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CENTER FOR EVIDENCE-BASED PRACTICES

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

CASE WESTERN RESERVE UNIVERSITY EST. 1826

A Technical-Assistance Center

Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services

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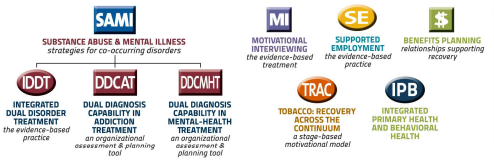
Service innovations for people with mental illness, substance use disorders



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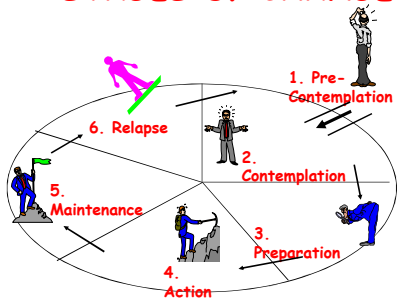
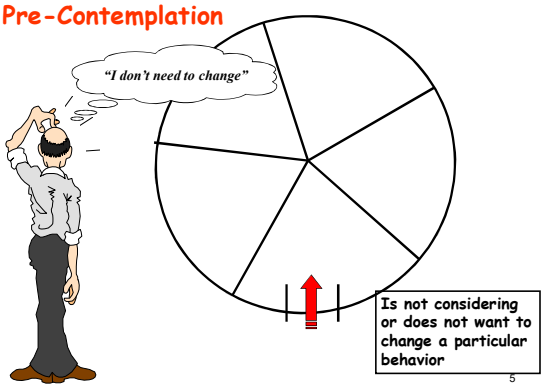
STAGES OF CHANGE



Adapted from Prochaska & DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change." *Psychotherapy: Theory, Research, and Practice*, 19: 276-288.

