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# **Implementing Evidence-based Services for Individuals with Co-Occurring Substance Use Disorders and Other Mental Illnesses: Lessons Learned in Missouri**

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the Substance Abuse and Mental Health Services Administration

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Conference, Washington, August 21, 2008



# Definition: Co-Occurring Disorders

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- Refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

(From TIP 42, p. 316)



# Definition Notes

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- Personality Disorders
- Developmental Disorders - ?
- SMI
- Other terms – MICA, CAMI, Dual Diagnosis, Dual Disorders



# Prevalence 2002 National Survey on Drug Use and Health

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- SMI - 17.5 million adults
- SUD - 19.7 million adults
- CO - 4.0 million adults
- The 4.0 million adults with SMI and a substance use disorder represented 23.2 percent of all adults with SMI and 20.4 percent of all adults with a substance use disorder



# Prevalence 1991 National Comorbidity Survey

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- MI - 40 million adults
- SUD - 20 million adults
- CO - 8 million adults
- The 8 million adults with MI and a substance use disorder represented 20% of all adults with MI and 40% of all adults with a substance use disorder



# Prevalence – Clinical Populations

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- MI Settings
  - 25% – 50%
  - Mood Disorders
  - Anxiety Disorders
  - Psychotic Disorders
- SA Settings
  - 50% – 75%
  - Personality Disorders
  - Mood Disorders
- 50% commonly used



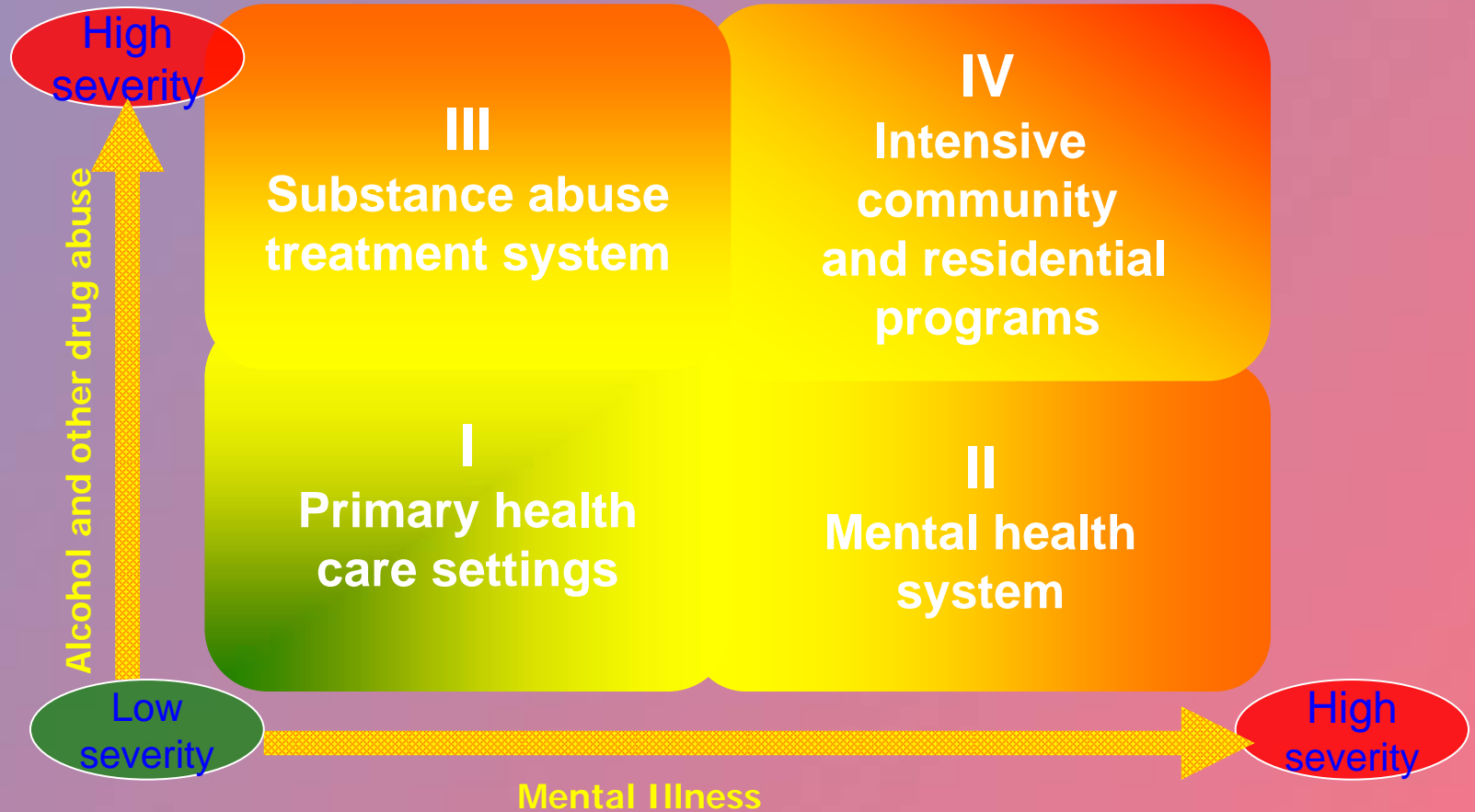
# Co-Occurring Disorders Impact

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- Poor Outcomes
  - Twice as many days in the hospital
  - Higher Relapse
  - Higher Suicide Risk
  - Higher Arrest Rates
  - More Violence
  - More HIV Infection
  - Higher Treatment Drop-out



