientific about what we know and do as an organization. This new understanding will add to the knowledge base about EBPs and will give us some evidence to inform our consultation and training services.”

INTRODUCING THE EVALUATION DATABASE (TED)

Under the direction of Hrouda, the RIG Project has been conducted in multiple phases, including the following:

• Building/programming the evaluation database (TED)
• Entering six years of fidelity-review data
• Collecting and entering additional organizational information not asked for in the typical fidelity review process
• Conducting initial analyses of data
• Creating a web-based fidelity-rating structure

As part of data collection for this project, RIG team members asked chief executive officers and other representatives of 30 service organizations to participate in a substantial interview-and-questionnaire process. Phone interviews and surveys were completed between September 2006 and January 2007. Hrouda notes that the individuals who generously gave their time and attention to this project have contributed to the knowledge base that will help improve services to Ohio residents.

RIG Project team members have completed programming of the evaluation database (TED) and its web interface. They have also entered all fidelity-review and organizational data and have conducted some data analyses.

INITIAL RESULTS: 24 TO 36 MONTHS TO REACH HIGH FIDELITY

Notable initial results show that programs which approach or reach high IDDT fidelity (mean scores of four or more) do so following 24 to 36 months of implementation. Hrouda notes that this finding may change as the Center conducts more analyses. Thus far, fewer than one-third of Ohio’s IDDT programs have been engaged in implementation for two years or more. Therefore, it is not known if this timeframe of 24 to 36 months is common to all organizations. Some organizations might take longer to reach the benchmark.

“The timeframe is fairly reasonable when considering that for some teams IDDT is a significant shift from their former way of approaching recovery services,” says Ric Kruszynski, MSSA, LISW, LICDC, director of IDDT consultation and training at the Ohio SAMI CC O E. He adds that the initial results from the RIG analysis should help implementation teams set realistic expectations for their efforts. Service team members sometimes feel discouraged and community stakeholders sometimes get impatient and desire immediate results. The CC O E’s consultants and trainers often have to reassure team members, managers, and executives that their attention to programmatic and clinical details today will pay off in the near future.
FIDELITY REVIEW, AT-A-GLANCE

The fidelity review (or assessment) provides a formal mechanism for independent evaluation of your IDDT services. It is not an audit or accreditation process. It is strictly a quality-improvement process that provides you with information about your progress and information to make decisions about your next steps. Research demonstrates that IDDT programs which maintain fidelity to the model achieve the best results. Optimally, organizations engage in an external IDDT fidelity review process at least once per year. The fidelity review and fidelity action plan create a continuous quality improvement process—a cycle of planning, implementation, evaluation, and service enhancement.

In Ohio, fidelity reviews are conducted onsite at the organization by a team that has been trained to conduct the reviews. The team often consists of representatives from the Ohio SAMI CCOE, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, and representatives from peer IDDT initiatives throughout the state. The SAMI CCOE does not recommend that organizations perform their own fidelity reviews. The experiences of Ohio organizations have demonstrated that external fidelity reviewers provide an objective perspective that is more helpful for future service enhancements.

FIDELITY SCALE

The fidelity-review team uses the IDDT fidelity scale. It is an evaluation instrument that is designed to measure the degree to which programs administer services according to IDDT’s 12 organizational characteristics (components) and 14 treatment characteristics. Obtain the IDDT fidelity scale online (see Resources below).

FIDELITY REVIEW PROCESS

For more information about the fidelity-review process, consult the Implementing IDDT booklet.

FIDELITY ACTION PLAN

The fidelity action plan is created by your implementation steering committee in consultation with your technical-assistance organization. The plan addresses all areas of the IDDT fidelity scale. It outlines next steps in your journey toward reaching and sustaining high fidelity and improved outcomes.

Resources


www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=136

IDDT Fidelity Scale & Definitions

www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=107

www.ohiosamiccoe.case.edu/library/resource.cfm?resourceid=109
When it comes to smoking and psychological well-being, statistics show an inextricable link between tobacco use and mental illness, with 44 percent of the cigarettes smoked in the United States being consumed by people with psychiatric disorders.

More specifically, the rate of smoking for people with schizophrenia is estimated between 65 to 85 percent, three to four times that of the general population. Of these people, 68 percent smoke 25 or more cigarettes per day. Studies also show that nicotine may interfere with the body’s ability to metabolize psychiatric medications, potentially leading to the need for higher doses to control psychiatric symptoms and prevent psychotic episodes.

In addition to the negative health effects—smoking (nicotine) claims up to 400,000 lives annually while other substance abuse claims 10,000 lives—the economic effects are also devastating. People with schizophrenia spend an average of 27 percent of their monthly income on cigarettes (see Hroudá in Resources).

SOLUTION: AN EVIDENCE-BASED RESPONSE
In an effort to draw upon the best practices and latest technologies to reduce tobacco use among mental health consumers, the Center for Evidence-Based Practices (EBPs) at Case Western Reserve University has been awarded a contract through project partners the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) from a grant received by the Ohio Tobacco Prevention Foundation. The partnership's mission is to design, implement, and evaluate a Tobacco Cessation (TC) model through the Ohio SAMI CCOE, targeting people with severe and persistent mental illness (SPMI) and service providers at behavioral healthcare organizations throughout Ohio. The initiative will also be disseminated in collaborative partnership with Ohio Advocates for Mental Health (OAMH), a consumer advocacy organization.

