

CHANGES Dual Recovery Program

Scott Madover, PhD, Administrator, CHANGES Dual Recovery Program;
Stephen Wilson, MD, Corporate Medical Director; and Shelley Levin, PhD,
Regional Director of Staff Development

One of the greatest challenges to mental health and substance abuse systems are clients with dual diagnoses. The strongest evidence for successful treatment has been the utilization of integrated treatment services, which combines both mental health and substance abuse treatment concurrently.¹ CHANGES is an evidence and innovation-based program in Oakland, California, that is specifically designed to engage and treat individuals in a community setting who are dually diagnosed.

Program Beginnings

In response to growing concern that Alameda County has among the highest rates of involuntary commitments and psychiatric hospitalizations in the state, the Alameda County Behavioral Healthcare Systems (ACBHS) developed a plan in 1999 for re-organizing access into ACBHCS. The Front Door Project conducted over 100 interviews with community stakeholders and analyzed data covering a two-year period, including 21,000 emergency episodes.

The Project report identified a number of system problems, including: lack of treatment for substance abusing clients with mental illnesses and lack of on-going services for many of the highest-utilizers of acute psychiatric care. The report concluded that individuals with a mental illness and a substance abuse disorder were not receiving effective services; experienced frequent crises; and relied heavily upon psychiatric emergency services, locked sub-acute inpatient programs, jails, and other county resources.

CHANGES was designed as a joint effort between Telecare Corporation and ACBHS to address these problems. Its three main goals were to decrease clients' frequent and inappropriate use of psychiatric emergency and acute care services, decrease overall systems costs, and empower clients to regain control of their lives.

PROGRAM FEATURES

CHANGES opened in June 2001 and 240 clients were enrolled within the first two years. Outreach to clients for the CHANGES was based upon several criteria: 18 years or older; co-occurring disorder diagnosis; three or more psychiatric hospitalizations within two years; and unsuccessful engagement by the traditional mental health system.

Potential clients came from a variety of sources: other ACBHCS service teams, closure of a co-occurring disorders day treatment, and a list of the top 100 utilizers of mental health services in the county who were dually diagnosed; discharges from jail through the California State Mentally Ill Offender Crime Reduction Grant initiative. CHANGES' evidence-based components include staged interventions, assertive outreach, motivational interventions, counseling, social support, maintaining a long-term perspective, comprehensiveness and cultural sensitivity and competence.ⁱⁱ

Along with evidence-based components, the program includes three unique innovative aspects developed by Telecare.

Evidence-Based Components

The first evidence-based principle is a commitment to comprehensive recovery, rather than illness and disability. CHANGES' recovery focus integrates treatment in a manner that de-emphasizes the two disorders and offers a singular, holistic approach for recovery of life roles.

The second evidence-based principle is a client-centered rather than a provider-centered approach. By designing services that are sensitive to clients' individual experiences, perceptions and needs, those who had previously been considered "treatment avoidant" become treatment receptive.

The CHANGES program structure is based upon Prochaska and DiClemente's Stages of Change modelⁱⁱⁱ. Three teams serve clients according to their Stage of Change: the Outreach Team for individuals in the pre-contemplation and early contemplation stages, the Services Teams for clients in the contemplation, preparation or action stages, and a Self-Help component for clients in the maintenance stage.

There are two service component teams: the Assertive Community Treatment (ACT) Team and the Intensive Case Management (ICM) Team. Both provide psychiatric evaluation

and treatment, medication support, crisis intervention, stage-appropriate motivational interventions, case management and community living skill development. Additionally, on-call response is available to all clients 24-hours-a-day, 7-days-a-week.

The ACT Team, with a 1:10 client-to-staff ratio, serves clients who are experiencing the greatest complexity of problems and need intense or frequent services. The ICM Team, with a 1:20 client-to-staff ratio, serves clients with less complexity. The Self-Help component provides clients in recovery with a gathering place and access to staff, and groups – including a Wellness Recovery Action Plan (WRAP) group led by a mental health consumer and a Relapse Prevention group.

Innovation-Based Components

An innovative data-supported decision-making component was conceived by Telecare to place information at the core of the CHANGES model. Information is captured using innovative assessment tools. Reports are generated reports to help clients make decisions, discuss trends, reinforce successful choice making or provide a context for clients to consider other life choices. Staff uses the reports to identify effective approaches and leadership uses the reports to continually improve program focus.

A second innovation-based element was development of measurement tools for both clinical risk and strength concepts such as risk, harm strengths and engagement. Clinical risk is measured using Telecare's assessment tools covering seven critical domains: suicide, violence, self-neglect, barriers to medical services, communicable disease, victimization and child/abuse neglect. Two additional assessments measure primary contributors to risk: alcohol and other drug use, and problems following a psychiatric medication plan.