# NASADAD/NASMHPD Model

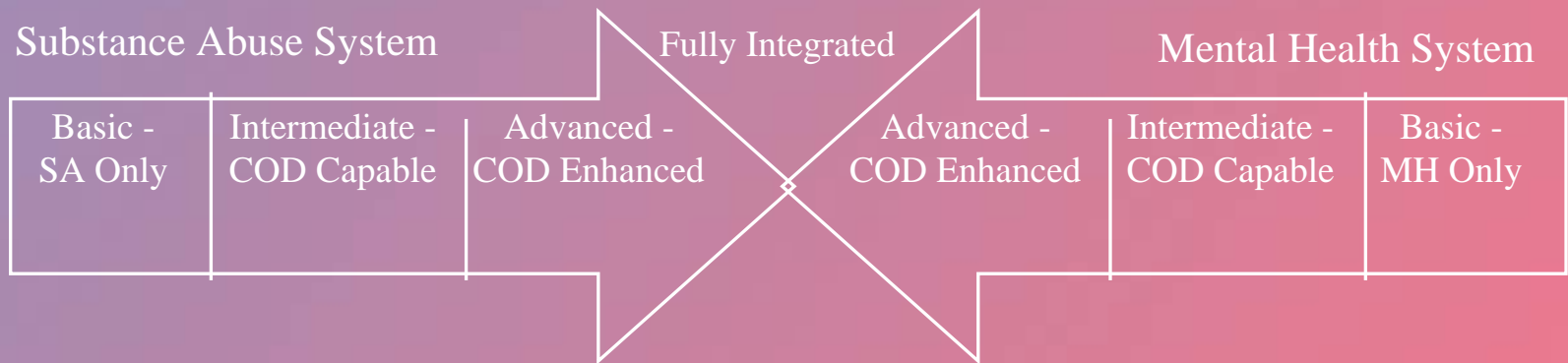




# Institute of Medicine

## Conceptualization of Co-occurring Treatment

### Levels of Program Capacity in Co-occurring Disorders





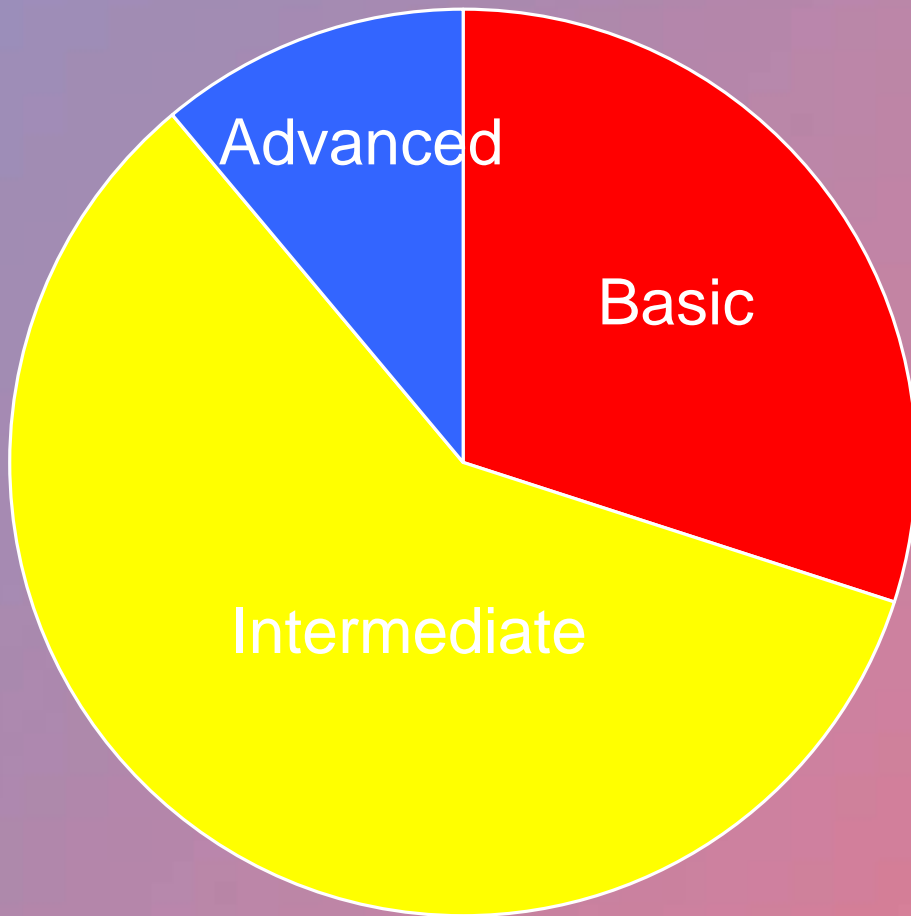
# Missouri DMH

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- Comprehensive Psychiatric Services
  - State Hospitals and “Administrative Agents”
  - Non-competitive contracts & Territories
  - Restrictive Eligibility (SMI)
  - Heavy Reliance on Medicaid
- Alcohol and Drug Abuse
  - Providers in non-exclusive territories
  - Competitive Bid Contracts
  - Little Medicaid
  - Managed Care