4

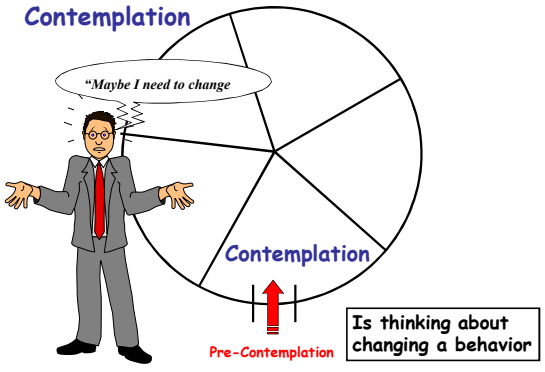
Pre-Contemplation



Is not considering or does not want to change a particular behavior

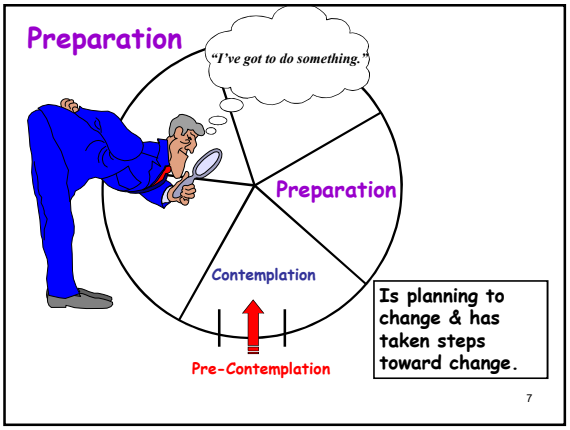
5

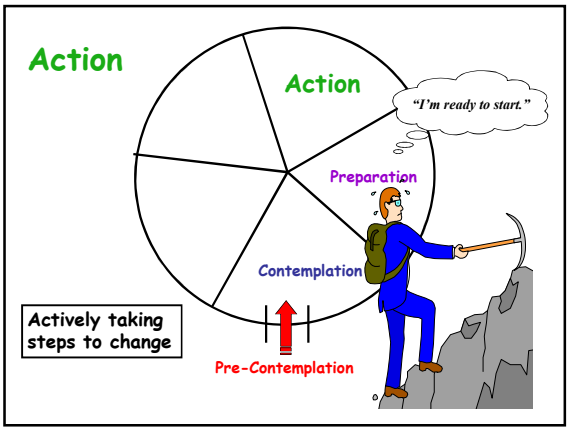
Contemplation

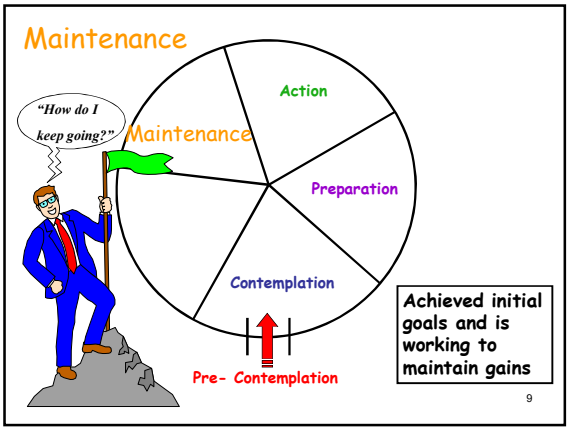


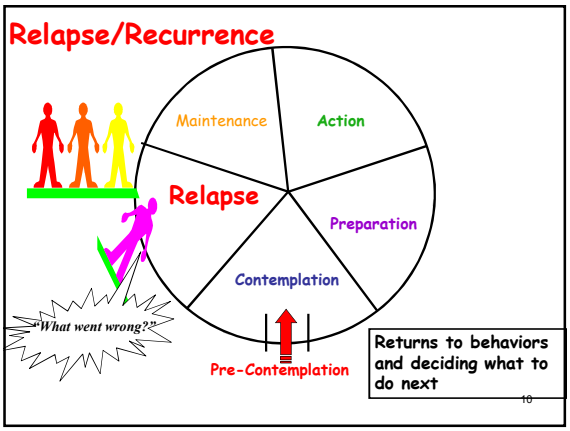
Is thinking about changing a behavior

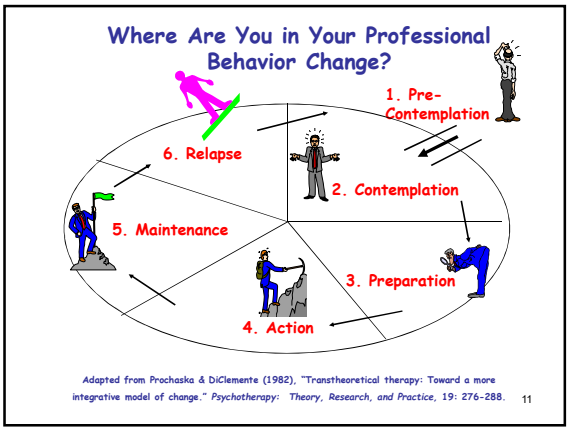
6

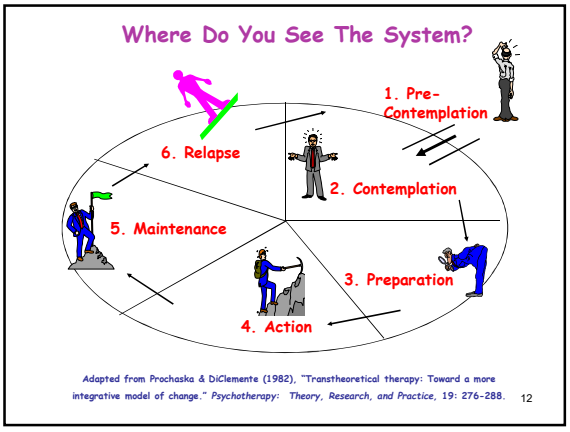

Preparation
"I've got to do something."
Preparation
Contemplation
Pre-Contemplation
Is planning to change & has taken steps toward change.
7


Action
Action
"I'm ready to start."
Preparation
Contemplation
Pre-Contemplation
Actively taking steps to change