Continued on page 18
The roll-out of the Center for EBP’s Tobacco Cessation (TC) model is expected to reach up to 15 organizations during the fiscal year.

With continuing evaluation over time, the project partners intend to create an evidence-based practice, one whose methods and outcomes can be replicated widely. Initially, the model will be implemented at select consumer-operated services and four community-based service organizations that have successfully implemented the Integrated Dual Disorder Treatment (IDDT) model with technical assistance from the Ohio SAMI CCOE. Organizations implementing IDDT are already familiar with the process of implementing new service models, which not only include changes in clinical practice but also changes in organizational policies and practices. These organizations are also familiar with the process of fidelity evaluation. The roll-out of the TC model is expected to reach up to 15 organizations during the fiscal year.

TOBACCO CESSION FOR CONSUMERS OF IDDT SERVICES

According to Ric Kruszynski, MSSA, LISW, LICDC, director of IDDT consultation and training at the Ohio SAMI CCOE and co-manager of the TC project, there is a logical relationship between IDDT and tobacco cessation. Nicotine is listed among the 11 classes of addictive substances in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Therefore, nicotine addiction is a co-occurring substance use disorder. Until recently, though, the harmful effects of nicotine have not been systematically addressed.

Kruszynski explains that one of the big barriers to tobacco cessation is perception. He cites a persistent myth among many service providers who believe that nicotine is a relatively minor addiction compared with such heavyweights as heroin, cocaine, and alcohol. In addition, many believe they are doing consumers a favor by not addressing the smoking (nicotine use) while they are trying to quit the so-called “more serious drugs”. However, new studies indicate that the nicotine in cigarettes is a leading factor in stunting full recovery. People with an addiction to alcohol and/or other drugs who also smoke have a higher rate of relapsing into substance use.

“Consumers are every bit as likely to put themselves at more of a health risk if they continue using tobacco,” Kruszynski says. “So, IDDT and tobacco cessation are a natural complement.” Together, both will advance the full recovery of consumers dealing with substance use. The new TC model will target all tobacco products, including chewing tobacco, which is often overlooked in other cessation projects.

NEGATIVE OUTCOMES FOR TOBACCO USE

- Smoking claims up to 400,000 lives annually
- Substance abuse claims 10,000 lives annually
- 20.9 percent of people in the general population use tobacco
- 44 percent of people with a psychiatric disorder use tobacco

Tobacco use among people with mental disorders

- 66 to 75 percent more likely to use tobacco than those who do not have a mental disorder

Disorder | % of those who use tobacco
---|---
Schizophrenia | 65 to 88
Bipolar disorder | 88
Alcohol dependence | 80
Depression | 49
Panic disorder | 35

Tobacco use among people with schizophrenia

- 68 percent smoke 25 or more cigarettes per day (vs. 11 percent of smokers in the general population who smoke 25 or more per day)

Sources: See Hrouda, Hughes, and Smeltz in Resources on page 19.

Effects upon psychiatric medication

- Nicotine may interfere with the body’s ability to metabolize psychiatric medications, potentially leading to higher doses needed to control psychiatric symptoms and prevent psychotic episodes.

Effects upon relapse

- People with an addiction to alcohol and/or other drugs who also smoke (use nicotine) experience a higher rate of relapse to substance use.

Effects upon income

- People with schizophrenia spend an average of 27 percent of their income on cigarettes.

POSITIVE OUTCOMES FOR TOBACCO CESSATION

- Consumers in treatment for other drugs who also participate in tobacco cessation programs are 25 percent more likely to achieve long-term abstinence from alcohol and other drugs.
- Treatment for heroin, cocaine, or alcohol addiction appears more effective if undertaken in tandem with treatment for tobacco addiction.

ADVICE FROM CARLO DICLEMENTE & OTHERS

Numerous Ohio stakeholders will be involved in shaping the Center for EBP’s Tobacco Cessation (TC) model through its advisory council. Thus far, the Center’s TC team has engaged in a planning process with representatives from collaborating organizations, including ODMH, ODADAS, OAMH, and the Tobacco Prevention Foundation.

The project team has also met with Carlo DiClemente, Ph.D., an internationally-known researcher, author, and consultant, who is among the original developers of the stages-of-change approach, which will be among the core components of the Center’s TC model. Joining him as a member of the Center’s Tobacco Cessation advisory council is Jill Williams, M.D., associate professor and director of the Division of Addiction Psychiatry at the UMDNJ-Robert Wood Johnson Medical School, Department of Psychiatry. Dr. Williams has developed a nationally-recognized practice to help consumers with severe and persistent mental illness stop smoking.
TOBACCO CESSION FOR ALL CONSUMERS OF MENTAL HEALTH SERVICES

According to Patrick E. Boyle, MSSA, LISW, LICDC, director of implementation services at the Center for EBPs and Ohio SAMI CCOE, the new TC model is being developed for all people with severe mental illness in Ohio, not just people with co-occurring severe mental and substance use disorders. As the research shows, tobacco has a particularly devastating impact upon all consumers with severe mental illnesses.