# Self-Report Capability to Provide COD Services

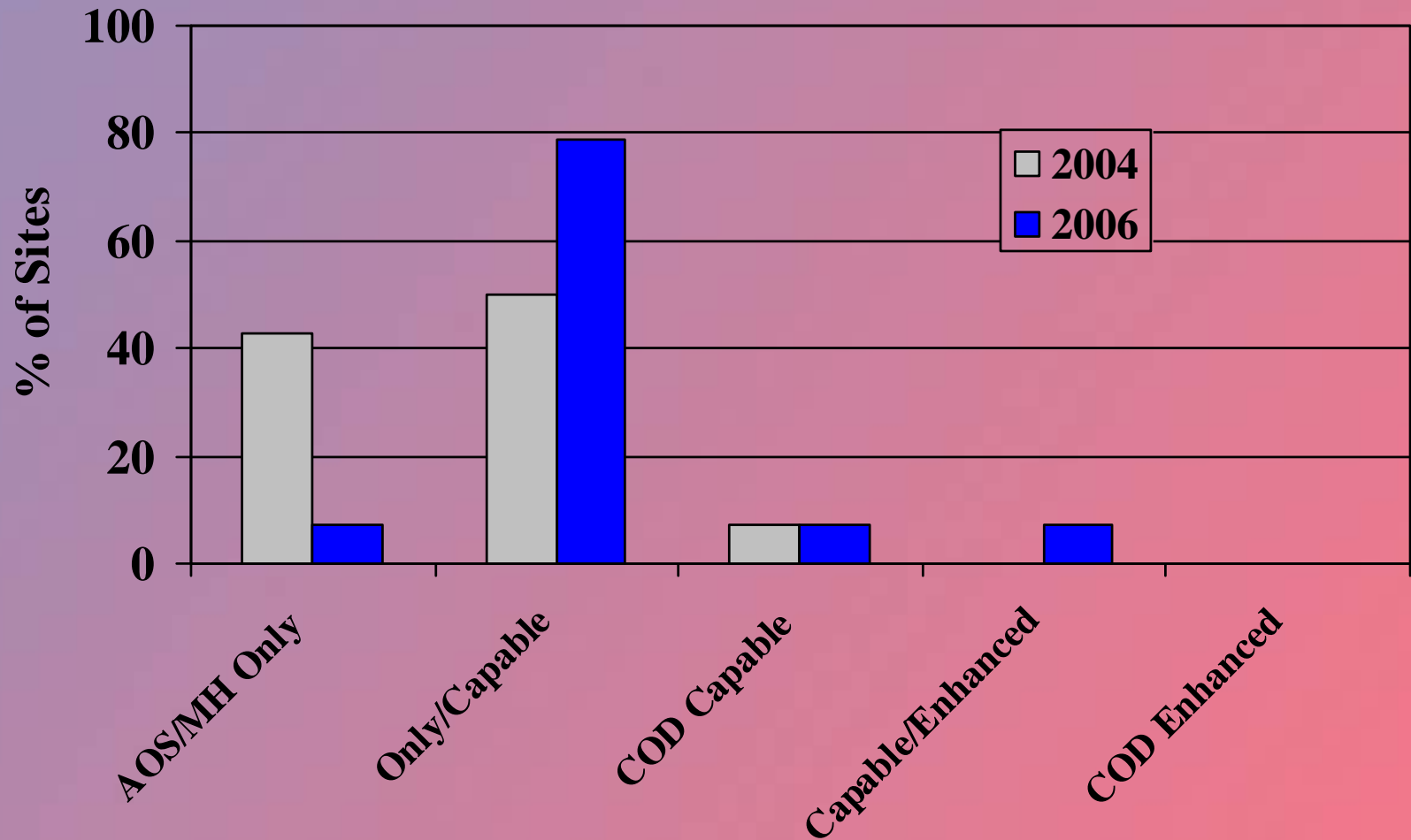


- Basic 30%
- Intermediate 59%
- Advanced 11%



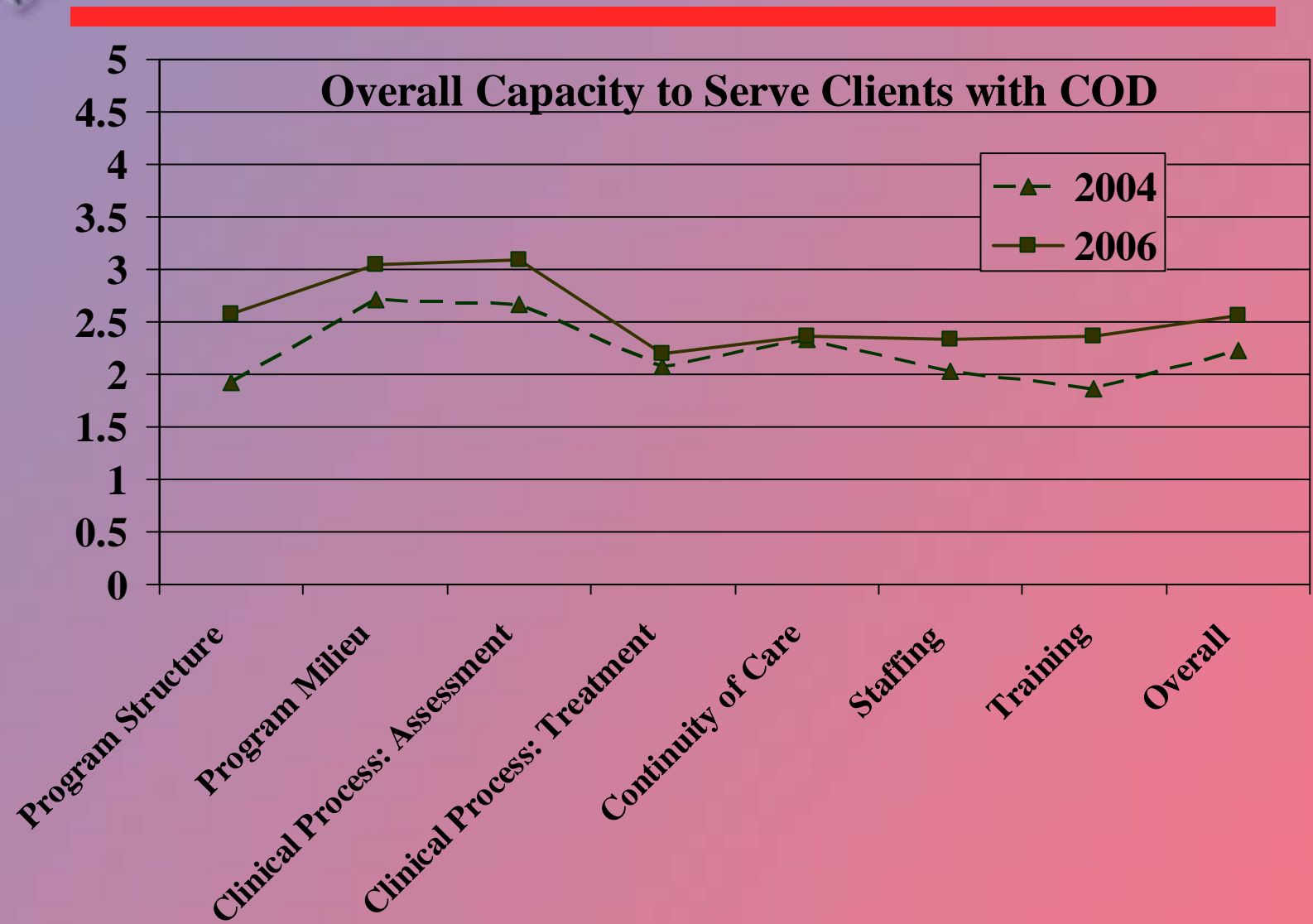
# Overall Capability to Serve Clients with COD

Overall Capacity by Category





# DDCAT Scores





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If you are not measuring  
fidelity,  
You are not doing  
evidence-based practices.



# Changes over Time

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- All scales and the overall capacity score showed statistically significant ( $p < .05$ ) increases in capability from 2004 to 2006 except for the *Clinical Process: Treatment and Continuity of Care* scales.



# ADA versus CPS Sites

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- In 2004, ADA programs scored lower on the DDCAT *Clinical Process: Assessment* scale. By 2006, both CPS and ADA programs had increased their capacity for assessment, with the ADA programs advancing to about the same level of capacity as the CPS programs.
- CPS programs consistently showed higher capacity on the Continuity of Care subscale of the DDCAT than did ADA programs, probably because CPS programs can provide ongoing medication management to clients when they are no longer in active treatment.



# Rural vs. Urban Sites

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- There were no differences between rural and urban sites in their capability to serve clients with COD.



# *Joint vs. Separate Contracts*

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- Compared to programs with either an ADA or a CPS contract, joint-contracted programs showed a higher level of overall capacity on the DDCAT in 2004 and 2006.
- It is important to note that the ADA- or CPS-contracted programs started at a lower capacity level and demonstrated greater positive change over time, while the jointly-contracted programs showed little change in capacity over time.



# Get a Good Team

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Heather Gotham

&

Pat Stilen

Mid-America ATTC

Ron Claus

Missouri Institute of Mental Health



Be the Change You Want

Use Evidence-Based Change  
Processes

# Implementing Co-Occurring Services at a Glance

STAGE	1	2	3	4	5
Stages of change	Pre-Contemplation	Contemplation	Preparation	Action	Maintenance
Stages of implementation	Unaware or uninterested	Consensus building	Motivating	Implementing	Sustaining