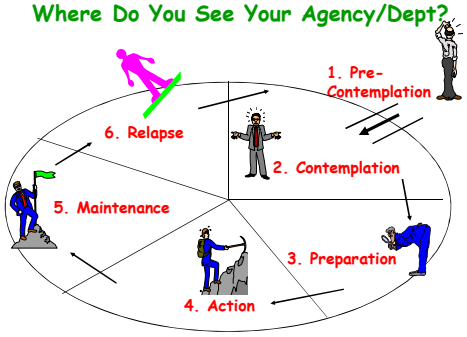

Maintenance
"How do I keep going?"
Maintenance
Action
Preparation
Contemplation
Pre- Contemplation
Achieved initial goals and is working to maintain gains
9


Relapse/Recurrence
Maintenance
Action
Relapse
Preparation
Contemplation
"What went wrong??"
Pre-Contemplation
Returns to behaviors and deciding what to do next
10


Where Are You in Your Professional Behavior Change?
1. Pre-Contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Relapse
Adapted from Prochaska & DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change." Psychotherapy: Theory, Research, and Practice, 19: 276-288.
11


Where Do You See The System?
1. Pre-Contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Relapse
Adapted from Prochaska & DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change." Psychotherapy: Theory, Research, and Practice, 19: 276-288.
12

Where Do You See Your Agency/Dept?



Adapted from Prochaska & DiClemente (1982), "Transtheoretical therapy: Toward a more integrative model of change." *Psychotherapy: Theory, Research, and Practice*, 19: 276-288. 13

Co-Occurring Disorders Treatment Quadrants

Mild to moderate Mental illness symptoms *Low to moderate substance use disorder* **I**	Severe mental illness symptoms *Low to moderate Substance use disorder* **II**
Mild to moderate Mental illness symptoms *Severe substance use disorder* **III**	Severe mental illness symptoms *Severe substance use disorder* **IV**

Integrated Dual Diagnosis Treatment

- The model focuses on treatment for persons with severe and persistent mental illness and substance use disorder
  - Psychotic disorders
  - Bipolar disorders
  - Other severely disabling disorders

Integrated Dual Diagnosis Treatment Eligibility

Non-Diagnostic Eligibility Issues

- Funder Priority
- Agency Priority
- Assessing & Prioritizing Need
- Identification
- Capacity (# of Consumers Served)

Integrated Dual Diagnosis Treatment Team Structure

- Team Leader
- Case managers
- Psychiatrist
- Nurse
- Substance Abuse Specialist
- Counselors
- Vocational, Housing, Criminal Justice specialists
- *Work collaboratively* on the team with evidence of excellent communication

Integrated Dual Diagnosis Treatment Team Structure

- Existing or Brand New Team?
- Voluntary or “Volunteered”?
- Size of the Team
- As the Team Leader goes, so goes the Team
- Clinical and Philosophical Compatibility

Integrated Dual Diagnosis Treatment Core Services

- Consumers have access to comprehensive range of services
  - Full range of Residential, Supported (competitive) Employment, Family Psycho-education, ACT/ICM (10-20:1), Illness Management;
  - Ancillary services are consistent with IDDT philosophy

Integrated Dual Diagnosis Treatment Core Services

- Substance Abuse Counseling, Group COD Counseling, Family COD Services, Pharmacological Treatment
- Stage-wise Treatment and Motivational Interventions
- Incremental Program Growth

Integrated Dual Diagnosis Treatment Team Leader Role & Tasks

- Establish, Recruit and Train the Team
- Administrative Functions
- Clinical Functions
- Sets Tone & Expectations
  (The supervisor "walks the walk")

Integrated Dual Diagnosis Treatment Team Leader Role & Tasks

- What's the DIF-ference?

