Integrated Dual Disorder Treatment Overview:

An Evidence Based Model for Treating Co-Occurring Severe Mental Illness & Substance Use Disorders

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1

A Technical-Assistance Center

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

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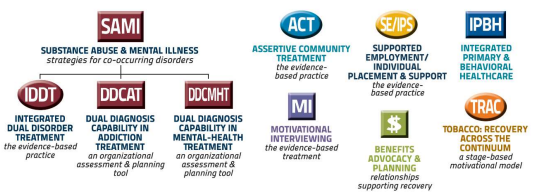
Service innovations for people with mental illness, substance use disorders



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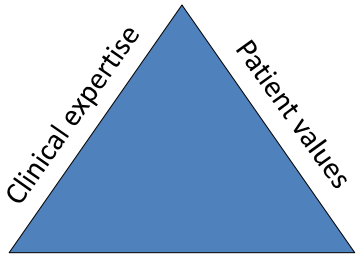
WHAT ARE EVIDENCE-BASED PRACTICES?

- Standardized treatments
- Controlled research
- Objective outcome measures
- More than one research group
  - Demonstrated effectiveness in helping consumers to achieve good outcomes in several different research trials

4

EBPs - Integration of:



Crossing the Quality Chasm (IOM, 2001)

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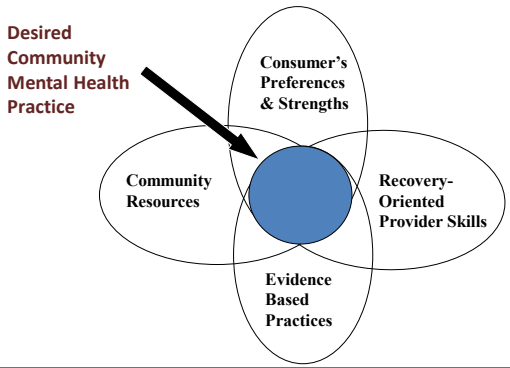
The Evidence-Based Practitioner Model



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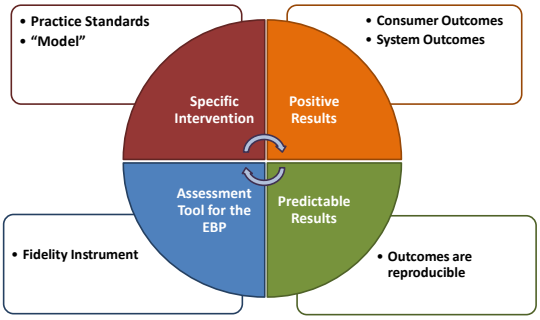
Four Parts of an Evidence-Based Practice



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7

The research on EBP's tells us:

Effective intervention practices
+ Effective implementation practices

= Good outcomes for consumers

No other combination of factors reliably produces desired outcomes for consumers

(Fixen, et al, 2005)

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8

WHAT IS INTEGRATED DUAL DISORDER TREATMENT?

- The New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental and substance use disorders through integrated service delivery.
- It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.

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INTEGRATED DUAL DISORDER TREATMENT (IDDT)

- Gold standard co-occurring treatment model
- Combines substance use services with mental health services
- Emphasizes individuals achieve changes (e.g., sobriety, symptom management) through a series of small, overlapping changes that occur over time.
- Promotes ongoing recovery from co-occurring disorders by providing service organizations with specific strategies for delivering services.
- Individualized to address the unique circumstances of each person's life.

10

WHY DO IT?

11

WHY DO IT?

IDDT Reduces

- Relapse of substance abuse and mental illness
- Hospitalization
- Arrest
- Incarceration
- Duplication of services
- Service costs
- Utilization of high-cost services

IDDT Increases

- Continuity of care
- Consumer quality-of-life outcomes
- Stable housing
- Independent living

12

WHY INTEGRATED TREATMENT OF DUAL DISORDERS?

- 26 studies show integrated treatment is more effective than traditional separate treatment.
- Most clients are unable to navigate the separate systems or make sense of disparate messages about treatment and recovery.