**1** ASK IMPORTANT QUESTIONS

**2** BEGIN THE CHANGE PROCESS

**1** CONDUCT A NEEDS ASSESSMENT

**2** DEVELOP AWARENESS OF AVAILABLE OPTIONS

**3** IDENTIFY CURRENT PRACTICES & RATIONALES

**4** EXAMINE YOUR MISSION, VALUES, GOALS, VISION

**5** CHECK IT OUT

**6** ENGAGE TECHNICAL ASSISTANCE

**7** ASSESS PROS & CONS

**8** DEVELOP INFORMED CONSENT & CONSENSUS

**9** EXPLORE CONCERNS

**1** DEFINE YOUR RATIONALE

**2** IDENTIFY STAKEHOLDERS

**3** BUILD CONSENSUS

**4** FIND YOUR CHANGE "CHAMPIONS"

**5** IDENTIFY \$ RESOURCES

**6** ASSEMBLE STEERING COMMITTEE

**7** CONDUCT A READINESS ASSESSMENT

**8** DECIDE TO IMPLEMENT OR NOT

**9** RECRUIT A TEAM LEADER

**10** PLAN TO START SMALL

**11** ASSEMBLE MULTIDISCIPLINARY SERVICE TEAM

**12** BEGIN AN IMPLEMENTATION PLAN

**1** CONDUCT BASELINE FIDELITY REVIEW (DDCAT)

**2** DEVELOP BASELINE ACTION PLAN (ESSENTIAL PROGRAM ELEMENTS)

**3** DEVELOP STAGE-WISE INTERVENTIONS

**4** ACQUIRE & INTEGRATE TRAINING

**5** ENGAGE IN CLINICAL CONSULTATION

**6** PROVIDE STAGE-WISE INTERVENTIONS

**7** DEVELOP & MONITOR OUTCOMES

**8** CONTINUE TO EDUCATE & TRAIN STAKEHOLDERS

**9** ADDRESS BARRIERS

**10** ADDRESS UNINTENDED CONSEQUENCES

**1** MAINTAIN OVERSIGHT

**2** MONITOR FIDELITY

**3** MONITOR OUTCOMES

**4** NETWORK WITH OTHERS

**5** PROVIDE ONGOING TRAINING

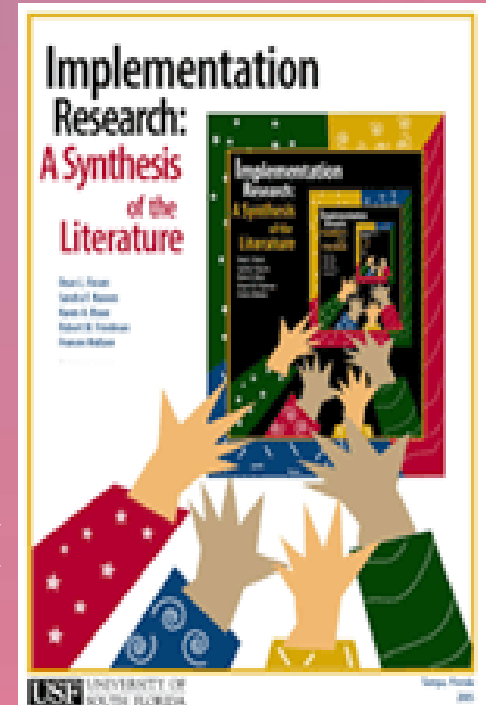
**6** ENGAGE IN ONGOING CONSULTATION

**7** EXPAND CO-OCCURRING SERVICES

**8** TRANSFORM ORGANIZATIONAL CULTURE

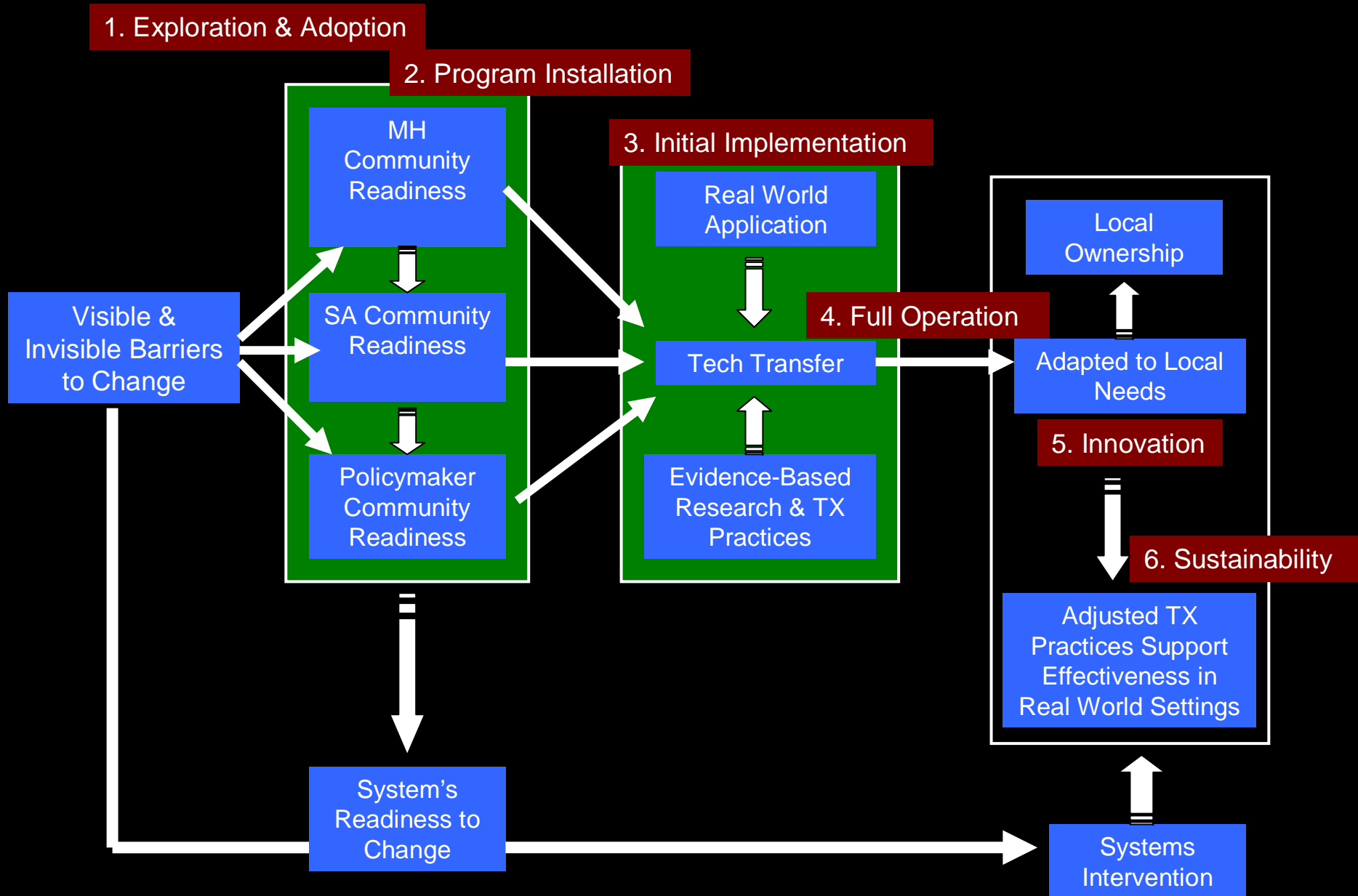


- Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).