Harm, strengths and engagement are measured using "Beaker Tools," a metaphor based on the scientific beaker. The tool uses a series of assessments to creatively measure engagement, strengths and harm. The engagement, strengths, and harm "beakers" help clients visualize progress and see how their choices can increase or decrease harm.

Choice is the third innovation-based concept used at CHANGES. Learning choice making skills is an essential part of recovery. Telecare staff work with clients to help them understand that the choices they make can bring them what they want, or can bring them harm.

PROGRAM EFFECTIVENESS

To assess the effectiveness of the CHANGES program, Telecare undertook a study of the first 142 clients who completed one year of service. The data compares client outcomes for the year prior to enrollment and for the first year of enrollment in the CHANGES program. Demographic data is presented in Table I and reflects the ethnicity of the community. Diagnostic data is presented in Table II.

Service Utilization

On average, individuals received a total of 167 hours of service in their first year of the program, or over three hours per week. Over half (57%) of the contacts were for individual rehabilitation, followed by group rehabilitation (18%), collateral contacts (17%), medication support (7%), and crisis intervention (1%). The high percentage of individual rehabilitation contacts likely reflects the highly individualized nature of the program. The program's emphasis on collaborating with family members and other service providers is reflected in the large percentage of collateral contacts. The small percentage of crisis contacts reflects the program's pro-active nature.

Clinical Outcomes

Client functioning improved in multiple domains. Clients improved 7% on the Multnomah Community Ability Scale. There was an 11% reduction in the level of harm in client's lives, and a 12% improvement in strengths. Thirty percent more clients were living independently after one year in the program, and there was a 57% decrease in the number of clients living in homeless shelters.

Cost Savings

Significant cost savings were realized in the program's first year. Psychiatric emergency room contacts decreased by 35% with an estimated cost saving of \$155,680. Psychiatric hospitalizations decreased by 40% and the average length of stay decreased by 31% with an estimated cost saving of \$504,849. Sub-acute inpatient admissions decreased by 34% and the average length of stay decreased by 54% with a cost saving of \$202,100.

Even when the cost of provided community services is added, the cost of all mental health services in the first year of the program (\$1,425,589; per client mean \$10,039) was significantly lower than the cost of services for the year prior to admission (\$2,109,289; per client mean \$14,854). (The California Short-Doyle/Medi-Cal Maximum Reimbursement Rate was used to provide a uniform rate for comparison purposes. It does not reflect the actual dollars paid to the program.)^{iv}

CHANGES is a long-term model and it will take time to understand its full impact. However, short-term results have been very positive and it is meeting its original goals for decreasing clients' frequent and inappropriate use of psychiatric emergency and acute care services; decreasing overall system costs, and empowering clients to regain control of their lives. As one of our clients recently said, "I would like to express my deepest gratitude to CHANGES staff for their commitment to me and my recovery. Their efforts saved my life and gave me hope. I never could have achieved my goals of reclaiming my life and career without their support and clinical expertise. Thank you!"

Table I
Demographic Data

N=142

ETHNICITY	
African American.....	58%
Caucasian.....	28%
Latino/Hispanic.....	10%
Native American.....	3%
Other.....	1%
AGE	
Average age at admission...	39
Age range.....	20-60
GENDER	
Male.....	63%
Female.....	37%

Table II
Diagnostic Data

N=142

MENTAL ILLNESS	
Schizophrenia.....	51
%	
Depression.....	18%
Bipolar Disorder.....	17%
Psychotic Disorder NOS...	10%
PTSD.....	3%
Other.....	1%
SUBSTANCE ABUSE/ DEPENDENCE	
Poly-substance.....	39%
Alcohol.....	22
%	
Cocaine.....	19%
Amphetamine.....	6
%	
None.....	2
%	
Other.....	1%

ⁱ Watkins, K. E., Hunter, S. B., Burnham, M. A., Pincus, H. A., & Nicholson, G. (2005). Review of treatment recommendations for persons with a co-occurring affective or anxiety and substance use disorder. Psychiatric Services, *56*(8), 913-926.

ⁱⁱ Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Richards, L. (2001a). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, *52*(4), 469-476.

ⁱⁱⁱ Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy; Toward a more integrative model of change. Psychotherapy: Theory, Research, and Practice, *19*, 276-288.

^{iv} We recognize the preliminary nature of this data analysis. The number of clients is small and they were not randomly assigned to the program. While an “intent-to-treat” analysis may have been more inclusive, data regarding the individuals who left the program because they moved, refused further service or disappeared were not available for analysis. It is important to note that the cost data presented are not comprehensive. Our analysis was intended as a mental health cost-utilization analysis (Hargreaves, Shumway, Hu, & Cuffel, 1989). Medication costs and laboratory costs were not available for analysis. Societal costs such as physical health care costs, family burden and entitlements are beyond the scope of this paper. Again, costs are for comparison purposes only and do not reflect the actual dollars paid to the program.