CENTER FOR EVIDENCE-BASED PRACTICES

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

A Technical-Assistance Center
Providing consultation, training, and evaluation for the implementation of integrated behavioral healthcare services

Service innovations for people with mental illness, substance use disorders
What are Co-occurring Disorders (COD)?

- Mental illness and substance abuse occurring together in one person

Why focus on COD?

Co-occurring disorders are:
- Common
- Interdependent
- Leading to worse outcomes and higher cost when not effectively treated

Co-occurring Disorders are Common

- Over 50% of people with schizophrenia, bipolar disorder and other severe mood disorders have a substance use disorder at some time in their life
- About one third of people with anxiety and depressive disorders have a substance use disorder at some time in their life
- According to SAMHSA's 2014 National Survey on Drug Use and Health, approximately 7.9 million adults had co-occurring disorders in 2014.
Co-occurring Disorders are Common

- 73% of persons in the criminal justice system with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime

- In substance abuse settings, very common to see:
  - Major Depressive Disorder (and other mood disorders)
  - Post-Traumatic Stress Disorder


Co-Occurrence of Serious Psychological Distress and Substance Use Disorders among Adults Aged 18 or Older

- 7.6 Million
- 55.0 Million
- 12.3 Million

Substance Use Disorder Only

Severe Psychological Distress (SPD) Only

* NSDUH 2016

Prevalence and Incidence of COD

- Epidemiologic Catchment Area Study
  - Presence of a mental disorder triples the risk of having a co-occurring substance use disorder
  - Presence of addictive disorder quadruples the risk of having a co-occurring mental disorder

- National Co-morbidity Study
  - 83.5% of time, mental disorder precedes the addictive disorder

- National Survey of Drug Use and Health
  - Uses a uniform definition mental illness to identify 7.9 million Americans with Severe Mental Illness (SMI) and a co-occurring substance use disorder (SUD)

Course of Co-Occurring Disorders

Symptoms related to intoxication and withdrawal:

- Mask
- Mimic
- Initiate
- Exacerbate psychiatric symptoms

Interactive Complexity of COD

<table>
<thead>
<tr>
<th>DEPRESSION</th>
<th>MANIA</th>
<th>ANXIETY</th>
<th>PSYCHOTIC</th>
<th>ORGANIC</th>
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</thead>
<tbody>
<tr>
<td>ETOH Intox</td>
<td>Amphetamine Intox</td>
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<td>ETOH Intox</td>
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<td>Cocaine Withdrawal</td>
<td>ETOH Withdrawal</td>
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<td>Amphetamine Withdrawal</td>
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<td>Sedative-Hypnotic Withdrawal</td>
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Quadrant Model for COD

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Mild to moderate SUD, Mild to moderate MH</td>
</tr>
<tr>
<td>II</td>
<td>Mild to moderate SUD, Severe MH</td>
</tr>
<tr>
<td>III</td>
<td>Severe SUD, Mild to moderate MH</td>
</tr>
<tr>
<td>IV</td>
<td>Severe SUD, Severe MH</td>
</tr>
</tbody>
</table>
Quadrant Model for COD

Quadrant I
- Low psychiatric problem severity
- Low addiction severity

Quadrant II
- High psychiatric problem severity
- Low addiction severity

Quadrant III
- Low psychiatric problem severity
- High addiction severity

Quadrant IV
- High psychiatric problem severity
- High addiction severity

COD leads to worse outcomes than single disorders

- Relapse of mental illness
- Treatment problems and hospitalization
- Violence, victimization, and suicidal behavior
- Homelessness and Incarceration
- Medical problems, HIV & Hepatitis risk behaviors and infection
- Family problems
- Increase service use and cost

Traditional Treatment for COD

Historically, the approach has been to treat each disorder separately/independently.