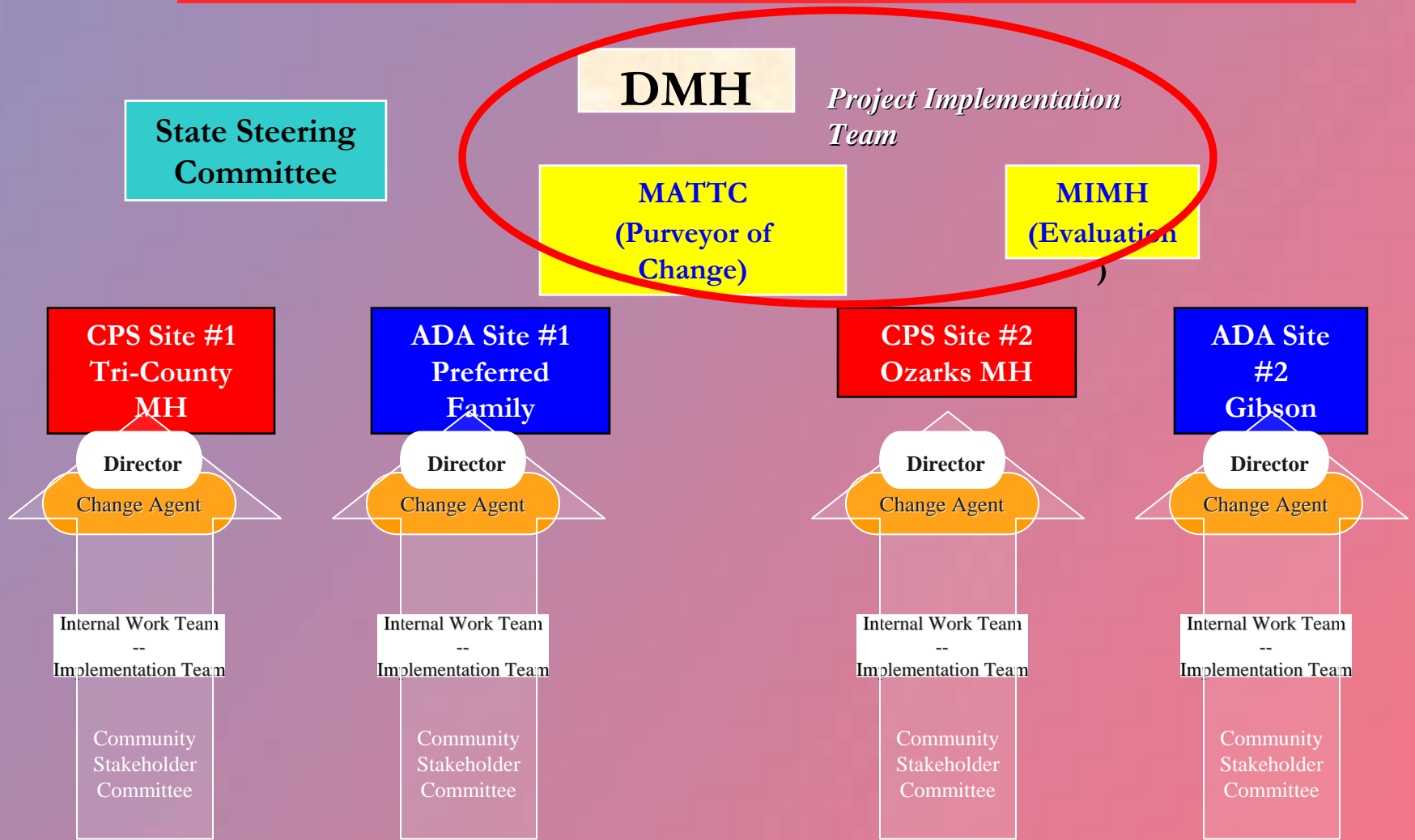
# Mid-America Addiction Technology Transfer Strategy: Stages of the Implementation Process

Sources: Baehni & Stilen, 2002; and Fixsen, et al, 2005





# COSIG Phase II: Role Definitions & Responsibilities





Get a good Model



# CPS Resources

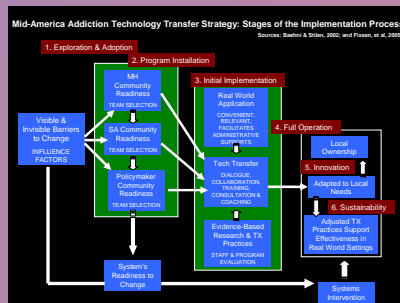
## The Change Book

Addiction Technology Transfer Centers (ATTC) Network (2000). *The Change Book: A Blueprint for Technology Transfer*. Kansas City: ATTC National Office.

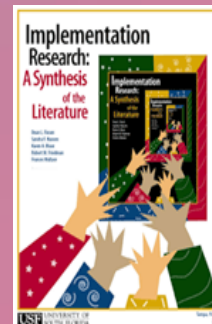
## The Stages of Change

Adapted from Prochaska and DiClemente (1982), "Transtheoretical" therapy: Toward a more integrative model of change." *Psychotherapy: Theory, Research, and Practice*, 19(3):276-288.

