THE DUAL DIAGNOSIS CAPABILITY OF THE STATE OF CONNECTICUT'S ADDICTION TREATMENT SERVICES: PROCESSES & PROSPECTS

6 September 2006

Co-Occurring State Incentive Grant (#5 KD1 SM56579-02) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to the State of Connecticut

Thomas A. Kirk Jr., Kenneth Marcus, Dennis Bouffard, Mike Hettinger, Sam Segal, Lauren Siembab, Minakshi Tikoo, Sabrina Trocchi

Department of Mental Health & Addiction Services, State of Connecticut

Heather Gotham, Ashley Haden, Ron Klaus

Missouri Institute of Mental Health, University of Missouri-Columbia

Jessica Brown, Joseph Comaty, Tanya McGee, Kirsten Riise

Department of Health & Hospitals, State of Louisiana

Aurora Matzkin, Robert E. Drake, Greg McHugo, Haiyi Xie

Dartmouth Psychiatric Research Center, Dartmouth Medical School

Gary Bond

Indiana University Purdue University Indianapolis

Addiction treatment providers and patients

Julienne Giard & Rhonda Kincaid

Department of Mental Health & Addiction Services

State of Connecticut

PLAN FOR TODAY

1. Co-occurring disorders in addiction treatment:
   Models for patients and services
2. Stagewise process of enhancing services for persons with co-occurring disorders receiving addiction treatment services in Connecticut
   Stage I: Provider Survey
   Stage II Phase I: DDCAT method
   Stage II Phase II: Assessing change in dual diagnosis capability
   Stage III: Mapping and enhancing the dual diagnosis capability of the system
3. Implications and prospects

CO-OCCURRING DISORDERS IN ADDICTION TREATMENT: MODELS FOR PATIENTS AND SERVICES

QUADRANT MODEL FOR CO-OCCURRING DISORDERS

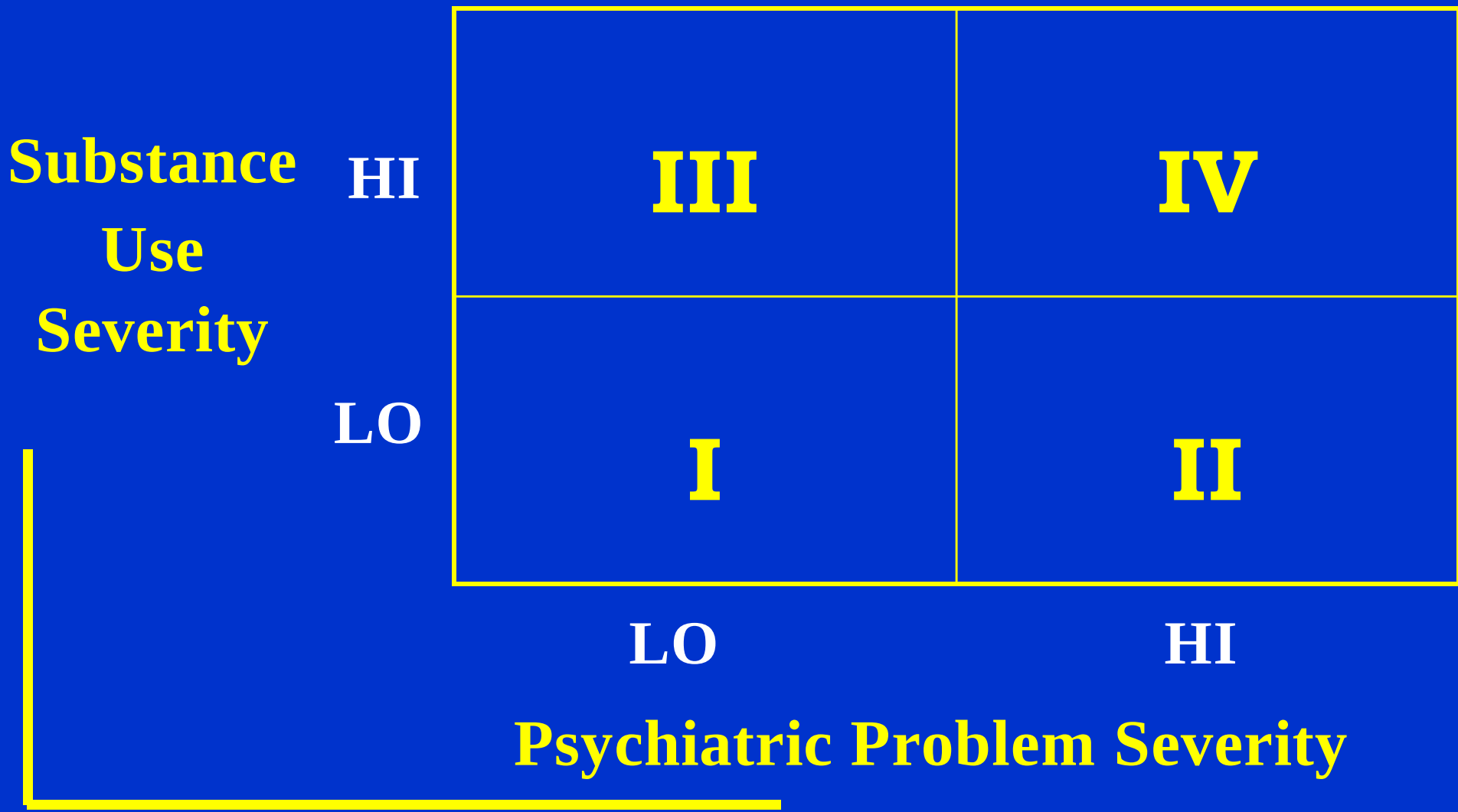
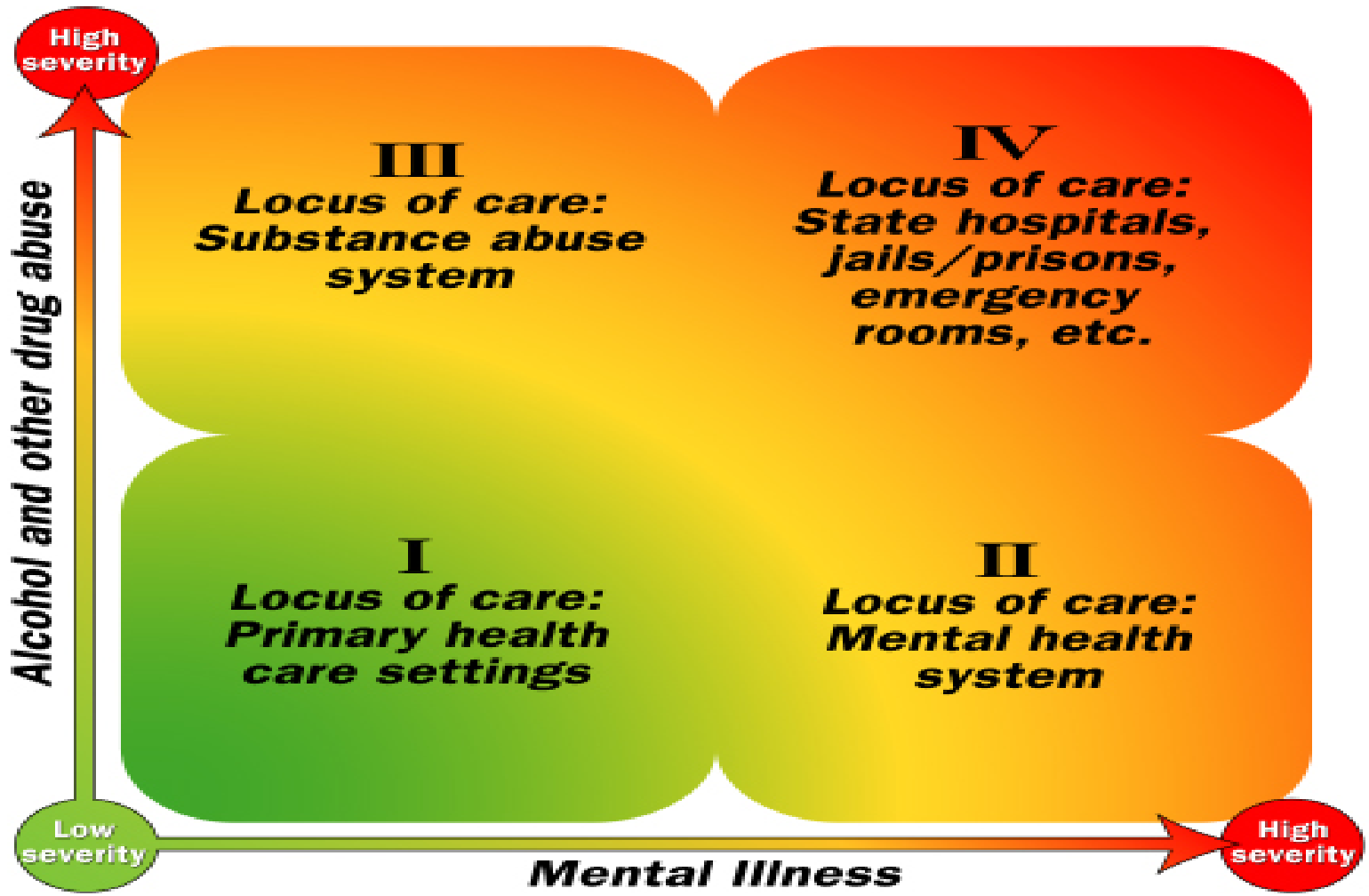


