OVERVIEW OF IMPLEMENTING INTEGRATED DUAL DISORDER TREATMENT (IDDT) FOR ORGANIZATIONS

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Supporting Recovery

The IDDT model is not a conventional service that is implemented within organizations simply to respond to specific client needs, such as improving social skills, anger management, or personal health.

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Supporting Recovery

- IDDT is implemented to reinvent service systems, organizations, and individual clinical practices to support positive personal change and recovery among people with co-occurring mental and substance use disorders and their social support networks.
- IDDT is designed to enhance consumer outcomes, program outcomes, and system outcomes simultaneously. When you implement this service model, you begin with the desired outcomes in mind.

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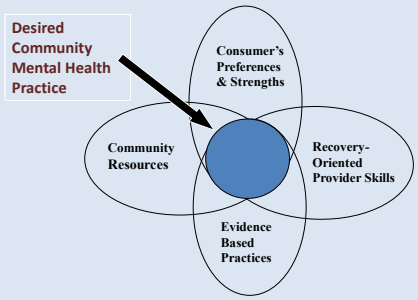
The Evidence-Based Practitioner Model



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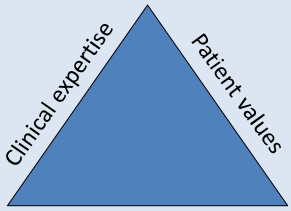
EBPs - Integration of:



Best research evidence

Crossing the Quality Chasm (IOM, 2001)

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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

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What's So Different About Quadrant IV?

1. **Stress Vulnerability Model**
- Heightened stress and intensity of circumstances contributes to exacerbation of and/or more rapid onset of MH symptoms
- High intensity interventions are counter-productive

2. **Insight & judgment are essential to processing consequences**
- Symptoms of SPMI (Anosognosia)
- Neurobiological impact of addiction

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What's So Different About Quadrant IV?

3. **Mental Status**
- Processing of consequences
- Behavioral based treatments vs insight-based treatments

4. **Harm Reduction Implications**

5. **Enabling vs Functional Impairment Needs**

6. **Models like IDDT can be contraindicated outside of Quadrant IV**

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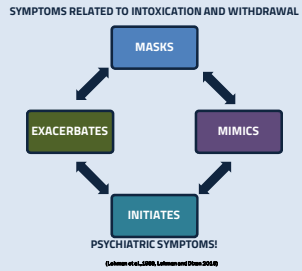
The Interactive/Interdependent Course of COD



(Lehman et al., 1998; Lehman and Dixon, 2011)

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Co-Occurring Disorders Lead to Worse Outcomes

- Episodes and/or relapse of mental illness & substance use
- Treatment problems and hospitalization
- Violence, victimization, and suicidal behavior
- Homelessness and Incarceration
- Medical problems, HIV & Hepatitis risk behaviors and infection
- Family problems/relationship difficulties
- Increase service use and cost
- Complications resulting from chronic illnesses such as diabetes and cancer

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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

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Shifting Away From Traditional Treatment

- ❑ Most mental health and substance abuse treatment systems and service organizations provide traditional (parallel or sequential) treatments.
- ❑ Clients must find help for each disorder in different departments or at different agencies, in different parts of town, with different service providers, often on different days.
- ❑ Services are frequently designed to respond to crises or to manage risks rather than to foster a full recovery process, including independent living and employment in the community.
- ❑ Administrators and providers may have an intuitive sense that this treatment structure is not working.

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Problems with Separate Treatment

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 Treatment

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.

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Problems with Separate Treatment

Lack of integration

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

Messages conveyed about recovery

- One “right” pathway versus several pathways

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Problems with Separate Treatment

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.

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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

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Organizational Characteristics

Item O1. Program Philosophy
Item O2. Eligibility/Client Identification
Item O3. Penetration
Item O4. Assessment
Item O5. Treatment Plan
Item O6. Treatment
Item O7. Training
Item O8. Supervision
Item O9. Process Monitoring
Item O10. Outcome Monitoring
Item O11. Quality Improvement (QI)
Item O12. Client Choice

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Incremental & Realistic Changes

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

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A COMMUNITY EFFORT

Successful implementation of IDDT is neither a top-down nor a bottom-up grassroots initiative.

- State and county authorities (e.g., mental health, substance abuse, criminal justice, housing, and health)
- Agency and organization administrators
- Direct service providers
- Community stakeholders
- Clients
- Family members and friends who support clients in their recovery

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Systems & Groups	Stakeholders
Mental Health Services	• State mental health authority • Community-based mental health centers and providers • Crisis services/state hospitals/community hospitals
Alcohol and Drug Services	• State alcohol and drug addiction services authority • Chemical dependency treatment programs and providers
Criminal Justice	• Law enforcement: police & sheriff's departments • Judges/Courts/Probation/Parole • Jails and prisons
Health Services	• Hospital emergency rooms • Primary care physicians
Vocational Rehabilitation	• State vocational rehabilitation (VR) authority • Vocational rehabilitation programs and providers • Business owners/employers • Employment programs within mental health agency/local community
Housing	• Homeless shelters & Group homes • Landlords/apartment owners