  Keep the clinical focus on decreasing the

  D - duration
  I - intensity
  F - frequency

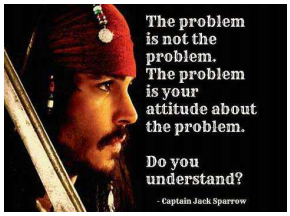
  of mental health and substance abuse symptoms

Integrated Dual Diagnosis Treatment Team Leader Role & Tasks

- Evaluate Staff Skills and Training Needs
- "Live" Supervision
- Emphasize, Monitor and Utilize Fidelity (Fidelity Action Plan)
- Emphasize, Monitor and Utilize Outcomes

Integrated Dual Diagnosis Treatment Team Leader Role & Tasks

- 60% of programs attain successful implementation
- High fidelity to model leads to good outcomes
- Without focus, fidelity erodes over time



Integrated Dual Diagnosis Treatment Team Leader Role & Tasks

- SAMI Program Progress Summaries

Staging:
Why stage?

- Drives treatment interventions
- Maintains client centered focus

Staging:
Process

- Team setting
- Utilize staging instrument
- Occurs regularly
- Documented in the treatment plan
- Treatment interventions to match consumers stage of treatment

Stages of Change and
Stages of Treatment

- Pre-contemplation - Engagement
- Contemplation and Preparation - Persuasion
- Action - Active treatment
- Maintenance - Relapse Prevention

Different services are helpful
at different stages of treatment

- **Engagement**
  - Outreach, Practical help, Crisis intervention, Develop alliance, Assessment **(Build Relationship)**
- **Persuasion**
  - Understand what matters to the person, Explore goals, Explore concerns and awareness of problem (Motivational counseling), Family support, Peer support **(Tip Ambivalence)**

Different services are helpful at different stages of treatment

- **Active Treatment**
  - Substance abuse counseling, Recovery skills training, Self help groups **(Develop Skills)**
- **Relapse prevention**
  - Relapse prevention plan, Continue skills building in active treatment, Expand recovery to other areas of life **(Support Life Changes)**

Staging Tools

- Substance Abuse Treatment Scale (SATS)
- CEBP MH & ATOD Staging Tool: A few thoughts…

Common Staging Errors

1. **Instrument Issues/Inconsistencies**
   - No staging tool used at all
   - No staging tool present while staging
   - Wrong staging tool used
   - Staging only completed by individual and not team

-Use SATS
-Look at SATS and Follow Guidelines
-SOCRATES, SOC, URICA are not for this purpose
-Staging is team based activity requiring multi-disciplinary input

Common Staging Errors

2. Frequency

- Too Often
- Irregular/Random

-Formally stage every 6 months, and/or discuss whenever clinically indicated

Common Staging Errors

3. Stage of Change vs. Stage of Treatment

- Stage of Change does not address provider behavior and relationship
- Stage of Change informs *client* readiness
- Stage of Treatment informs clinical intervention(s)

-Use Stage of Treatment (SATS) to guide interventions

Common Staging Errors

4. Documentation

- Staging is being done, but not reflected in clinical record

- Documentation of stage in ISP and elsewhere (ex: Progress notes, quarterly summaries, etc.)
  - **reinforces stage appropriate treatment.**
  - **increases likelihood of communication among team members** re: stage appropriate strategies

Common Staging Errors

5. Lost in Translation

- Staff are not yet proficient at stage appropriate interventions (ex: have not yet learned MI, CBT, or lack engagement skills, etc.)
- Staging occurs, though subsequent interventions don't reflect appropriate strategies for the identified stage

- Train and supervise for full spectrum of skills appropriate to each stage
- **Supervision, supervision, supervision**

What is Motivational Interviewing (MI)?

A collaborative,
person-centered
form of guiding
to elicit and strengthen
motivation for change

February 2009 Revised definition

Motivational Interviewing: Foundations

- Therapist style is a powerful determinant of client resistance and change
- Ambivalence is normal
- Motivation can be increased by variety of therapeutic strategies
- Argumentation is poor method for inducing change
- When resistance is evoked, clients tend not to change

Eight Tasks of Learning Motivational Interviewing

1. Getting the "Spirit" of MI
2. Using client-centered skills (OARS)
3. Recognizing change talk
4. Eliciting and reinforcing change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating client commitment
8. Transition and Blending

What Do We Know About Learning MI?