Figure 4

Service coordination by Severity



Consultation

Collaboration

Integrated Services

IS THERE A CONCEPTUAL MODEL THAT COULD GUIDE POLICY AND PRACTICE FOR ADDICTION TREATMENT SERVICES?

- The American Society of Addiction Medicine (ASAM) Patient Placement Criteria Second Edition Revised (PPC-2R) outlined the framework for a model
- The ASAM-PPC-2R is designed for addiction treatment services
- The ASAM-PPC-2R patient placement criteria have been widely adopted in public and private community addiction treatment (CCPC)

THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S TAXONOMY

(ASAM, 2001)

- ADDICTION ONLY SERVICES (AOS)
- DUAL DIAGNOSIS CAPABLE (DDC)
- DUAL DIAGNOSIS ENHANCED (DDE)

STATEMENT OF THE PROBLEM

- Practices for co-occurring disorders in addiction treatment settings are presently guided more so by conceptual models and clinical guidelines, less so research-based evidence (QIII, QIV).
- The evidence base is not as advanced as in MH settings (QII, QIV).
- Clinicians, programs, agencies and systems are motivated, *internally and externally,* to improve services for persons with co-occurring psychiatric disorders in their programs, but lack guidance on specific and objective approaches.

STAGES I, II AND III

I. To objectively determine the dual diagnosis capability of addiction treatment services.

II. To develop practical operational benchmarks or guidelines for enhancing dual diagnosis capability and implementing evidence-based practices, and examine if positive changes in program services can be detected.

III. To obtain a representative sample of the system of care, provide practical guidance for enhancement, and begin to link capability with outcomes.

STAGE I:
PROVIDER SURVEY

STAGE I: ADDICTION TREATMENT PROVIDER ESTIMATES BY QUADRANT

(n=456)(McGovern et al, 2006a)

Substance Use Severity	Psychiatric Problem Severity: LO	Psychiatric Problem Severity: HI
HI	III **50.0%**	IV **24.5%**
LO	I **15.1%**	II **15.8%**

STAGE I: DETERMINING DUAL DIAGNOSIS CAPABILITY BYADDICTION TREATMENT PROVIDER SURVEY

Addiction Only Services (AOS)	97 (23.0%)
Dual Diagnosis Capable (DDC)	275 (65.3%)
Dual Diagnosis Enhanced (DDE)	49 (11.6%)

(n=456)(McGovern et al, 2006b)

ASAM DUAL-DIAGNOSIS TAXONOMY SURVEY IS USEFUL BUT MAY HAVE PROBLEMS WITH ACCURACY

- 92.9% of sample responded to item (421/453)
- No differences in categories by professional role: Agency Directors vs. Clinical Supervisors vs. Clinicians
- Survey method is rapid and economical: Provides initial data (screening)
- Modest agreement among staff within programs: 47.3%
- Survey method may have bias and error (ambiguity)

THE NEED FOR A MORE OBJECTIVE ASSESSMENT OF ADDICTION TREATMENT SERVICES' DUAL DIAGNOSIS CAPABILITY

- ASAM offered the road map, but no operational definitions for services
- Fidelity: Adherence to an evidence-based practice or model
- Fidelity scales: Objective ratings of adherence
- Observational ratings of adherence to consensus clinical guidelines or principles
- "Triangulation" of data

STAGE II:
ASSESSING AND MEASURING CHANGE IN DUAL DIAGNOSIS CAPABILITY

APPLYING THE FIDELITY SCALE METHODOLOGY FOR A MORE OBJECTIVE ASSESSMENT OF DUAL DIAGNOSIS CAPABILITY

- Site visit (yields data beyond self-report)
- Multiple sources: Chart, brochure & program manual review; Observation of clinical process, team meeting, & supervision session; Interview with agency director, clinicians & clients.
- Objective ratings on operational definitions using a 5-point scale (ordinal)

DDCAT INDEX RATINGS

1 - Addiction only (AOS)

2 -

3 - Dual Diagnosis Capable (DDC)

4 -

5 - Dual Diagnosis Enhanced (DDE)

DDCAT INDEX DIMENSIONS

(and # of items)

I. PROGRAM STRUCTURE (4)
II. PROGRAM MILIEU (2)
III. CLINICAL PROCESS: ASSESSMENT (7)
IV. CLINICAL PROCESS: TREATMENT (10)
V. CONTINUITY OF CARE(5)
VI. STAFFING (5)
VII. TRAINING (2)

Total number of items: 35

STAGE II PHASE I:
Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Development & Feasibility

- Index (instrument) construction
- Feedback from experts in dual-diagnosis treatment and research, state agency administrators, addiction treatment providers, and fidelity measure experts
- Field testing the DDCAT index 1.0
- Site visits and self-assessments
- Key questions were:

  1) Is it doable?

  2) Does it provide useful information and for whom?

  3) How does the index hold up?

STAGE II PHASE I: DDCAT distribution of ASAM program type (CT & MO)

ASAM CATEGORY	Total	%
Addiction Only Services	19	68
Dual Diagnosis Capable	9	32
Dual Diagnosis Enhanced	0	0