(Drake et al, Schiz Bull 1998 and Drake et al, Psych Services 2001, Psych Rehab Jrnl. 2004 for summaries)

13

WHY FOCUS ON CO-OCCURRING DISORDERS?

Regardless of our professional preferences:

- It's common
- It's interdependent
- Common risk factors lead to the predisposition of both disorders
- It leads to worse outcomes and higher cost when not treated

14

CO-OCCURRING CONDITIONS ARE COMMON

- Over 50% of people with schizophrenia, bipolar disorder and other severe 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

15

CO-OCCURRING DISORDERS LEAD 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

16

IT'S INTERACTIVE & INTERDEPENDENT

- Too often, we don't have the luxury of determining whether the chicken or the egg came first…they're both here now, so now what?

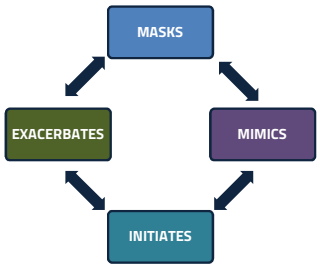
  They are inter-dependent with each other

- "Primary" and "Secondary" distinctions are insurance concepts, not clinical treatment classifications.
- Substance use is a potential threat to mental health recovery, and unmanaged mental health symptoms are a threat to substance abuse recovery

17

The Interactive/Interdependent Course of COD

SYMPTOMS RELATED TO INTOXICATION AND WITHDRAWAL



PSYCHIATRIC SYMPTOMS!

(Lehman et al.,1989, Lehman and Dixon 2016)

18

Interactive Complexity of COD

DEPRESSION	MANIA	ANXIETY	PSYCHOTIC	ORGANIC
ETOH Intox	ETOH Intox			ETOH Intox
	Amphetamine Intox	Amphetamine Intox	Amphetamine Intox	Amphetamine Intox
Cannabis Intox		Cannabis Intox	Cannabis Intox	Cannabis Intox
	Cocaine Intox	Cocaine Intox	Cocaine Intox	Cocaine Intox
Opioid Intox				
Hallucinogen Intox		Hallucinogen Intox	Hallucinogen Intox	Hallucinogen Intox
Cocaine Withdrawal		PCP Intox	PCP Intox	PCP Intox
Opioid Withdrawal		ETOH Withdrawal	ETOH Withdrawal	ETOH Withdrawal
Amphetamine Withdrawal		Amphetamine Withdrawal		
Cannabis Withdrawal		Cannabis Withdrawal		
Sedative-Hypnotic Withdrawal		Sedative-Hypnotic Withdrawal	Sedative Hypnotic Withdrawal	Sedative-Hypnotic Withdrawal

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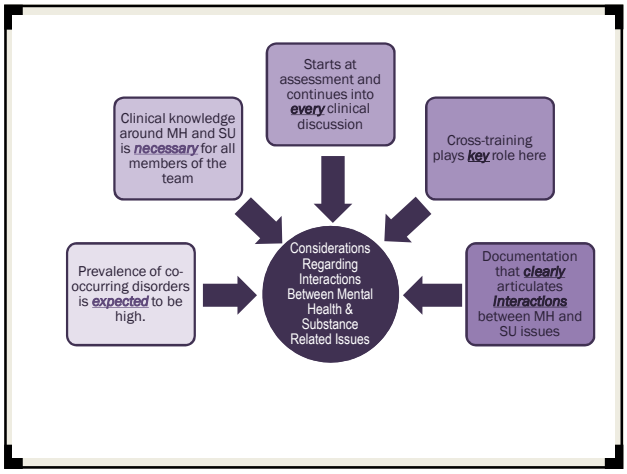
19



20

TREATMENT OPTIONS

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

1. Parallel
   - Treating the disorders at the same time however in different organizations, departments, or with different clinicians
2. Sequential
   - Treating the disorders one at a time

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21

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

22

PROBLEMS WITH SEPARATE MENTAL ILLNESS AND SUBSTANCE ABUSE TREATMENTS

Different treatment approaches

- Harm Reduction versus full abstinence
- Prescriptive versus Stage Wise treatment
- Implication that the person was a failure, not the treatment

Variable clinical expertise and focus

- Some lack knowledge or skills – but the majority rests in attitude and preference.