## Mid-America ATTC



## The Stages of Implementation

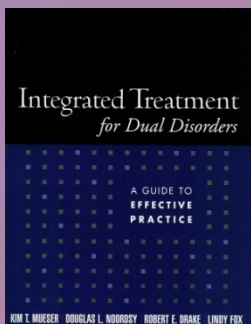


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## IDDT Toolkit

Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit, SAMHSA (January 2003)

Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice*. New York: The Guilford Press.



# ADA Resources

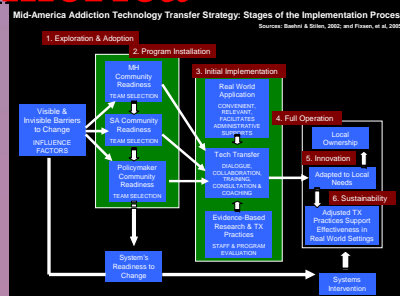
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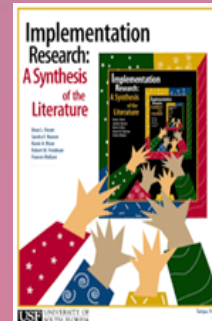
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Substance Abuse Treatment  
For Persons With  
Co-Occurring Disorders

A Treatment  
Improvement  
Protocol  
**TIP  
42**

## TIP 42 Inservice Guide

U.S. Department of Health and Human Services  
SAMHSA/CSAT (2007)

Developed by Mid-America ATTC/TIP 42 Consensus Panel



# COSIG Phase II Process

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- Invited agencies interested in developing state-of-the-art programming
- Basic requirements
  - Change Agent
  - Screening/Assessment
  - Staff and team commitment
  - Substance Abuse specialist
  - Participate in Training and TA



## Mid-America ATTC: Activities of the “Purveyor of Change”/Coach

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- On-site meetings with change agent, multidisciplinary &/or executive teams, stakeholder groups
- Monthly conference call updates
- Training specific to agency identified needs (e.g., Motivational Interviewing, drug/alcohol education, etc.)
- Resources for staff training and client population
- Assisted in formulating agency-specific “Action Plan” based on program fidelity evaluation



# Change Management

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When your up to your neck in alligators,  
its hard to drain the swamp!



# Distractions

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- Budget Crisis
- Two Governors
- Three Department Directors
- Two ADA Directors
- Three Psychiatric Services Directors



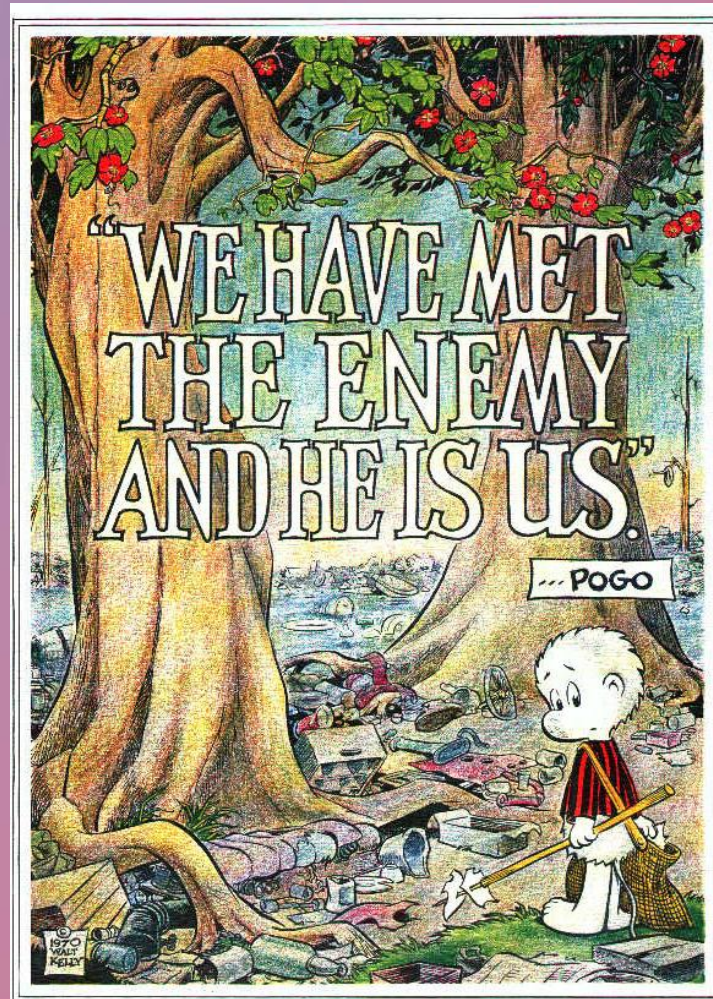
# COSIG: Missouri

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Persist beyond all reason.