STAGE II PHASE I: CORRESPONDANCE BETWEEN ESTIMATE OF DUAL DIAGNOSIS CAPABILITY BY SURVEY vs. DDCAT ASSESSMENT

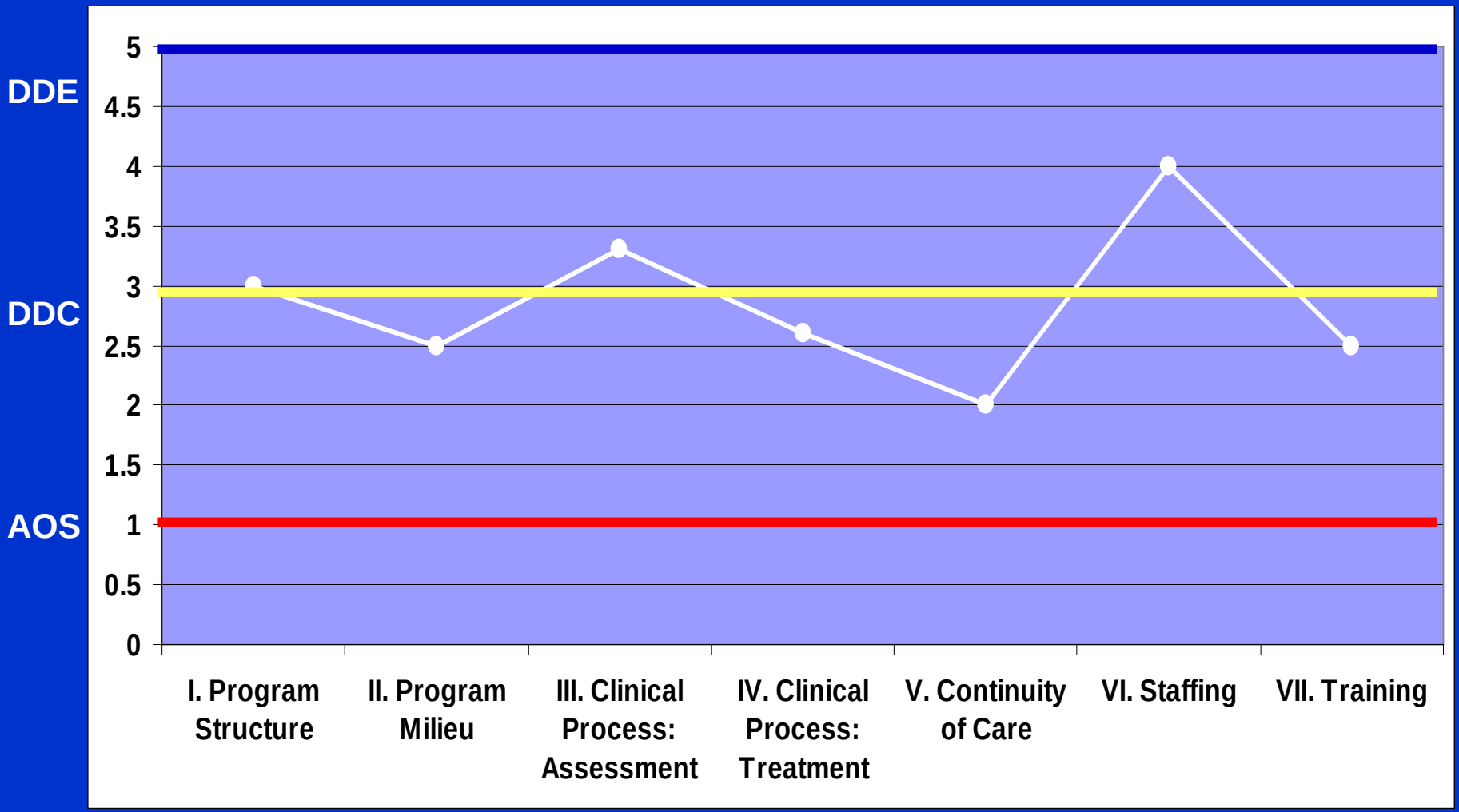
- 28.6% agreement about program's dual diagnosis capability (2/7)
- Differences were always in dual diagnosis capability being rated higher in self-report survey (5/7)

STAGE II PHASE I: DDCAT PSYCHOMETIC PROPERTIES

- Median alpha = .81 (Range .73 to .93)
- Inter-rater reliability: % agreement = 76%
- Kappa = .67 (median)
- Validity: Correlation with Integrated Dual Disorder Treatment Fidelity Scale: .69 (.38 to .82)

(Gotham et al, 2004)

DDCAT PROFILE: PRACTICAL GUIDANCE FOR PROVIDERS

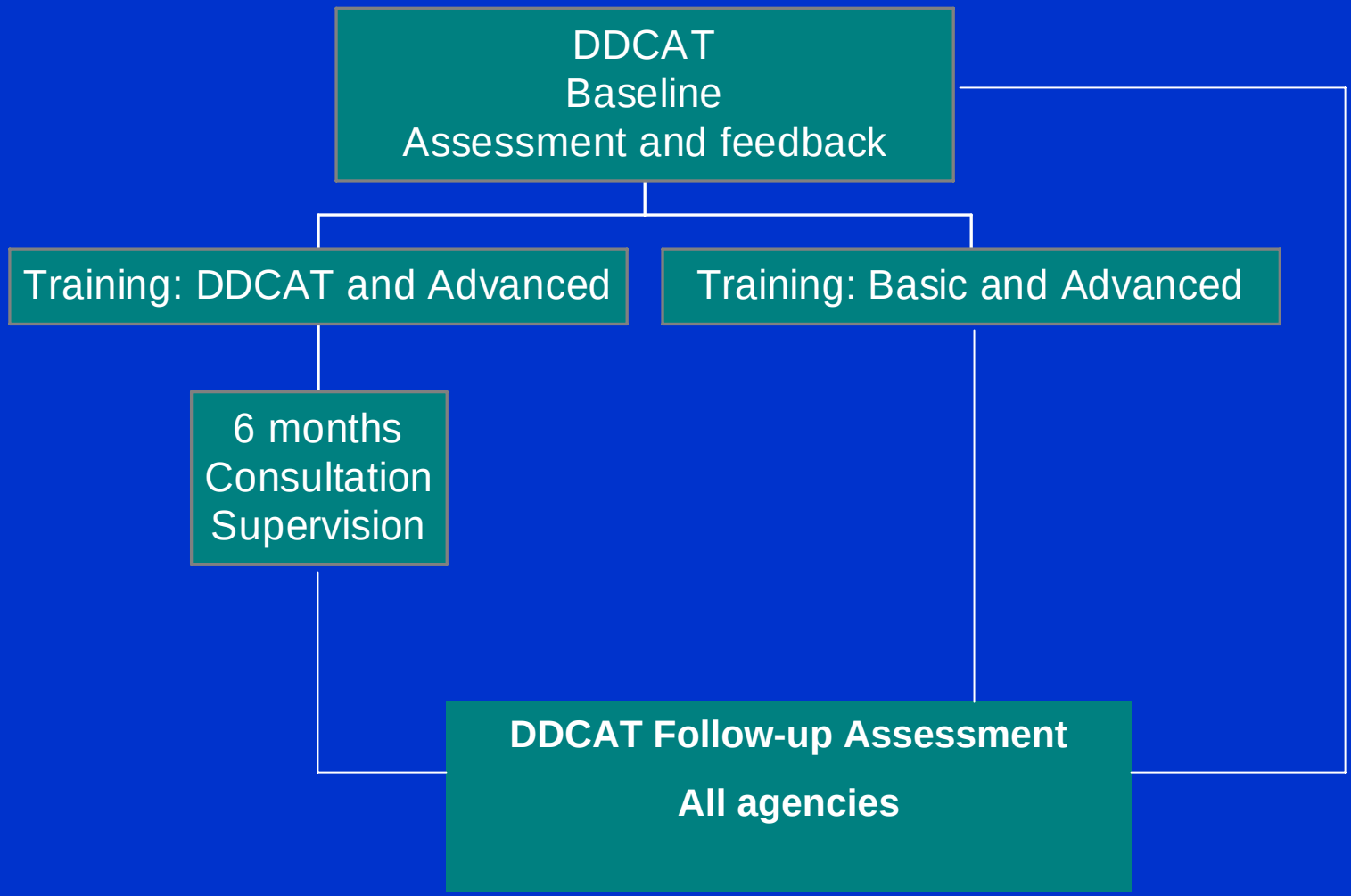


STAGE II PHASE I: SUMMARY OF FINDINGS

- 20 programs in NH: Self-assessment
- 7 programs in CT & 7 in MO: Site surveys
- Demonstrated feasibility in:
  - DDCAT ratings feasible using both formats
  - Useful process for providers and state agency:
    User-friendly, concrete, self-assessment, identifies specific avenues for change
- Acceptable psychometric properties

(McGovern et al, 2006c)