Lack of integration

- Waiting for resolution of one disorder before treating the other perpetuates the chronicity of the co-occurring disorder.

23

PROBLEMS WITH SEPARATE MENTAL ILLNESS AND SUBSTANCE ABUSE TREATMENTS

The bottom line with all these problems is:

The more challenges for the person to deal with, the more likely they are to drop out of treatment

24

RATIONALE FOR INTEGRATED TREATMENT

If >50% of mental health clients have substance use disorders

AND

Substance use worsens most outcomes:

(hospitalization, incarceration, violence, victimization, homelessness, family disruptions, HIV, etc.)

AND

Parallel treatment is less effective

THEN

Why NOT have an integrated focus?

25

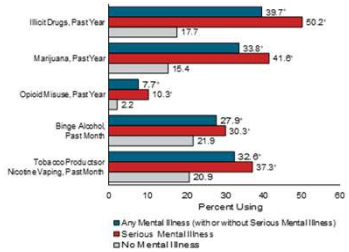
PREVALENCE

- 9.2 million people have a co-occurring disorder
- Among the 17.9 million adults aged 18 or older in 2021 with co-occurring AMI and an SUD, 52.5% (or 9 million people) received treatment.
- Among the 5.8 million adults aged 18 or older in 2021 with co-occurring SMI and an SUD in the past year, 66.9% (or 3.9 million people) received treatment.

(SAMHSA, National Substance Use and Mental Health Survey, 2021)

26

SUBSTANCE USE: AMONG ADULTS AGED 18 OR OLDER BY MENTAL ILLNESS STATUS, 2021



27

PREVALENCE

- About half of people with a serious mental illness also have a substance use disorder
- About half of people with a substance use disorder are also affected by mental illness
- Co-occurring disorders lead to worse outcomes and higher costs than single disorders

28

Quadrant Model for COD

I Mild to moderate SUD Mild to moderate MH	II Mild to moderate SUD Severe MH
III Severe SUD Mild to moderate MH	IV Severe SUD Severe MH

29

WHAT IS SO DIFFERENT ABOUT QUADRANT IV?

1. Stress Vulnerability Model
   a) Heightened stress and intensity of circumstances contributes to exacerbation of and/or more rapid onset of MH symptoms
   b) High intensity interventions are counter-productive
2. Insight & judgment are essential to processing consequences
   a) Symptoms of SPMI
   b) Neurobiological impact of addiction

30

WHAT IS IT?

31

IDDT IS A RECOVERY MODEL

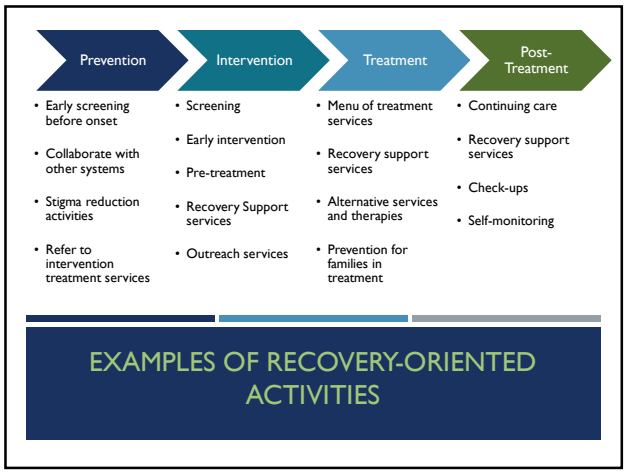
- Goals are driven by consumer preference
- Services are provided with unconditional respect and compassion
- Practice provider shares responsibility for helping consumer with motivation for recovery
- Practice focuses on consumer goals and improving consumer's functioning
- Consumer choice and shared decision making are important

32

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

33



34

CRITICAL COMPONENTS

- Staged Interventions
- Motivational Interventions
- Assertive Outreach
- Counseling
- Social Support Interventions
- Long term perspective
- Comprehensiveness
- Cultural Competency