“When you consider how much consumers use this addictive substance and how badly it affects their health, it feels as if we are addressing not just an everyday health issue but an epidemic,” Boyle says. “Realizing what we now know, it is our responsibility to address the issue in treatment.”

BIOPSYCHOSOCIAL APPROACH: IDDT APPLIED TO TOBACCO CESSION

The new TC model being designed by the Center for EBPs will include core principles of IDDT as well as tested pharmacological approaches to reducing nicotine dependence among the SPMI/SAMI populations. The IDDT-inspired model also incorporates psychoeducation about the ill-effects of tobacco use as well as skill-building that enhances self-sufficiency among consumers for replacing their unhealthy tobacco use with positive lifestyle changes—for example, healthy eating, exercise, employment, and tobacco-free social events and activities.

Specific components of the IDDT model being incorporated into the TC model include the following:

• Multidisciplinary treatment approach
• Psychopharmacology
• Time-unlimited services
• Stage-appropriate interventions
• Intervention to promote overall health
• Overall program philosophy that supports recovery from co-occurring disorders.

ON THE ROAD TO AN EBP

Deb Hroura, MSSA, LISW, assistant director of research and evaluation at the Center and co-manager of the TC project, explains that the project team is developing a fidelity measure that consists of organizational characteristics (components) and treatment characteristics. The fidelity measure provides standard definitions of the elements of the model. The instrument will be used by the Ohio SAMI CCOE’s consultants and trainers to guide organizations through implementation and to examine how closely the TC services adhere to the model. The TC project will also examine consumer outcomes in conjunction with organization outcomes, because both are core components of an effective service model. Research shows that once improved outcomes are reached, the best way to achieve them consistently is through fidelity to the model’s design.

“It’s the heart of an EBP,” Hroura emphasizes. “If providers are consistent with how they implement the model, we can more comfortably attribute good consumer outcomes to our intervention. We want good outcomes that are replicable in many settings. Our Tobacco Cessation model is not an evidence-based practice—yet. However, we have been gathering a set of outcome measures to help us evaluate and improve the services.”

Center Co-Directors Robert J. Ronis, M.D., MPH, chair of the Department of Psychiatry at the Case School of Medicine, and Lenore A. Kola, Ph.D., associate professor of social work at the Mandel School of Applied Social Sciences at Case, conclude that TC model development will take several years, which is typical for an EBP. Development will involve an ongoing process of evaluation and quality improvement.

Resources

Debra R. Hroura, MSSA, LISW, and Barbara L. Wieder, Ph.D. (In press).
www.ctri.wisc.edu
http://smokingcessationleadership.ucsf.edu/Resources.html
http://healthrecovery.org/projects/tobacco_education_and_treatment/default.asp
Ohio Tobacco Prevention Foundation
www.standohio.org

11 CLASSES OF ADDICTIVE SUBSTANCES

In the DSM-IV-TR, the term substance refers to a drug of abuse, a medication, or a toxin. Substances are grouped into 11 classes:

• Alcohol
• Amphetamine or similarly acting sympathomimetics (stimulants—e.g., Ecstasy, methamphetamine, ephedrine)
• Caffeine
• Cannabis
• Cocaine (e.g., powder cocaine, crack cocaine)
• Hallucinogens (e.g., LSD, Ecstasy, psilocybin, mescaline)
• Inhalants
• Nicotine
• Opioids
• Phencyclidine (PCP) or similarly acting arylcyclohexylamines
• Sedatives, hypnotics & anxiolytics

(Source: DSM-IV-TR, p193)
SAMI Matters is produced by the Ohio SAMI CCOE. Additional copies of this publication may be obtained by contacting our office or by visiting our web site. We welcome and encourage your comments, questions, and suggestions. Please send address changes.

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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 severe mental and substance use disorders.

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Service systems and organizations that wish to implement or enhance Integrated Dual Disorder Treatment (IDDT) services are encouraged to contact us.

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Tuesday, October 2 & Wednesday, October 3
Crowne Plaza Hotel
Columbus North
Columbus, Ohio
www.ohiosamiccoe.case.edu/events/event.cfm?eventid=354

HIGHLIGHTS
- 36 Workshops
- 2 Plenary Sessions
- Keynote Speakers: Fred Osher, MD, SAMSHA’s COCE; Sandra Stephenson, MSW, LISW, Director of ODMH; Angela Cornelius, Director of ODADAS
- Ohio IDDT service team presentations: teams from rural communities, small cities, large cities that provide general IDDT services as well as specialized services for specific populations (homeless, criminal justice community re-entry, acute & forensic inpatient, multicultural)

REGISTRANTS
- 400 people
- 13 states
- Multiple disciplines (social workers, addictions counselors, mental health counselors, psychologists, vocational specialists, nurses, psychiatrists, among others)
- Administrators, program managers, team leaders, direct-service providers, researchers, policy makers, consumers, advocates

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