# COSIG: Missouri





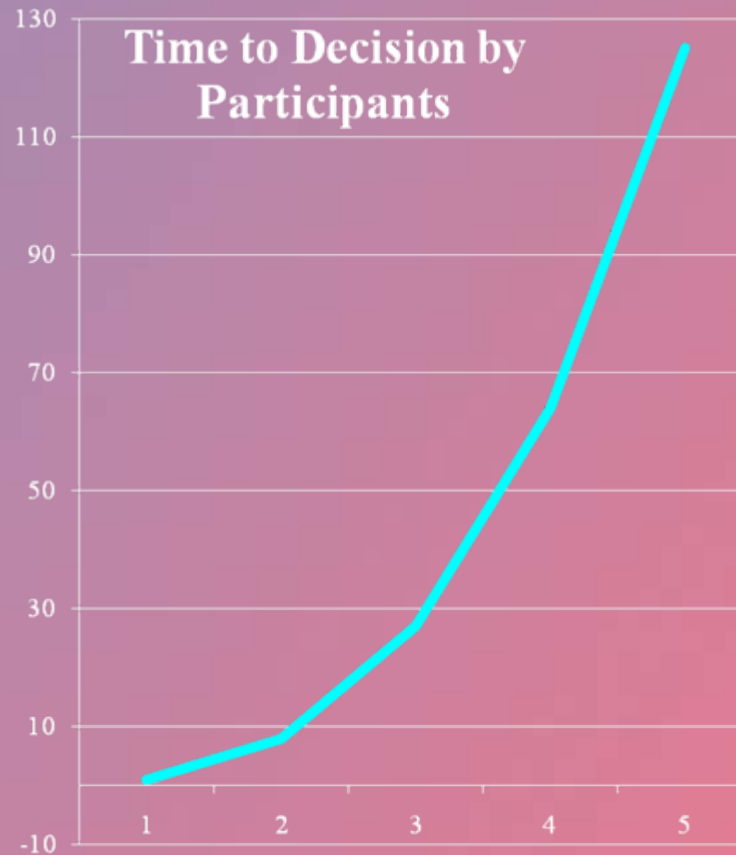
# COSIG: MISSOURI

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Things take longer than they do.



# Homer's First Law of Collaboration





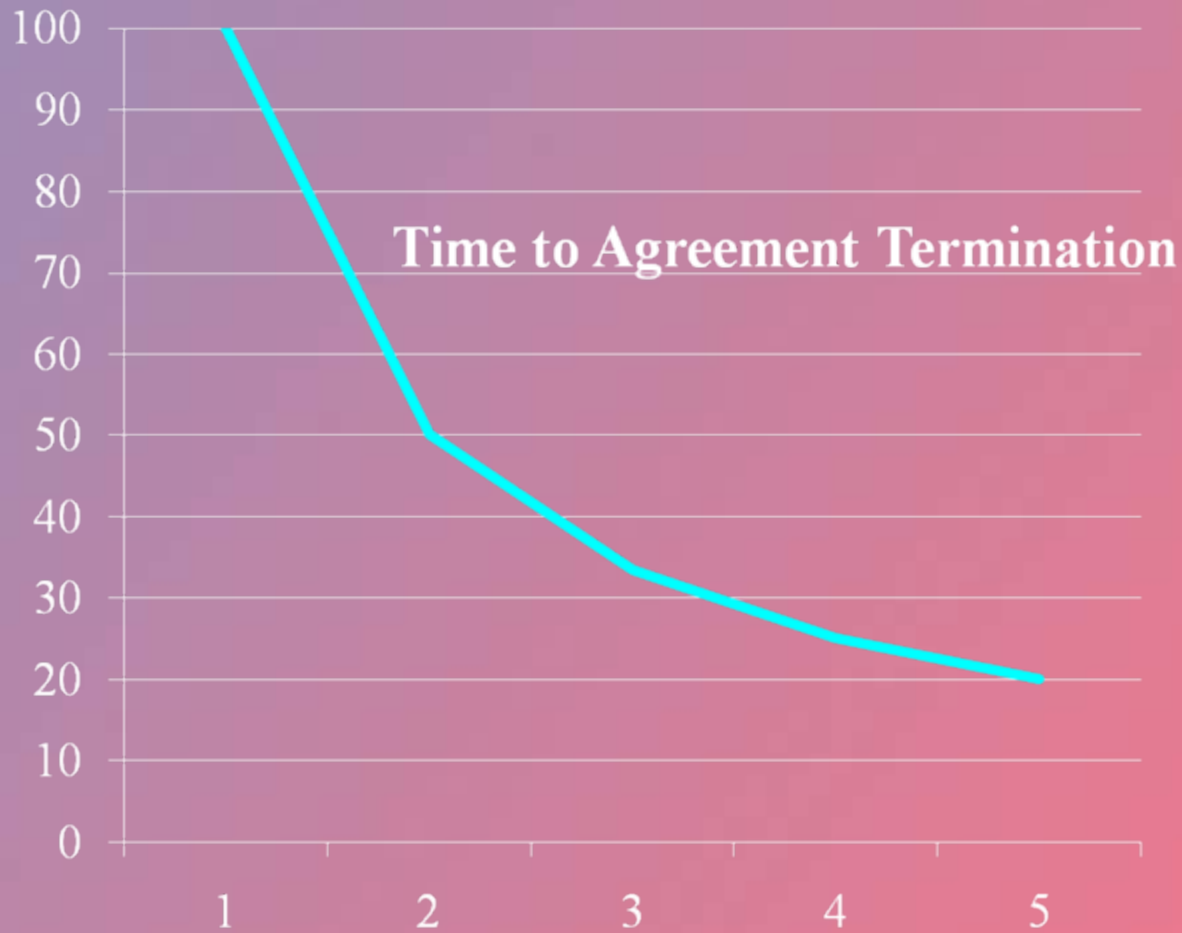
# COSIG: MISSOURI

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Start working with your  
Medicaid agency early  
(see Homer's First Law)



# Homers Second Law of Collaboration





# Get it in Writing

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- Policies
- Contracts
- Regulations
- Statutes



Change is hard,  
but  
May be that's a good thing.



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**The opinions expressed in this presentation are solely the author's , and no one else really agrees withhim.**