35

IDDT GUIDING TREATMENT PRINCIPLES

1. Integration of substance abuse & mental health treatments

2. Flexibility & specialization of clinicians
   - cross-trained staff

36

IDDT GUIDING TREATMENT PRINCIPLES

3. Assertive outreach

4. Recognition of client preferences
   - client centeredness
   - cultural competence

37

IDDT GUIDING TREATMENT PRINCIPLES

5. Close Monitoring

6. Comprehensive Services

7. Range of Stable Living Situations

38

IDDT GUIDING TREATMENT PRINCIPLES

8. The Long-term Perspective

9. Stage-wise Treatment

10. Optimism

39

IDDT MODEL TREATMENT CHARACTERISTICS

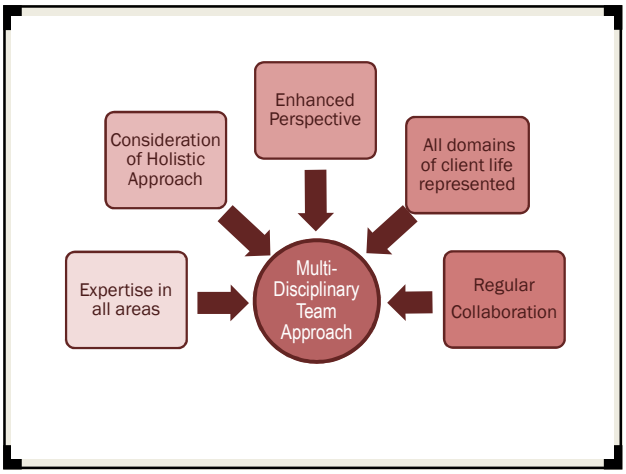
- Multidisciplinary Team
- Stage-Wise Interventions
- Access to Comprehensive Services
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interviewing
- Substance Abuse Counseling
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol & Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Treatment Non-Responders

40

MULTIDISCIPLINARY TEAM

- Team Leader
- Case Manager
- Substance Abuse Specialist
- Counselor
- Prescriber/Psychiatrist
- Nurse
- Employment Specialist
- Peer Support Specialist
- Housing Specialist
- Criminal Justice Specialist
- Naturalization Specialist
- Benefits Specialist
- Any other needed Specialist

41

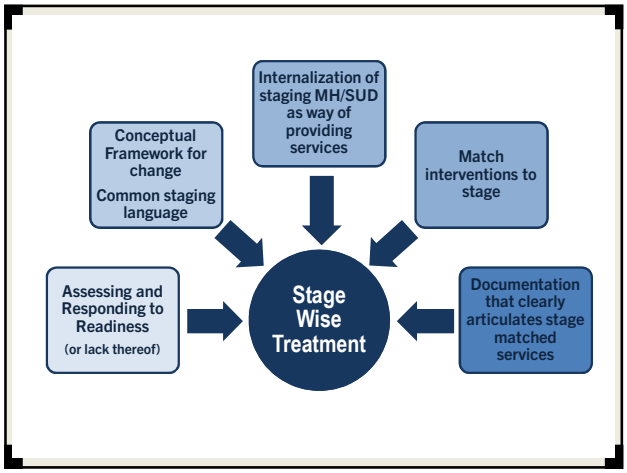


42

STAGE-WISE INTERVENTIONS

- "Meeting the client where they are at"
- Change happens incrementally in all of us
- Retention in treatment can be life saving
- Provides the increased internal confidence to sustain change
- Common reference documents
  1. Matching stages of change document
  2. Staged based decisions guidelines document

43



44

ACCESS TO COMPREHENSIVE SERVICES

- Offer comprehensive services because recovery happens in the context of daily living
  - Case management
  - Integrated MH and SU care
  - Medical Services
  - Housing support/residential services
  - Supported Employment / IPS
  - Family Services
  - ACT

45

TIME UNLIMITED SERVICES

- Cycles of relapse and decompensation are ***expected***
- Setbacks occur naturally as part of a ***lifelong cycle*** of relapse and recovery
- Continuity of care is ***expected***

46

ASSERTIVE OUTREACH

- Engagement is clinical focus
- Frequency and intensity adjusted based on client stage of change and need
- Provided to all people who would benefit from the service – whether they would come to us or not.