Evaluating Methods for Motivational Enhancement Education (EMMEE)

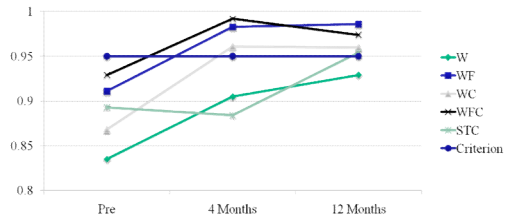
Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). *A Randomized Trial Of Methods To Help Clinicians Learn Motivational Interviewing*. Journal Of Consulting And Clinical Psychology, 72, 1050-1062.

Study Design

- 140 clinicians treating substance use disorders randomly assigned to:
- W: 2 day CPE workshop only
- WF: Workshop + **Feedback** from practice samples
- WC: Workshop + 6 Telephone **Coaching** sessions
- WFC: Workshop + **Feedback and Coaching**
- STC: **Self-Training Control** (waitlist)

DID THE CLINICIANS LEARN MI?

Percent MI-Consistent Responses

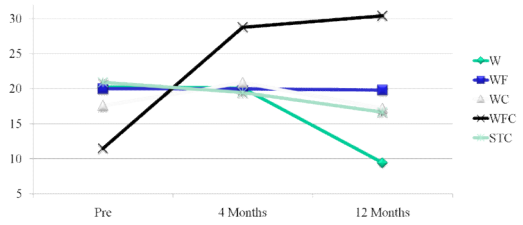


- **Trained groups > control at 4 months p < .001**
- **All enhanced training groups exceed criterion**
- **Due mostly to decreased MI-inconsistent responses**

(Miller, Research and History of MI, 2005)

DID THE CLIENTS RESPOND?

Percent Client Change Talk



No significant increase except in Group WFC

Supervisory MI Skill Assessment & Development

- How & when were you trained in MI?
- How were you supervised in MI?
  - How did that affect your MI skill development?
  - What did you learn about what works/what doesn't?
- How & when were you trained to coach this practice?
  - Have you received 24 hours of training in MITI or MIA STEP?

Motivational Interviewing: Supervising

- Utilize MI tools in handout packet
  - Supervision
  - Direct service observation
  - Role play
  - Constructive feedback
  - Support skill development

Motivational Interviewing

Application Exercises

Family Services: Myths

- Mental Health system has historically been a "welcoming" system for families
- Families don't want to be involved in treatment
- Consumers don't want family members involved in their treatment
- Family members don't want to learn about mental illness/substance abuse
- Family involvement has no impact of consumer recovery

Family Services: Why?

- Consumers and their families often know very little about mental illness, substance use and their interactions
- Family interventions are effective in helping consumers recover
- Family interventions facilitate improved family coping and skill development

Family Services: Why?

- Family stress worsens the course of consumer mental illness
- Families want to be involved
- Loss of family support may contribute to homelessness
- Families have more frequent contact with consumers

Family Services: Research

- Over 15 controlled studies
- Family programs shown to reduce relapse rates 25% - 75%
- Effective programs improve functioning of all family members, focus on present and future, provide social support and are long-term
- Several service delivery formats are effective

Group Services: Philosophy

- Integration of mental health and substance use disorders
- Stage-wise interventions
- Comprehensive service array
- Consumer choice
- Long-term perspective

Group Services:
Service Menu

Types of Groups

- Stage-wise
  - Persuasion
  - Active Treatment
  - Relapse prevention
- Social Skills Training
- Self-help (12 Step)

Medical Services

- Medical professional trained in COD
- Works with client and team to support medication adherence
- Abstinence is not a requirement for medications

Medical Services

- Avoid prescribing addictive medications
  - Benzos and stimulants
- Offer medications that may reduce addictive behavior
  - Naltrexone, disulfiram, clozapine
- Role of nursing…