STAGE II PHASE II: DETECTION OF CHANGE IN PROGRAM SERVICES

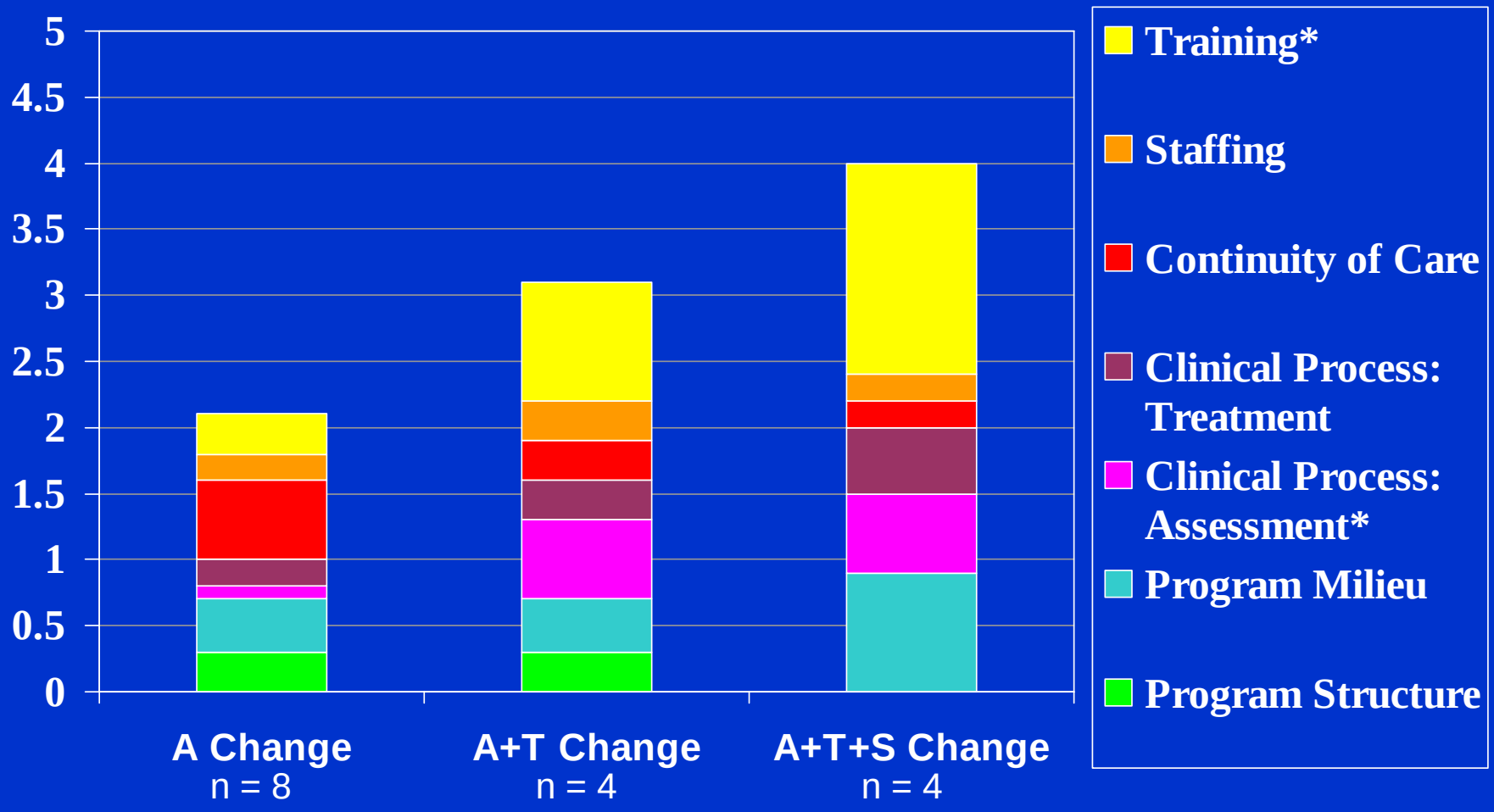


STAGE II PHASE II: PARTICIPANT PROGRAMS (n = 16) BY DDCAT LEVEL*

Addiction Only Services (AOS)	12 (75%)
Dual Diagnosis Capable (DDC)	4 (25%)
Dual Diagnosis Enhanced (DDE)	0 (0%)

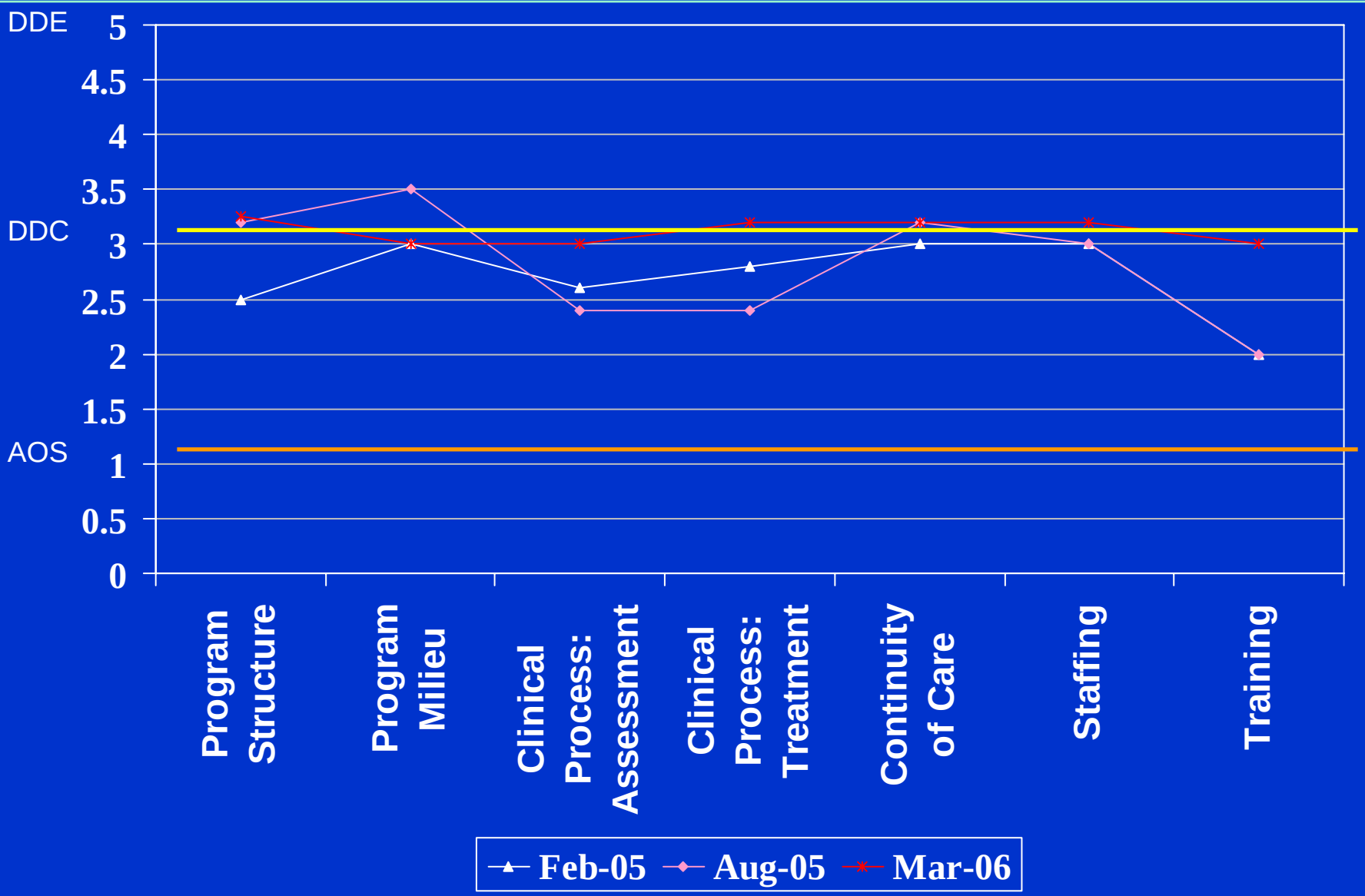
* Baseline DDCAT Assessment (Version 2.0)