47

ASSERTIVE OUTREACH

- Service providers meet regularly with consumers and offer practical assistance with daily needs and living skills
- Engage in assertive outreach with all individuals, whether symptoms are severe or mild.

48

Assertive Outreach Considerations

When a person is not very likely to come seek help from the place that offers help for the problem that they don't think they have…

- We have to go to them, as it may be a matter of life and death
- Death is a poor predictor of recovery
- Enabling ONLY happens when one does something for someone, they can do themselves
- Community based vs. Clinic based services
  - *(Bond et al, 2001, Drake et al, 2008, White, 2008, Kelly et al, 2019)*

49

Assertive Outreach Considerations

If you hear the phrase: "You shouldn't be working harder than the client is", there are two things you might consider:

1. That comment potentially lacks understanding of severe and persistent mental illness and related symptom management dynamics
2. Those phrases highlight limited understanding of the process of change we ALL go through (and communicates a divide of sorts)
3. "We don't see people as they are, we see people as we are" – Anais Nin

50

MOTIVATIONAL APPROACH

- Helps clients with internal motivators and skill building that is needed for living self sufficiently
- Helps normalize ambivalence and challenges in behavior change

51

Motivational Interviewing

- Low expectation for change, but high support for participation, attendance, communication
- Suppress expectations for change (for now)
- Don't contribute to defensiveness or create situations to defend behavior
- Explore and express understanding of purpose / impact of behaviors
- Demonstrate patience and provide optimism

52

SUBSTANCE ABUSE COUNSELING

Clients who are in active treatment stage or relapse prevention stage receive SU counseling that includes:

- Techniques to identify and manage cues and triggers and cravings
- Refusal Skills
- Problem solving skills
- Skills to avoid high risk situations
- Coping skills
- Techniques to deal with consequences of SU
- Relapse prevention

53

GROUP TREATMENT

- Clients with DD achieve better outcomes if they engage in stage-wise groups that discuss both MH and SU and the interaction between the two.
- Microcosm of society
- Develop peer relationships
- Learn and practice skills (communication, social, etc.)

54

FAMILY PSYCHOEDUCATION

- Social supports play key role in sustaining recovery
- Network and connection for families
- Reduce caregiver stress
- Reunification or healthy separation
- "Burned Bridges"

55

PARTICIPATION IN ALCOHOL AND DRUG SELF-HELP GROUPS

- Increases social and community group network
  - DRA
  - Double Trouble
  - SMART Recovery
  - Celebrate Recovery
  - AA, NA, CA
- Be mindful of "safe" groups for clients.

56

Self-Help Participation & Active Linkage

Practitioners connect clients in ***Action or Relapse Prevention stages*** with substance use and/or mental health self-help programs

- Active linkage means:
  - *Orientation to 12 step meetings*
  - *Preparation for 12 step meetings*
  - *Accompany to 12 step meetings*
  - *Warm handoffs*
  - *Use of Peer Support Specialists*

57

PHARMACOLOGICAL TREATMENT

- Continue to prescribe needed psychiatric medications even with active use. Abstinence is not a requirement for medications
- Trained in co-occurring disorders
- Close working relationships with the team, clients and natural supports
- Medication adherence strategies
- Avoid medications with addictive properties
- Offer medications that may reduce addictive behavior

58

INTERVENTIONS TO PROMOTE HEALTH

- Focus on healthy lifestyle and minimization of negative health and wellness consequences
  - Exercise
  - Nutrition
  - Safe housing
  - Protection from Exploitation
  - Safe sex practices
  - Avoid high risk behaviors (drinking and rinking, safe needle programs, safety from violence)
  - Positive social supports

59

Harm Reduction

- A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use (or other harmful behaviors that interfere with personal goals).
- A realistic, pragmatic, humane and successful approach to addressing issues of substance use and mental health.
- Recognizes that abstinence may be neither a realistic or a desirable goal for some users (especially in the short term) the use of substances is accepted
- Main focus is placed on reducing harm while use continues.