Interventions to Promote Health

- Consumers experience many negative consequences from substance abuse and mental illness
- Consumers with COD are at higher risk for negative consequences than general population

Interventions to Promote Health

Examples of negative consequences

- Physical effects, disease, malnutrition
- Relapse of "other" disorder
- Unsafe sex
- Victimization
- Loss of family support, housing
- Legal, incarceration, DUI

Interventions to Promote Health

Strategies to promote health

- Teaching safe sex practices
- Needle exchange programs
- Tobacco cessation
- Support switching to use of less harmful substance
- Assisting consumers to avoid high risk situations for victimization
- Secure housing (wet, damp)
- Safe driver programs
- Providing support to families

Non-Response to Treatment

- Consumers that don't respond to treatment plan may need more intensive treatment interventions

Non-Response to Treatment

- How does your agency define "non-responders" or those persistently not engaged in services?
- Develop working definition for persistently no-engaged

Non-Response to Treatment

- Develop policy
  - Time frame for identification
  - Method for review
    - team meeting
    - frequency
    - document
  - Menu of intensive interventions
    - What has been tried - response
    - Identify additional interventions
    - Action plan
    - Evaluate

Non-Response to Treatment

- Potential interventions
  - Supervised housing
  - Intensive family interventions
  - Protective payeeship
  - Changing medications
  - Residential treatment
  - Conditional discharge
  - Guardianship

Community Outcomes

1. Consumer
2. Agency
3. Systems
4. Tracking-Monitoring-Reporting
   - MIS Capacity

Community Outcomes

1. Consumer

   - Quality of Life
   - Psychiatric Symptoms
   - AOD use/misuse/abuse/dependence
   - Vocational & Educational
   - Community Reintegration
   - Independent Living
   - Family, Peer, Social Support Relationships
   - Criminal Justice Involvement
   - Service Satisfaction

Community Outcomes

2. Agency

- Fidelity Self-study
- Return On Investment
- Resource Maximization

Community Outcomes

3. System

- Cost-effectiveness
- Psychiatric Hospitalization
- Bed Days – detox or subacute detox
- Episodes of Care
- Criminal Justice Involvement
- Independent Living

Community Outcomes

4. Tracking – Monitoring – Reporting

- Process monitoring
- Organizational fidelity characteristic
- Teams present outcomes regularly to their Steering Committees or other relevant Stakeholder groups
- SAMHSA NOM's

Part I: Treatment Characteristics
T1a: Multidisciplinary Team

- Definition
  - Substance abuse specialist, case managers, psychiatrist, nurse, counselors, and other ancillary providers *work collaboratively* on the team
- Barriers?
- Facilitators?

T1b: Integrated SA Specialist

- Definition
  - Substance abuse specialist with at least 2 years experience works collaboratively with team
- Barriers?
- Facilitators?

T2: Stage-Wise Interventions

- Definition
  - All interventions (including ancillary) are consistent with and determined by client's stage of treatment/recovery
- Barriers?
- Facilitators?

T3: Access to Comprehensive DD Services

- Definition
  - Consumers have access to comprehensive range of services [full range of Residential, Supported (competitive) Employment, Family Psycho-education, ACT, Illness Management]; ancillary services are consistent with IDDT philosophy
- Barriers?
- Facilitators?

T4: Time-Unlimited Services

- Definition
  - Clients with DD are treated on a time unlimited basis with intensity modified according to need
- Barriers?
- Facilitators?

T5: Outreach

- Definition
  - All clients (esp. engagement stage) provided with assertive outreach (practical assistance in natural living environments)
- Barriers?
- Facilitators?

T6: Motivational Interventions

- Definition
  - All practitioners understand and base interventions on motivational approach
- Barriers?
- Facilitators?

T7: Substance Abuse Counseling

- Definition
  - practitioners demonstrate understanding of basic substance abuse principles and provide to clients in active treatment and relapse prevention stage
- Barriers?
- Facilitators?