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Systems & Groups	Stakeholders
Education	• Colleges, universities, and training programs • General Education Degree (GED) programs • Supportive Education programs
Clients	• Interested individuals
Family Members	• Client support networks (i.e., individuals who clients identify as close and important, which may include biological family members and others)
Advocacy Groups	• Representatives from consumer groups • Representatives from the National Alliance of the Mentally Ill (NAMI) • Other local, regional, and national advocacy groups
Media (may assist with public education and consensus building)	• Health, human service, and human-interest writers, reporters, and editors in print, radio, television, cable television, and web-based media (i.e., commercial, public, and college media)

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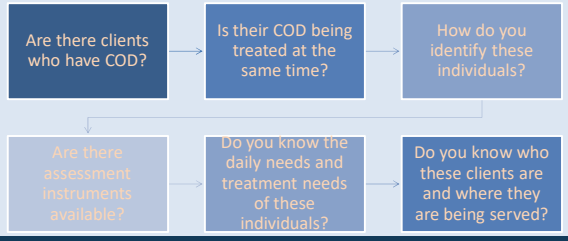
Stage 1: Unaware or Uninterested



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Stage 2: Consensus Building

- Conduct a needs assessment.
- Develop awareness of available options.
- Identify current practices and rationales.
- Examine your mission, values, goals, and vision.
- Check it out.
- Engage technical assistance.
- Assess the pros and cons.
- Develop informed consent and consensus.
- Explore concerns.

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Stage 3: Motivating

- Define your rationale
- Identify Stakeholders
- Build Consensus
- Find your IDDT "Champions"
- Identify Financial Resources
- Assemble a Steering Committee
- Conduct a readiness assessment
- Decide to implement or not
- Recruit a team leader
- Plan to start small
- Assemble multidisciplinary team
- Begin implementation plan

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Stage 4: Implementing

- Conduct a baseline fidelity review
- Develop a baseline fidelity action plan
- Develop stagewise interventions
- Acquire and integrate training
- Engage in clinical consultation
- Provide stagewise interventions
- Develop and monitor outcomes
- Continue to educate and train stakeholders
- Address barriers
- Address unintended consequences

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Stage 5: Sustaining

- Maintain oversight
- Monitor fidelity
- Monitor outcomes
- Network with others
- Provide ongoing training
- Engage in ongoing consultation
- Expand IDDT services
- Transform the organizational culture

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IDDT Outcomes in Fargo, ND

Data for Cohort One, which includes 12 consumers receiving 48 months of IDDT services between January 2007 to May 2011.

Service utilization	Percentage of decrease from Year 1 to Year 4	Number in Year 1	Number in Year 4
Admissions to emergency room	29 percent decrease	24 admissions	17 admissions
Days of acute psychiatric hospitalization	90 percent decrease	97 days	10 days
Days of long-term psychiatric hospitalization	70 percent decrease	908 days	268 days
Days in crisis unit	40 percent decrease	83 days	50 days
Days in respite care	87 percent decrease	94 days	12 days
Days incarcerated	98 percent decrease	199 days	3 days

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IDDT Outcomes in Fargo, ND

Data for Cohort Two, which includes 12 consumers receiving 30 months of IDDT services between January 2007 to May 2011.

Service utilization	Percentage of decrease from Year 1 to Year 4	Number in Year 1	Number in Year 4
Admissions to emergency room	40 percent decrease	15 admissions	9 admissions
Days of acute psychiatric hospitalization	18 percent decrease	34 days	28 days
Days of long-term psychiatric hospitalization	69 percent decrease	149 days	46 days
Days in crisis unit	3 percent decrease	33 days	32 days
Days in respite care	100 percent decrease	48 days	0 days
Days incarcerated	71 percent decrease	225 days	65 days

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IDDT Outcomes in Fargo, ND

Data for Cohort Three, which includes 24 consumers receiving 12 months of IDDT services between June 2010 to June 2011.

Service utilization	Percentage of decrease from Year 1 to Year 4	Number in Year 1	Number in Year 4
Admissions to emergency room	18 percent decrease	71 admissions	58 admissions
Days of acute psychiatric hospitalization	38 percent decrease	139 days	86 days
Days of long-term psychiatric hospitalization	24 percent decrease	184 days	139 days
Days in crisis unit	39 percent decrease*	270 days	165 days
Days in respite care	N/A	N/A	N/A
Days incarcerated	300 percent increase **	2 days	8 days

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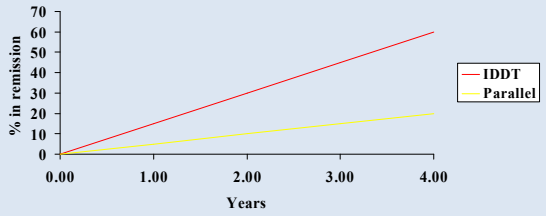
Abstinence after Integrated Dual Disorder Treatment



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Celebrate & Evaluate Successes!

- Take time to celebrate and evaluate successes together, so everyone becomes conscious of the organizational processes that produce positive outcomes.
- Be sure to include direct-service providers, administrators, steering committee members, community stakeholders, consumers, and family members in the celebration and evaluation and share the results openly.
- The process of organizational self-reflection will provide energy for future innovations.