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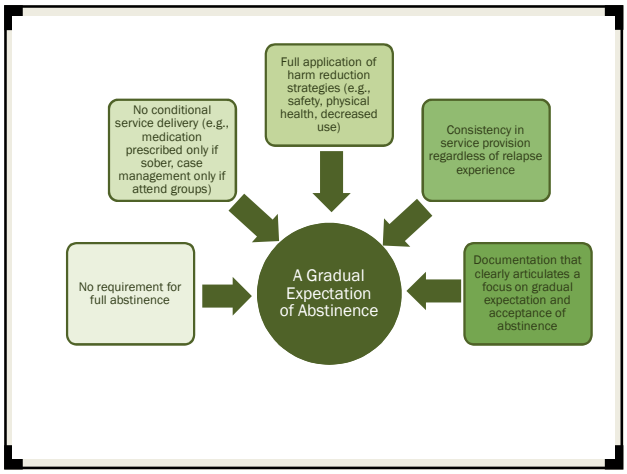

61

SECONDARY INTERVENTIONS FOR TREATMENT NON-RESPONDERS

Specific plan to go above and beyond to keep individuals engaged

- Assertive Outreach
- Increased Monitoring
- Pharmacological Management
- Psychosocial interactions

62

A Note about Confrontation

There is no scientific research to support confrontation in treatment. In fact, there are many studies that show confrontation leads to worse outcomes (Miller, W & White, W, 2007)

63

A Note about Confrontation

There is a robust body of empirical data which supports a non-confrontational approach which now goes back several decades. What does work?

- *Empathy*
- *Warmth*
- *Genuineness*
- *Respect*
- *Concreteness*

64

A Note about Confrontation

- Carkhuff, R. R., & Truax, C. B., 1966
- Valle, S. K., 1981
- Miller, W. R., 1983
- Mattson, M. E., Allen, J. P., Miller, W. R., Hester, R. K., Connors, G. J., Rychtarik, R. G., Randall, C.L., Anton, R.F., Kadden, R.M., Cooney, N.L. and DiClemente, C. C., 1993
- Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35, 1999.
- Polcin, D. L., 2003
- Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L., 2010
- **AND… 2,000 additional controlled studies that demonstrate the efficacy of MI.**

65

Integrated Dual Disorder Treatment (IDDT)

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

66

Integrated Dual Disorder Treatment (IDDT)

Item 01. Program Philosophy	Item 07. Training
Item 02. Eligibility/Client Identification	Item 08. Supervision
Item 03. Penetration	Item 09. Process Monitoring
Item 04. Assessment	Item 010. Outcome Monitoring
Item 05. Treatment Plan	Item 011. Quality Improvement (QI)
Item 06. Treatment	Item 012. Client Choice

67

ORGANIZATIONAL IMPLICATIONS

68

IMPLEMENTATION BARRIERS

- Policy Barriers
- Program Barriers
- Clinical Barriers
- Consumer and Family Barriers

69

LIMITATIONS OF THE RESEARCH

- Federal & State levels not in alignment with organizational funding
- Lack of data on cost savings of IDDT impedes policy development
- Lack of specificity of treatments and interventions
- Controlled research has not addressed those who do not respond to outpatient services
- Lack of training and expertise
- Family programming is challenging
- Research has demonstrated positive outcomes for 20% of the co-occurring population

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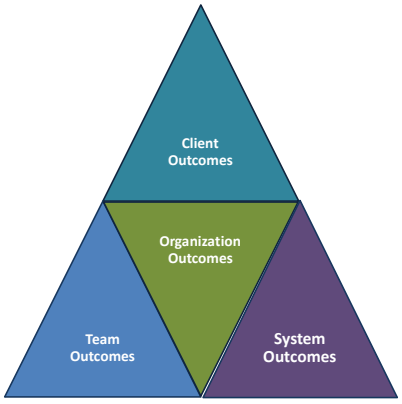