STAGE II PHASE II: MEAN CHANGE IN DDCAT PROFILE SCORES BY CONDITION



*Kruskal-Wallis non-parametric test p<.05

DDCAT PROFILE: CASE STUDY OF ONE WATERBURY PROGRAM OVER TIME



STAGE III:
MAPPING AND ENHANCING THE DUAL DIAGNOSIS CAPABILITY OF THE ADDICTION TREATMENT SYSTEM

STAGE III: OBJECTIVES

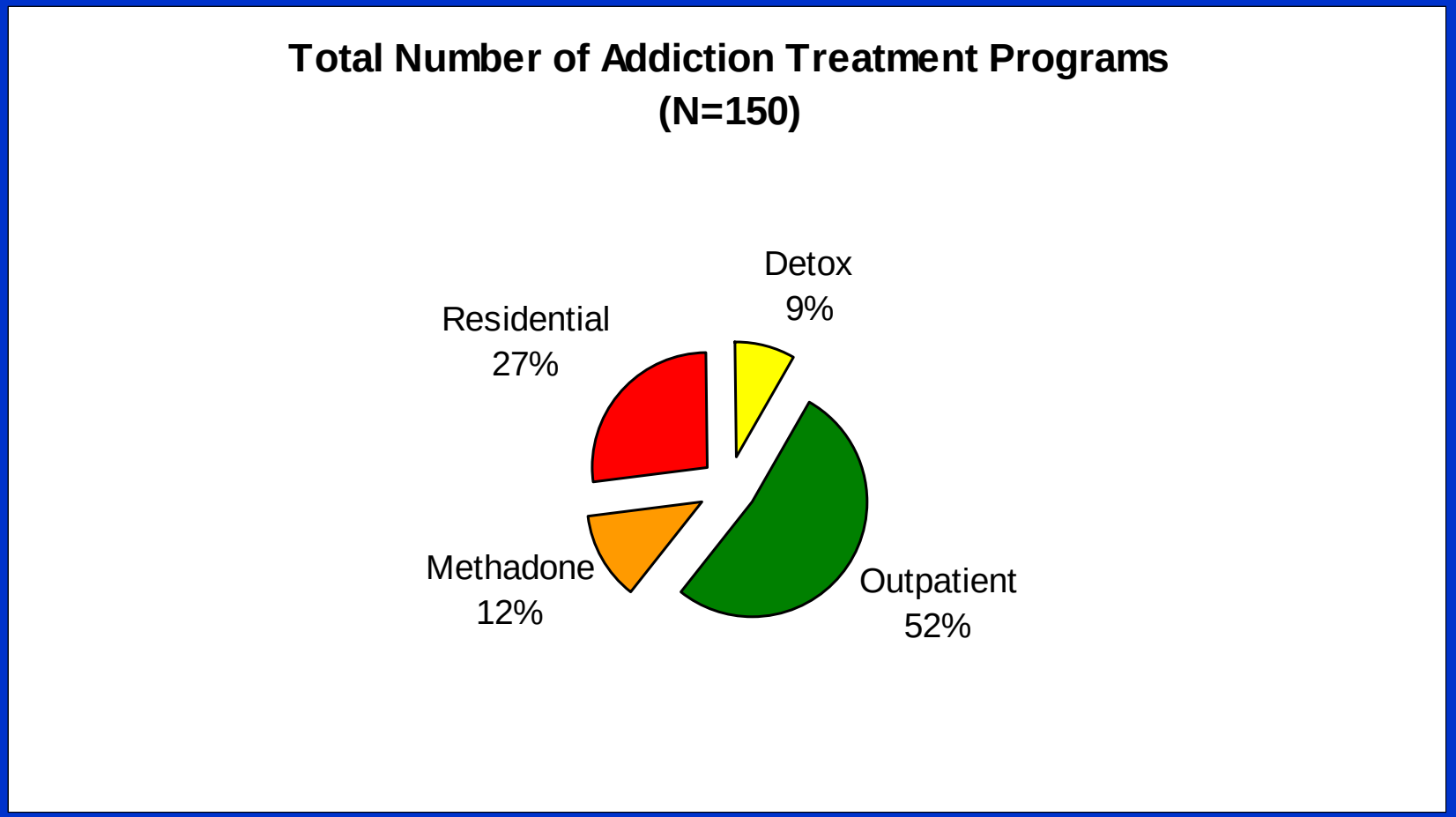
1. Larger (in number) and broader (in levels of care and stage of motivation) sampling of CT programs' dual diagnosis capability*
2. Map the representative sampling of providers' capability by level of care and region
3. Develop a toolkit to provide practical guidance to providers in moving from AOS to DDC and DDC to DDE services.
4. Link DDCAT assessments with other data: Program, client, financial.
5. Make suggestions for enhancing services and traction for change.

*DDCAT version 2.4

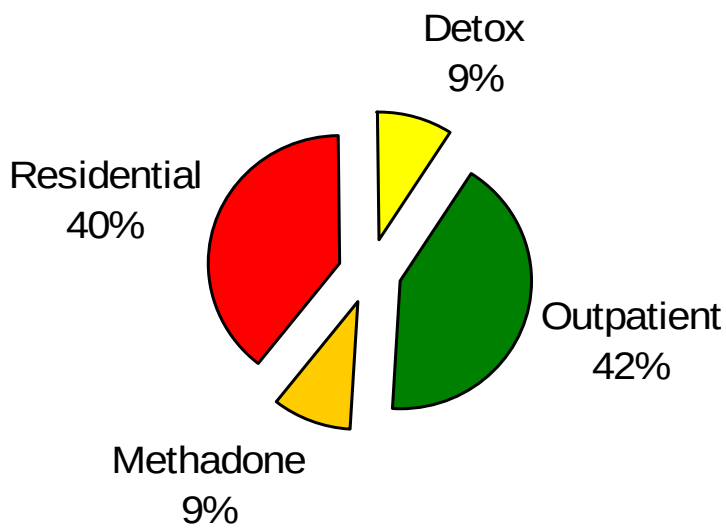
SAMPLE CHARACTERISTICS

	N	n	%
TOTAL	150	53	35.3
Detoxification	13	5	38.5
Outpatient/ IOP	78	22	28.2
Methadone Maintenance	18	5	27.8
Residential	41	21	51.2

STATEWIDE DISTRIBUTION OF ADDICTION TREATMENT SERVICES BY LEVEL OF CARE



STAGE III: DISTRIBUTION OF SAMPLE BY LEVEL OF CARE



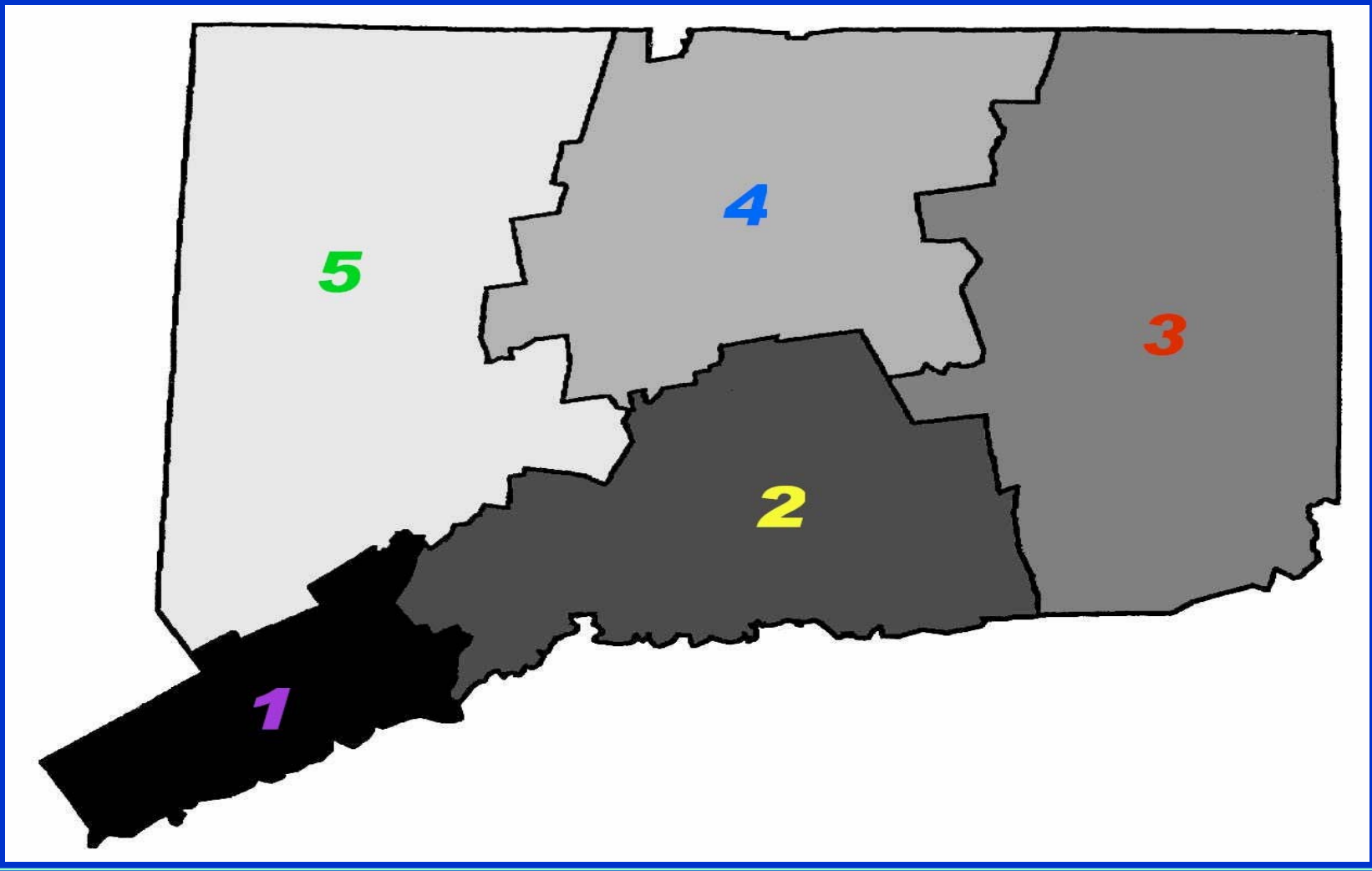
SAMPLE CHARACTERISTICS

Type of Programs:	n	%
Private/Non-Profit	47	88.7
State-operated	6	11.3
Location:		
Rural	14	26.4
Urban	39	73.6