- Parallel
  - Treating both disorders at the same time, however in different organizations, departments, or with different clinicians

- Sequential
  - Treating the disorders one at a time
Problems With Separate Mental Illness And Substance Abuse Treatments

• Different eligibility requirements
  • Not eligible or prematurely discharged

• Trouble accessing both services
  • Territorialism or parallel/sequential treatment approaches

• Primary/secondary distinction
  • Billing should not dictate service delivery on recovery based care

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Problems With Separate Mental Illness And Substance Abuse Treatments

• Different treatment approaches
  • Harm Reduction versus Abstinence Based
  • Prescriptive versus Stage Wise treatment

• Variable clinical expertise and focus
  • Knowledge, skills, beliefs and attitudes

• Lack of integration
  • Waiting for resolution of one disorder before treating the other perpetuates the chronicity of COD.

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Rationale For Integrated Treatment

If COD are more common than not in behavioral healthcare settings...

And, substance abuse worsens most outcomes (hospitalization, incarceration, risk of violence, victimization, homelessness, family disruptions, physical health, etc.)...

And, parallel/sequential treatment is less effective...

Then the real question becomes why wouldn’t you have integrated co-occurring capability?
Integrated Treatment for COD Works

There is a robust body of empirical data which supports superior COD integrated treatment outcomes which now goes back several decades.

- McLellan et al, JAMA (1993)
- Weisner et al, JAMA (2001)
- Van den Bosch and Verdel, Curr Opin Psych (2007)
- Drake et al, JSAT (2008)
- Torme et al, Sub Use & Misuse (2012)
- Kelly and Bailey, Soc Work Health (2013)

Consider this…

- How do “we” (providers/practitioners/system) stigmatize the people we aim to help?
- What are our attitudes toward people with serious mental illness and co-occurring substance use issues?

Overarching Considerations

- Knowledge of Basic Addiction Issues & Integrated Co-occurring (Substance Use/Mental Health) Treatment Interventions
- Motivational and Stage-wise treatment approaches
- Recovery Oriented System of Care
- Trauma Informed Care
- Person-centered treatment planning
<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics - Issues</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Pre-contemplation  
("Unaware") | "Nothing needs to change" | • RELATIONSHIP  
• TRUST  
• BASIC NEEDS |
| Contemplation  
("On the Fence") | "I am considering change" | • ACKNOWLEDGE MIXED FEELINGS  
• DEVELOP DISCREPANCY |
| Preparation  
("Testing the Waters") | "I am figuring out HOW to change" | • BUILD CONFIDENCE  
• INFO, OPTIONS, ADVICE  
• CAREFUL - DON'T PUSH… |
| Action  
("Started Moving") | "I'm working on reaching my goals." | • PLAN REACHABLE GOALS  
• TEACH RECOVERY SKILLS |
| Maintenance  
("Holding Steady") | "I've changed, now to just keep it up." | • SUPPORT CHANGE  
• RELAPSE PRE-PLAN |
| Relapse Prevention  
("Falling off the Wagon")  
("Revisiting the Past") | "I've gone back to old behaviors. Have I lost everything I worked for?" | • CAREFUL - AVOID SHAMING  
• WHAT WENT WRONG?!  
• TRY AGAIN!! |

### Integrated Care Strategies

- Dual Disorder Capability for Addiction Treatment  
  - DDCAT Index
- Dual Disorder Capability for Mental Health Treatment  
  - DDCMHT Index
- Integrated Dual Disorder Treatment/IDDT  
  - IDDT Fidelity Scales

### DDCAT/CMHT Index

- 7 Domains  
  - Subdivided into 35 Program elements
- Utilizes taxonomy outlined by American Society of Addiction Medicine (ASAM)
Continuum of Co-occurring Capability

1. Addiction Only Services/Mental Health Only Services
2. Dual Diagnosis Capable
3. Dual Diagnosis Enhanced

AOS or MHOS

DDC

DDE

Dual Diagnosis Capable (DDC)

**DDCAT**

Programs that have some capacity to provide services for both disorders, however there is greater capacity to serve individuals with substance-related disorders.