71

CLIENT OUTCOMES

- Allow care to those who can't/won't come to agency
- Stage-wise and motivational approaches allow clients continued stay in programs longer than traditional
- Decreases client negative outcomes

72

ORGANIZATIONAL OUTCOMES

- Same financial landscape
- Allow for clinically specialized care for most acute clients
- Compartmentalize the least responsive to treatment
- Increase treatment adherence by in vivo approach

73

TEAM OUTCOMES

- Allow for clinically specialized care for most acute clients
- Increased staff engagement / retention
- Reduce burn-out

74

SYSTEM OUTCOMES

- Ongoing Statewide data analysis
- For the last 12-month period analyzed
  - N=1,122
  - 14.3% of consumers accounted for 65% of total system costs for N= 1,122
  - Service cost reductions for 160 highest utilizers from 12 months pre-IDDT to 12 months post IDDT= $1.4 million in 1st year of services

75

Utilization Categories

(Based on 12 months pre IDDT; N=1122)

Category	% (#)	Total
None	14.5% (163)	$ 0
Low/moderate	71.2% (799)	$3,099,664
High	14.3% (160)	$5,749,983
Total cost 12 mo. before IDDT		$ 8,849,647

14.3% of consumers accounted for 65% of the cost

76

* Average cost per consumer by category

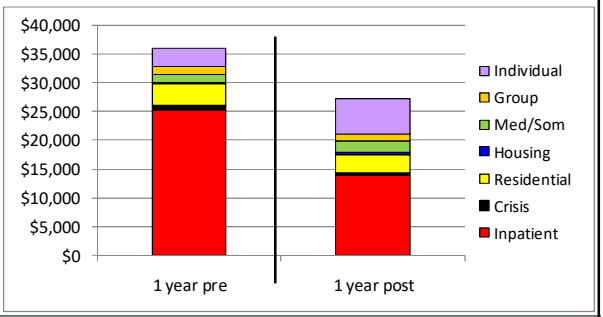
(People in Highest Util. level only; N=160)

	12-0 mo. Pre-IDDT	0-12 mos. Post-IDDT
Individual	$3,254	$ 6,129
Group	1,304	1,199
Med/som.	1,395	2,041
Housing	266	428
Residential	3,745	3,086
Crisis	842	512
Inpatient	25,133	13,723
Totals	**$ 35,939**	**$ 27,117**

77

Average cost per consumer by category

(People in Highest Util. level only; N=160)



78

*Cost Difference Pre- to Post-

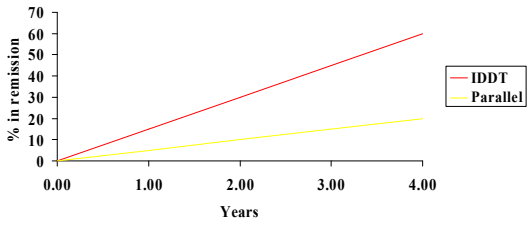
(n=1,122)

Category	% (#)	12 mo post – 12 mo pre (NOTE: + value means cost went up; - value means costs went down)
None	14.5% (163)	$976,721
Low/moderate	71.2% (799)	$4,722,761
High	14.2% (160)	- $1,410,965

IDDT saved >$1.4 million for
People with the Highest Util. after the first year

79

Abstinence after Integrated Dual Disorder Treatment



80

ABSTINENCE LEADS TO IMPROVEMENTS IN OTHER OUTCOMES

- Reduce institutionalization
- Reduce symptoms, suicide
- Reduce violence, victimization, legal problems
- Better physical health
- Improve function, work
- Improve relationships and family

81

Helpful Resources

- CEBP Integrated Dual Disorder Treatment Resources: https://www.centerforebp.case.edu/practices/sami/iddt
- 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
- ASAM Public Policy Statement on **Definition of Addiction**, Adopted: April 12, 2011 http://www.asam.org/docs/publicy-policy-statements/1definition_of_addiction_long_4-11.pdf

82

Helpful Resources

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83

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84

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85

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86