SAMPLE CHARACTERISTICS

Region	N	n	%
I	27	8	29.6
II	25	14	56.0
III	34	12	35.3
IV	37	12	32.4
V	22	7	31.8

DMHAS Regional Map



STAGE III FINDINGS: OVERALL DISTRIBUTION OF PROGRAM TYPE

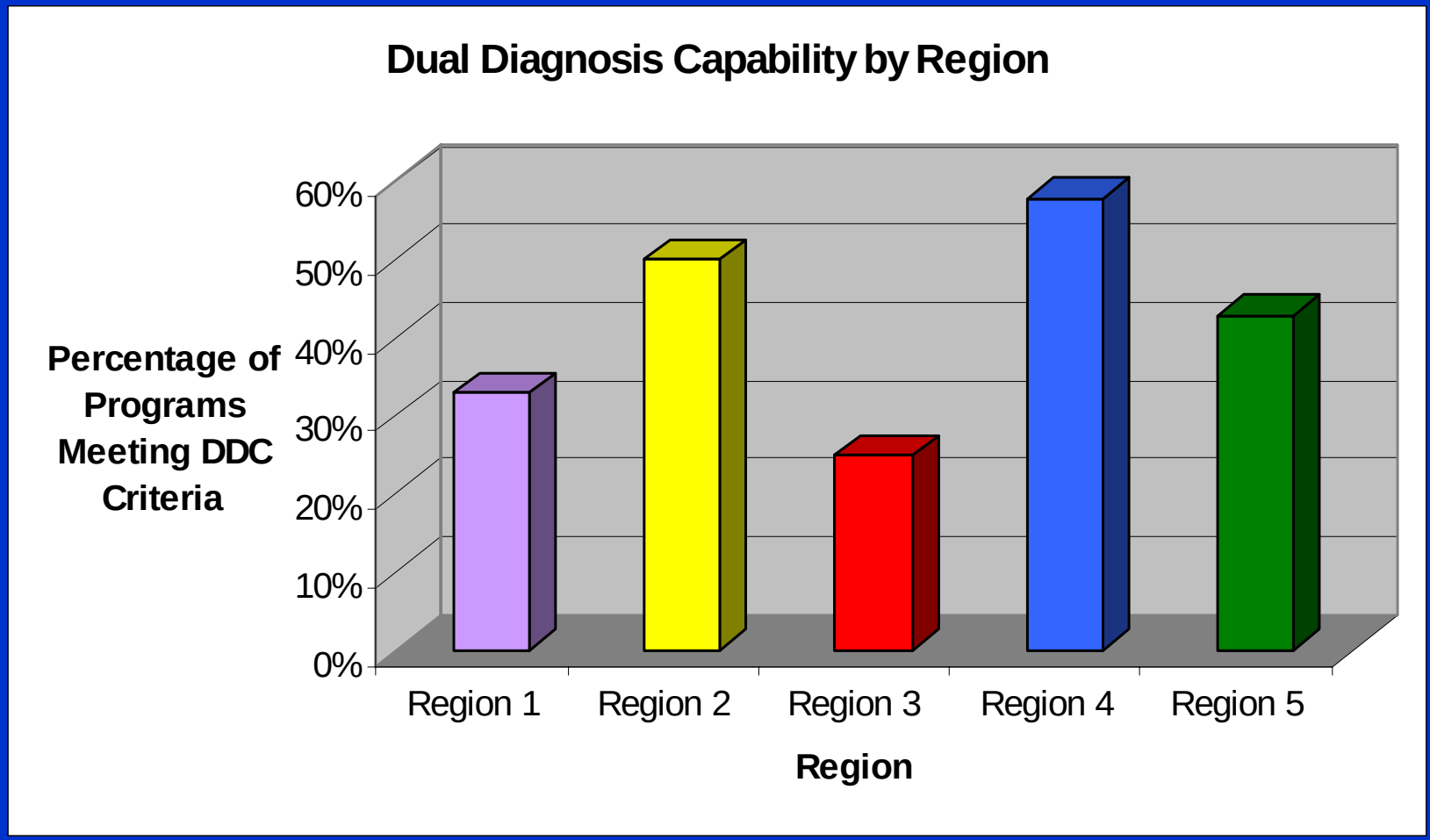
Dual diagnosis capability of Stage III programs (n=53):

AOS=31 (58.5%); DDC= 22 (41.5%)

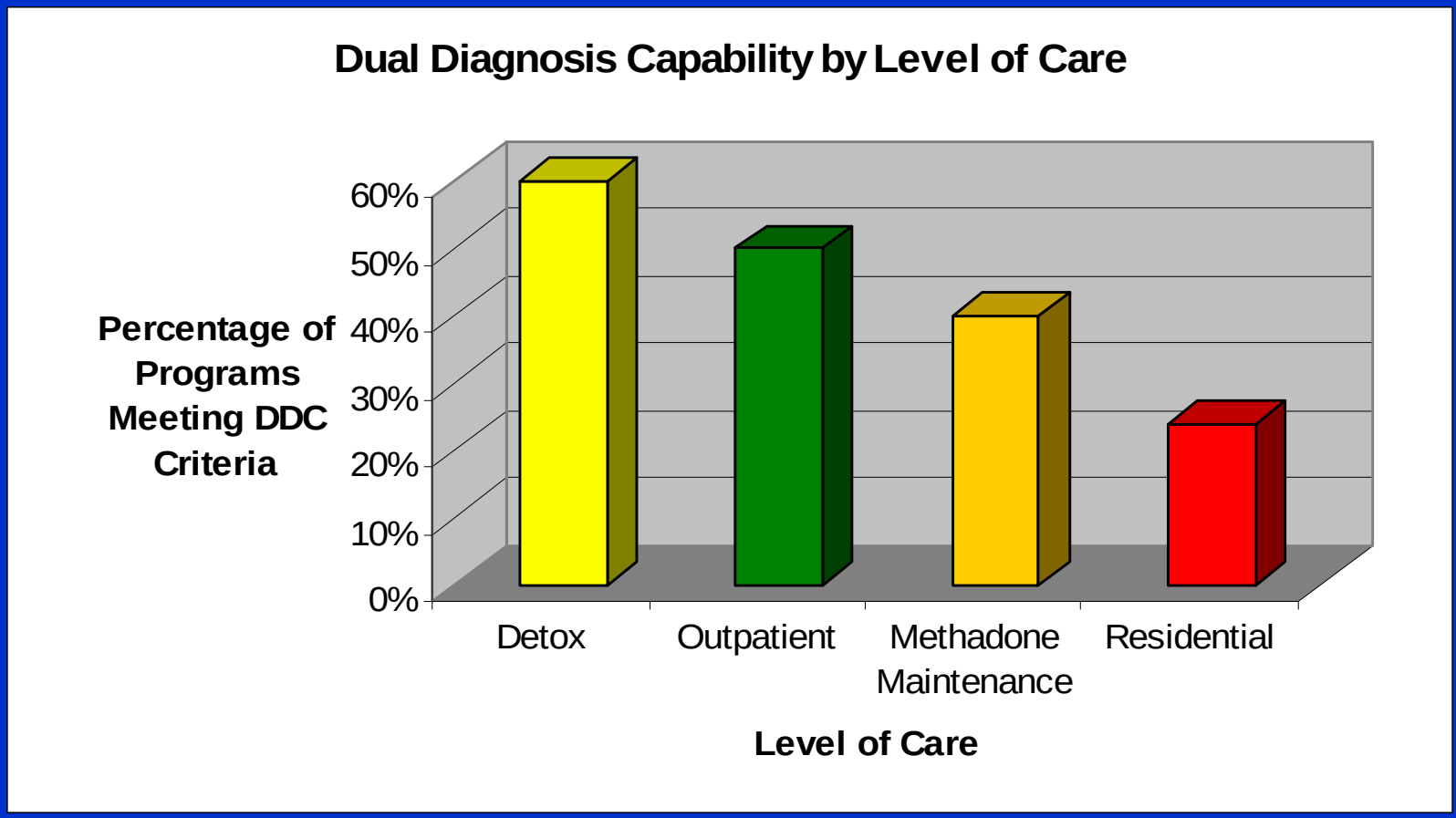
DISTRIBUTION OF PROGRAM TYPE ACROSS FOUR STUDIES:
All stages to date