**DDCMHT**

Programs that have some capacity to provide services for both disorders, however there is greater capacity to serve individuals with mental health-related disorders.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Content of Items</th>
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<tbody>
<tr>
<td>I</td>
<td>Program Structure</td>
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<tr>
<td>II</td>
<td>Program Milieu</td>
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<tr>
<td>III</td>
<td>Clinical Process: Assessment</td>
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<tr>
<td>IV</td>
<td>Clinical Process: Treatment</td>
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<tr>
<td>V</td>
<td>Continuity of Care</td>
</tr>
<tr>
<td>VI</td>
<td>Staffing</td>
</tr>
<tr>
<td>VII</td>
<td>Training</td>
</tr>
</tbody>
</table>

Dimension Content of items

- **I Program Structure**: Program mission, structure and financing, format for delivery of co-occurring services.
- **II Program Milieu**: Physical, social (welcoming), and cultural environment for persons with dual conditions.
- **III Clinical Process: Assessment**: Processes for accessibility into services, screening (dual/severity), stage-wise assessment & dx.
- **IV Clinical Process: Treatment**: Processes for tx with interactive plans/phase and stage-wise, psychosocial evidence-based formats.
- **V Continuity of Care**: Discharge and treatment continuity for both problems and peer recovery supports.
- **VI Staffing**: Recruitment, role-integration of staff with co-occurring treatment expertise, supervision process.
- **VII Training**: Program vision, training and strategy for training.
Integrated Dual Diagnosis Treatment (IDDT) Implementation

- 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

IDDT Fidelity Scale

General Organizational Index
Characteristics aimed at improving program’s ability to implement any EBP
- 12 Items – multiple data sources

Treatment Index
Characteristics for IDDT Service Delivery
- 14 Items – multiple data sources

Organizational Characteristics

01: Program Philosophy
02: Eligibility/Client Identification
03: Penetration
04: Assessment
05: Treatment Plan
06: Treatment
07: Training
08: Supervision
09: Process Monitoring
10: Outcome Monitoring
11: Quality Improvement
12: Client Choice
Treatment Characteristics

- T1a: Multidisciplinary Team
- T1b: Integrated SA Specialist
- T2: Stage-Wise Interventions
- T3: Comprehensive Services
- T4: Time-unlimited Services
- T5: Outreach
- T6: Motivational Interventions
- T7: Substance Abuse Counseling
- T8: Group DD Treatment
- T9: Family Psychoeducation on COD
- T10: Participation in Self-help Groups
- T11: Pharmacological Treatment
- T12: Interventions to Promote Health
- T13: Secondary Interventions for Treatment Non-Responders

Implementation Strategy

- Assess Readiness & Foster Consensus for Change
  - Identify Organization's Stage of Change
  - Work group/steering committee
- Baseline evaluation (or assessment)
- Action Plan
- Consultation, training and supervision
- Ongoing outcomes monitoring
  - Implementation – program-level
  - Intervention – participant-level

Implementation Lessons Learned

- Best practices and EBPs are preferred because they have strong conceptual support – and/or - empirical support that they work
- Training alone is insufficient to change practice behavior. On-going supervision is essential.
- Change occurs in stages and takes time
Implementation Lessons Learned

• Intellectual buy-in does not necessarily equal changed practice….new behavior is required

• Leaders often underestimate the complexity of implementation

• Using instruments that help you compare your progress across specific structural and clinical domains helps focus an intentional process

• Ongoing attention to process/fidelity/outcomes is critical

Helpful Resources

• CEBP Integrated Dual Disorder Treatment Resources: https://www.centerforebp.case.edu/practices/sami/idt

• CEBP Dual Diagnosis Capability Resources: https://www.centerforebp.case.edu/practices/sami/ddc

• SAMHSA Co-Occurring Disorders Overview & Resources: https://www.samhsa.gov/disorders/co-occurring


Helpful Resources

• Center for Substance Abuse Treatment, Substance Abuse Treatment for Persons With Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42: DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005


Helpful Resources


www.centerfor ebp.case.edu
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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