Co-Occurring Disorders: Integrated Dual Disorders Treatment

Implementation Resource Kit

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Implementation Tips for Public Mental Health Authorities

The Implementing Evidence-Based Practice Project presents the public mental health authority with a unique opportunity to focus the attention of constituent groups on the clinical foundation of services for adults with severe mental illnesses. We now have the opportunity to offer this cluster of practices that have demonstrated consistent positive impact on the lives of consumers and their families as a service foundation of community-based services.

This document is designed to help public mental health authority leaders who are planning to implement integrated dual disorders treatment in their systems. Integrated dual disorders treatment varies from "customary" approaches to providing services for adults with dual disorders by providing comprehensive services to treat both disorders with the same practitioners. (For more information about this practice, see *Information for Public Mental Health Authorities*.) A variety of strategies have been used to put integrated dual disorders treatment into action. This document presents ideas that we have gathered from leaders who have successfully implemented integrated dual disorders treatments in their states or regions.

We divide the task of implementing integrated dual disorders treatment into three phases: 1) building a consensus for change, 2) making the change, and 3) sustaining the change. We next outline strategies that other mental health program leaders have found helpful at each phase.

Building a Consensus for Change

- **Vision.** Articulate your own vision of integrated dual disorders treatment that is based on the concepts of integrated services and dual recovery.
- **Collaboration.** If the substance abuse treatment system is separate in your region or state, involve them in articulating the vision and planning for changes within the mental health system. Also involve all of the traditional stakeholders—consumers, families, practitioners, and program leaders—in anticipating and planning for change.
- **Planning.** Examine all of the expectations, goals, funding, contracts, oversight, etc. that may relate to or be affected by integrated dual disorder services.

Making the Change

Strategy

Begin with pilot or demonstration sites. This may be useful when managing the inevitable problems that arise and will give all the constituents an opportunity to see that this intervention works. Alternatively, some states have used a broader strategy and encouraged programs to compete for incentives related to improving performance.

Training

Develop a working relationship with an evidence-based practice implementation center or establish a training and consultation capacity at your county or state level to overcome the problem of standardizing approaches and limited training resources at the program level.

Organizational and financing mechanisms

The public mental health authority has the opportunity to designate an office and key staff with whom to consult, encourage, and monitor dual disorders treatment services. Other common approaches are to develop explicit program guidelines, use contracting mechanisms, credential staff or programs, and use fidelity as well as outcome measures. Financing should correspond with services, and policymakers must ensure that integrated dual disorders treatments are reimbursed at a realistic level by some combination of state mental health and substance abuse dollars, Medicaid, and other insurers.

Sustaining the Change

Infrastructure

The state public mental health authority must provide information regarding the difference between traditional parallel treatment and integrated dual disorders treatment and to actively collaborate with related agencies to involve all stakeholders.

Problem solving

Policymakers must address the organizational and financing problems that inevitably arise with input from relevant programs and constituents.

Data

To improve services over time, policymakers need good data. Public health administrators commonly use site visits, fidelity measures, and outcome data in addition to service utilization data.

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