	Stage I	Stage II Phase I	Stage II Phase II	Stage III
n	456	28	16	53
AOS	23.0%	68.0%	75.0%	58.5%
DDC	65.4%	32.0%	25.0%	41.5%
DDE	11.6%	0	0	0

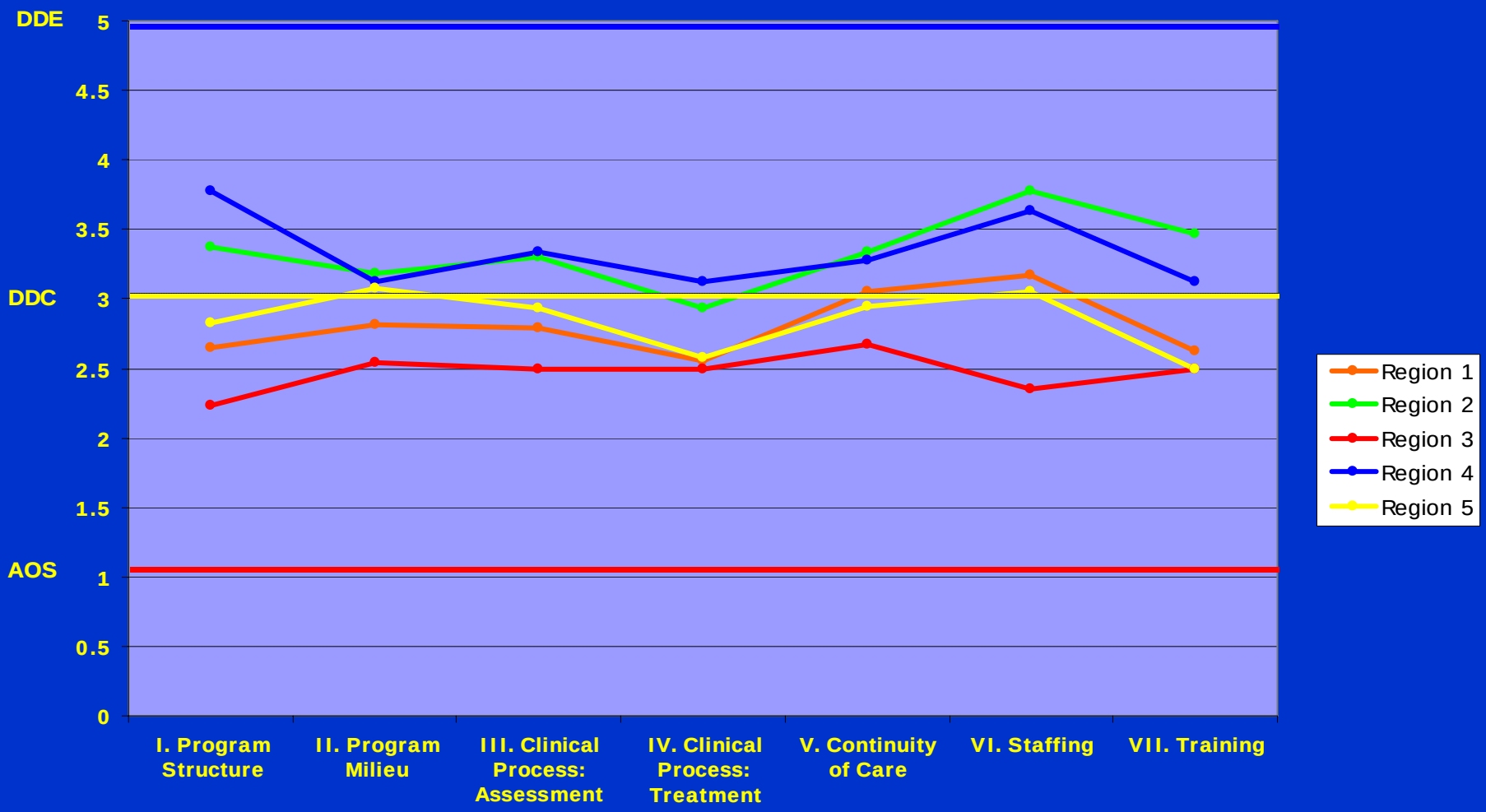
STAGE III FINDINGS: PROGRAM TYPE BY REGION



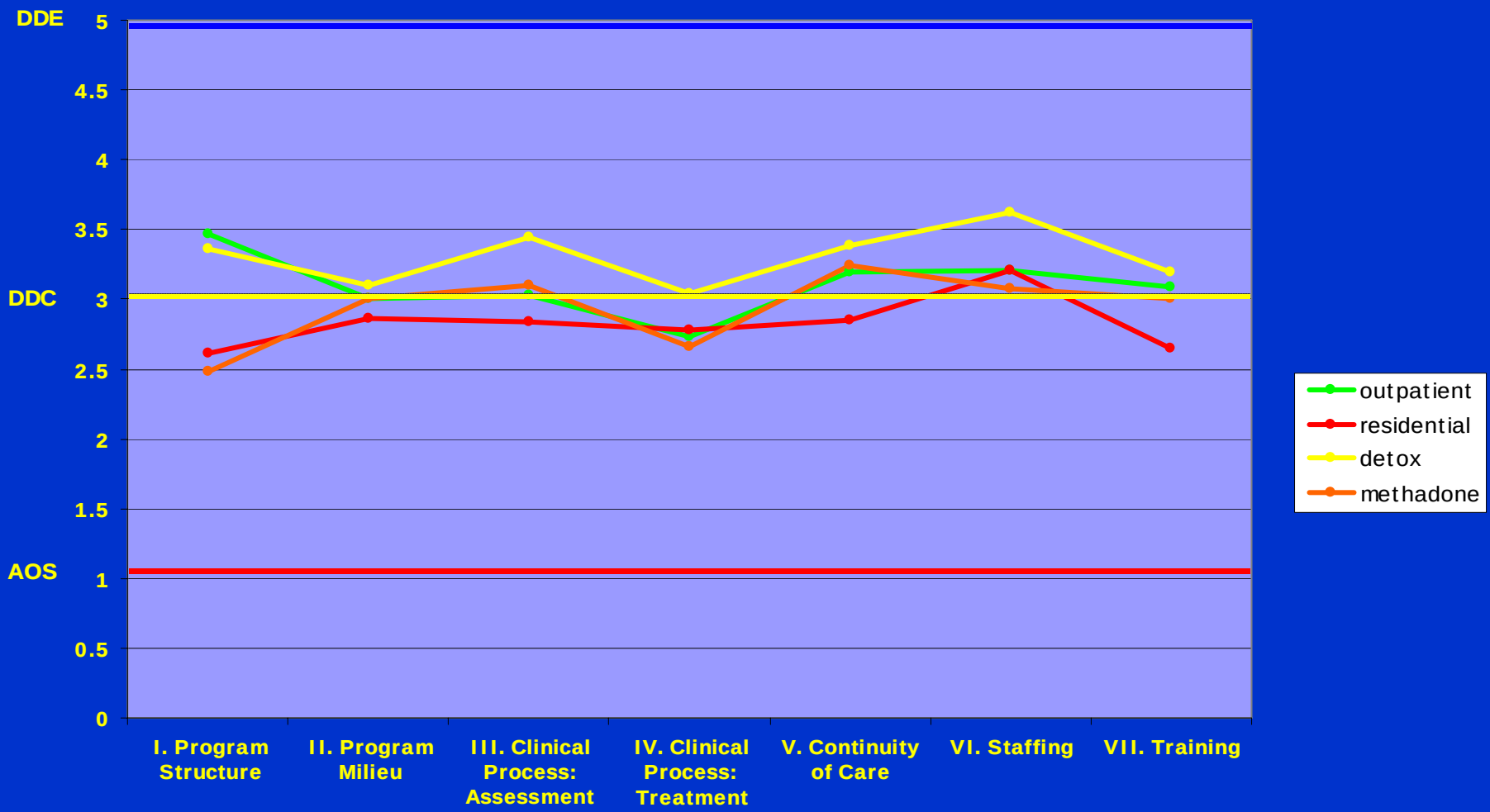
STAGE III FINDINGS: PROGRAM TYPE BY LEVELS OF CARE