T8: Group DD Treatment

- Definition
  - All clients are offered integrated group treatment and 2/3 regularly attend
- Barriers?
- Facilitators?

T9: Family DD Treatment

- Definition
  - practitioners always attempt to involve family/ support network to give DD psychoeducation and promote collaboration with treatment team
- Barriers?
- Facilitators?

T10: Self-Help Participation

- Definition
  - practitioners connect clients in active treatment or relapse prevention stages with substance abuse self-help programs
- Barriers?
- Facilitators?

T11: Pharmacological Treatment

- Definition
  - Prescribers are trained in DD treatment; derive input from client and team to increase appropriate medication adherence; no medication prohibition; offer medication known to decrease use; avoid addictive meds
- Barriers?
- Facilitators?

T12: Interventions to Promote Health

- Definition
  - Clients receive a comprehensive, structured, basic education on how to promote health; all staff are well-versed in such techniques
- Barriers?
- Facilitators?

T13: Secondary Interventions for Treatment Non-Responders

- Definition
  - Program utilizes a specific plan to identify, evaluate, and link non-responders to more intensive interventions (e.g., supervised housing, payeeship, changing meds, etc.)
- Barriers?
- Facilitators?

Part II: Organizational Characteristics
01: Program Philosophy

- Definition
  - Committed to clearly articulated philosophy consistent with IDDT
- Barriers?
- Facilitators?

02: Eligibility/Client Identification

- Definition
  - All SMI clients screened using standardized tools/admission criteria for already active clients & new admissions
  - routine & systematic eligibility tracking
- Barriers?
- Facilitators?

03: Penetration

- Definition
  - All consumers who could benefit have access to IDDT
- Barriers?
- Facilitators?

04: Assessment

- Definition
  - All clients receive high quality, standardized, comprehensive & timely, assessments; that are individualized, staged, with risk factors; updated annually targeting domains for intervention
- Barriers?
- Facilitators?

05: Treatment Plan

- Definition
  - Explicit (i.e, treatment plans that identify the target of intervention, the intervention designed to address problem; and how it will bring about change) individualized plan for all IDDT consumers; updated every 3 mo.
- Barriers?
- Facilitators?

06: Treatment

- Definition
  - All IDDT clients receive unique IDDT treatment consistent with their individualized treatment plan
- Barriers?
- Facilitators?

07: Training

- Definition
  - All new practitioners receive standardized training in IDDT (2-day equivalent); existing staff receive annual refresher training (1-day equivalent) w/in 2 months of hire
- Barriers?
- Facilitators?

08: Supervision

- Definition
  - Staff receive structured, weekly client- specific supervision (individual or group) from an experienced IDDT clinician; sessions explicitly address clinical application of IDDT model
- Barriers?
- Facilitators?

09: Process Monitoring

- Definition
  - Supervisors and program leaders monitor implementation semiannually and use relevant data in a systematic approach to improve program
- Barriers?
- Facilitators?

010: Outcome Monitoring

- Definition
  - Leaders monitor standardized client outcomes quarterly and share data with practitioners to improve services
- Barriers?
- Facilitators?

011: Quality Improvement

- Definition
  - The agency's QI committee has an explicit plan to review IDDT components and progress semiannually
- Barriers?
- Facilitators?

012: Client Choice

- Definition
  - All clients receiving IDDT services are offered choices; staff consider and abide by client preferences when offering and providing services
- Barriers?
- Facilitators?

Our Mission

The Center for Evidence-Based Practices (CEBP) at Case Western Reserve University is a technical-assistance organization that promotes knowledge development and the implementation of evidence-based practices (EBPs) for the treatment and recovery of people diagnosed with mental illness or co-occurring mental illness and substance use disorders.

Our technical-assistance services include the following:

- Service-systems consultation
- Program consultation
- Clinical consultation
- Training and education
- Program evaluation (fidelity & outcomes)
- Professional peer-networks
- Research

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Stories

- News about us and our collaborators.
- Recovery stories told by consumers, family members, service providers, employers.
- Conversations with people who implement service innovations.

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