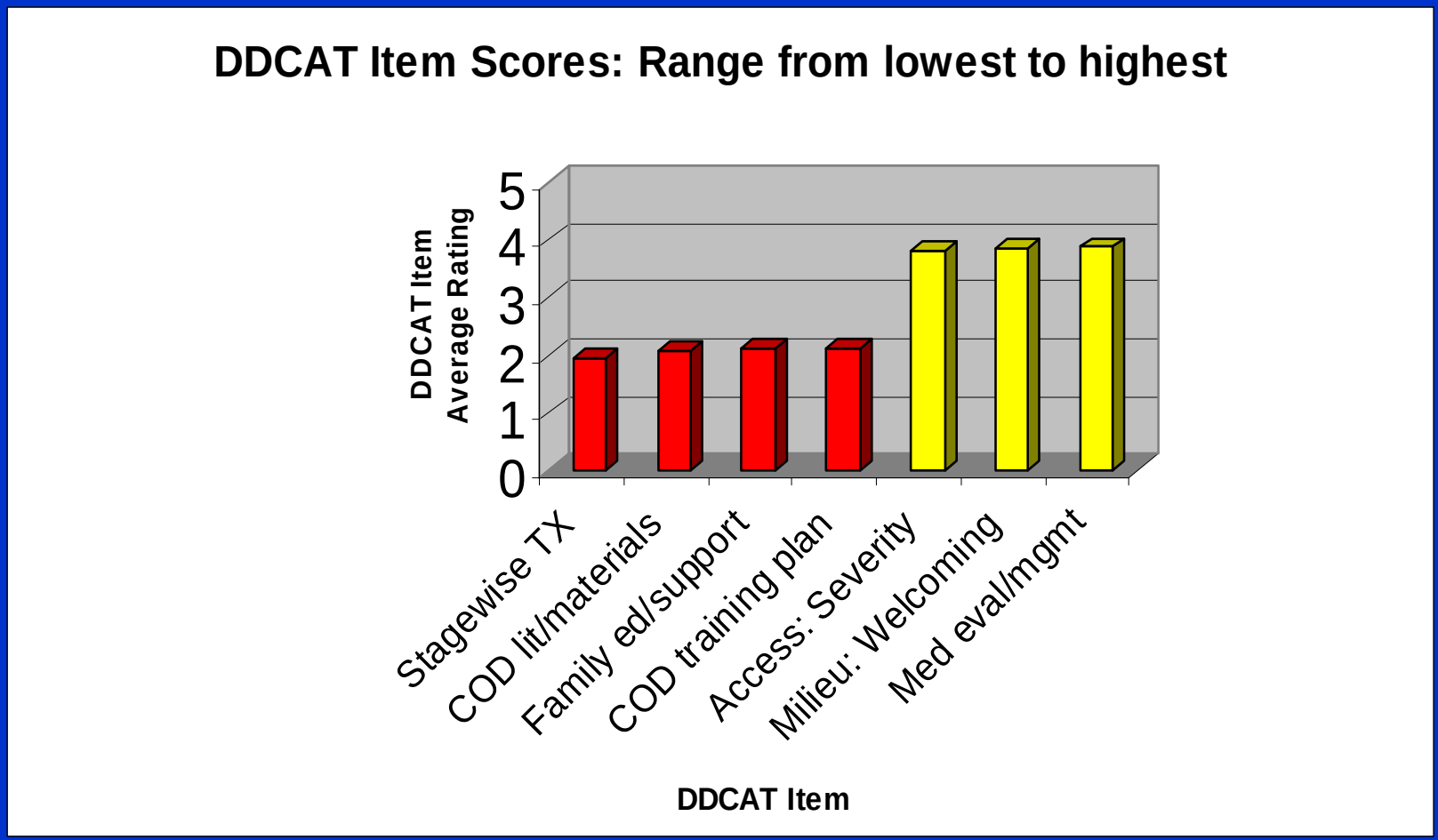
DDCAT PROFILES BY REGION



DDCAT PROFILES BY LEVEL OF CARE



DDCAT ITEMS: ADDITIONAL DETAILED LEVEL OF ANALYSIS



PRELIMINARY ANALYSES: PROGRAM CATEGORY AND 3-MONTH OUTCOME DATA

	AOS % Change	DDC % Change
% Employed	-2.4	-0.8
% Homeless	-10.0	-11.9
% w/Social Support	+71.4	+66.0
% Arrested	-5.6	-4.5
% Abstinent: Alcohol	41.0	26.8
% Abstinent: Drugs	35.2	16.7

NEXT STEPS: ONGOING ASSESSMENT AND MONITORING OF PROGRAMS

- DDCAT assessments over time: State or regional authority (LA); COSIG (MO); services research (TX)
- Use profiles to highlight strengths and opportunities: Provider interest, consumer benefit (LA)
- Caution about self-report DDCAT assessments: Balancing accuracy with effort (IN, VT)
- Clinical management information system monitoring: access, acceptance, & retention (CT)
- "Walk-thru": Ethnographic methods (IA)

NEXT STEPS: IMPLEMENTATION SUPPORT STRATEGIES

- RFP/RFA for programs interested in enhancement and implementation support
- Centers of Excellence: Statewide conference/workshops
- Identify needs based on profiles: Staffing, structural, and/or intervention resources
- Availability of toolkit (AOS to DDC; DDC to DDE)
- Regional and local MH/AT networks developing protocols, staff sharing & exchange, consumer advisors
- Implementation supports: Medications, MI/CBT, services for families, & peer recovery networks

NEXT STEPS: UTILIZATION OF CLINICAL MANAGEMENT INFORMATION SYSTEMS

- Create or use existing mechanisms to identify persons with co-occurring disorders (diagnosis, quadrant, severity, acuity)
- Integrate self-report measures
- Add to consumer satisfaction survey: Were addiction and mental health needs met? How? Where?
- Monitor process and outcomes
- Simple proxies for outcome: Access, acceptance, retention, and linkage
- Report cards and agency profiles

NEXT STEPS: RESOURCE ALLOCATION AND REGULATORY STANDARDS

- Some aspects of service enhancement are not cost-related: Stagewise treatment, COD literature & materials, family services (COD), structured staff training plan
- Some aspects are cost related: Staffing
- Examine potential to incentivize DDC or DDE services (medication is only one component)
- Monitoring by site review (DDCAT), client level data (client satisfaction survey) and program outcomes (SATIS; NOMS)

RATIONAL SERVICE SYSTEM DESIGN?

- Variation in health care is ubiquitous
- Independent of disease prevalence or needs of consumers (demand side)
- Typically driven by supply-side of providers: From surgical procedures to dentistry
- What should the configuration/ratio of levels of care and co-occurring capability be by region, and by state?

  LOCs I/II/III: 50/30/20 or 50/40/10

  DDE/DDC/AOS: 15/70/15
- Services matched to patient acute need, and with a plan for illness self-management and ongoing recovery

Mark McGovern
Department of Psychiatry
Dartmouth Medical School
2 Whipple Place, #202
Lebanon, NH 03766
(603) 381-1160
(603) 448-3976 FAX
mark.p.mcgovern@dartmouth.edu