April 2006

Best Practice Bulletin

Training, Research, Evaluation, & Dissemination
Department for Mental Health & Mental Retardation Services
Division of Administration and Financial Management

KDMHMRS Hosts Best Practice Forums for Consumers and Family Members

Molly Clouse and Missy Richard attend Consumer and Family Best Practice Forum

A series of Consumer and Family Best Practice Forums are being held as part of an evidence-based practices state planning grant from the National Institute of Mental Health. The goal of the forums is to increase the leadership skills of consumers and family members so that they can more fully participate in the transformation of mental health service systems, as called for in the *Report of the President's New Freedom Commission on Mental Health*. Dr. Dean Fixsen of the National Implementation Research Network at the University of South Florida kicked off the first of these forums with a full-day workshop on the role of consumers, family members, and youth in promoting the quality of mental health care by advocating for evidence-based practices. In May, consumers and family members from across Kentucky will spend a day with John Morris, Director of the Human Services Practice of the Technical Assistance Collaborative and Professor and Director of Health Policy Studies, Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine. Mr. Morris will address evidence-based practices and performance measures and outcomes with the group.

Dr. Dean Fixsen of the National Implementation Research Network

Addressing Crisis Among Clients with Co-Occurring Mental Health and Substance Abuse Problems

The Department for Mental Health and Mental Retardation Services is sponsoring a 6-hour training with Randy Hignite, Substance Abuse Director for Bluegrass Regional Mental Health and Mental Retardation Board, Inc. The target audience is crisis stabilization staff in our community mental health centers. Randy will share information on the disease of addiction, assessment of medical need, withdrawal symptoms and guidelines, co-occurring disorders, stages of change, and relapse prevention. Workshops will be held from 9am—4pm at the following locations:

April 19th in Hazard May 18th Lexington June 15th Hopkinsville

Registration is FREE but space is limited. Please RSVP via email at Barbara.Kaminer@ky.gov

KY Receives Traumatic Brain Injury Implementation Grant

Project CLIP: Collaboration and Learning in Partnership

~Colleen Ryall, Branch Manager

The Brain Injury Services Branch, within the Department for Mental Health and Mental Retardation Services, has received notification that Kentucky has been awarded a three year implementation grant by the federal Human Resources and Services Administration, beginning April 1, 2006. Funds will be used to strengthen the state's efforts to maximize access to services within existing programs for children and adults with brain injuries, through the promotion of best practices. The project, known as *CLIP: Collaboration and Learning in Partnership*, has the following goals:

♦ Improve and enhance the capacity of existing service delivery systems to meet the needs of children and adults with brain injuries
♦ Develop consensus on the desired outcomes of services to children and adults with brain injuries, that reflect cultural competence
♦ Promote the use of promising and evidence-based practices in the delivery of services to children and adults with brain injuries

To achieve these goals, Project CLIP staff will be working closely with stakeholders, including people with brain injuries and their family members, service providers, and clinicians. Project CLIP activities will include the development of training and consultation materials for use by professionals, the organization of an annual conference on co-occurring disorders, and the development of recommendations for the integration of best practices into existing community-based services. Additionally, surveys and focus groups for people with brain injuries and their families are planned to obtain much needed information about the desired outcomes of services.

People with brain injuries or their family members, service providers, and clinicians who may be interested in participating in planned activities of Project CLIP are encouraged to contact Colleen Ryall, in the Brain Injury Services Branch, at 502-564-3615. Persons with disabilities and their family members may call toll free at 800-374-9146.

Research Briefs

Panzano et al. (in press). The innovation diffusion and adoption research project (IDARP): Moving from the diffusion of research results to promoting the adoption of evidence-based innovations in the Ohio mental health system. *New Research in Mental Health*, *16*. ~ Review by Lou Kurtz, TREaD

The Ohio Department of Mental Health (ODMH) has a longstanding focus on improving quality of care within its public mental health system. A major foundation of this effort is the establishment of Coordinating Centers of Excellence (CCOEs), structural mechanisms designed to facilitate the adoption and assimilation of evidence-based practices (EBPs) by county-level service providers. The Innovation Diffusion and Adoption Research Project (IDARP) which is associated with the CCOE initiative, focuses on two broad questions: 1) What factors and processes influence the adoption of innovations by behavioral healthcare provider organizations ? and 2) What factors and processes contribute to the longer-term assimilation and impacts of innovations by adopting organizations?

IDARP uses four models to guide the project:
Model 1: The Adoption Decision (focusing on the decision to adopt, or not to adopt, an innovation such as an EBP
Model 2: Multi-level Model of Implementation Success (expressing the idea that factors at many different levels of analysis impact implementation success)
Model 3: Cross-Phase Effects on Implementation Outcomes (representing the idea that aspects of each of the three key phases of the innovation adoption process are likely to impact the outcomes of implementation)
Model 4: Effects of Implementation Variables on Outcomes Over Time (incorporating two major messages – that past implementation policies may or may not explain what is currently being seen with regard to implementation outcomes and secondly, what is likely to matter most are present implementation policies and practices).

The study uses a longitudinal design to gather information about implementation efforts and outcomes as they progress. In Ohio, four EBPs (cluster-based planning, Multisystemic Therapy, Ohio Medication Algorithm Project, and Integrated Dual Disorder Treatment) and 91 behavioral healthcare organizations are studied to determine the usefulness of the four models on adoption and implementation success. Results of the project tend to confirm the applicability of the four models in providing practical guidance to organizations contemplating adopting or maintaining EBPs. Implications from this research include:

- Adoption decisions are made in a context of risk assessment;
- Attention needs to be paid to multiple levels during the implementation process;
- All phases of the decision and implementation process are important; and
- Successful implementation must be supported over time.

The IDARP project offers a useful framework for thinking about adoption and implementation processes as well as key lessons for state and local public mental health service systems contemplating the promotion of evidence-based practices by individual provider organizations.

Research Briefs *(continued)*

DeSantis, A.D. (2003). A couple of white guys sitting around talking - The collective rationalization of cigar smokers. *Journal of Contemporary Ethnography*, *32*, 432-466. ~ Review by Johnnie Woods, Substance Abuse Prevention

"Although he continued to interact as a patron throughout the three years covered by this article, DeSantis was carefully conducting an ethnographic study of the reasons that cigar smokers hold firmly to their defensive arguments."

DeSantis, an associate professor at the University of Kentucky in the Department of Communication, weaved findings from his three-year patronage of a local cigar shop into an interesting narrative from which he teased five pro-smoking arguments. DeSantis' proposal that the arguments serve as a "linguistic defense shield" for smokers when faced with anti-smoking messages is accompanied by frequent observations of the other cigar shop patrons. More than simply a store that sold cigars, the cigar shop was a meeting place for an eclectic group of primarily white males aged 30 to 65. Smoking and talking were the two most important group activities, with college basketball and the pro-smoking arguments the two main topics of discussion. Although he continued to interact as a patron throughout the three years covered by this article, DeSantis was carefully conducting an ethnographic study of the reasons that cigar smokers hold firmly to their defensive arguments. According to DeSantis, the regular patrons at the shop were engaging in group rationalization, and this served as the basis for their pro-smoking arguments. Generally, a discussion of one or more of the arguments would be precipitated by a health report or some anti-smoking remark from the news. Most often, the shop proprietor would begin the pro-smoking rebuttal to the health report or remark and one of the regular patrons would respond. As other regulars joined in, the discussion would continue. DeSantis pointed out that he observed no awareness among the patrons that they were participating in any group thinking, or rationalization. Following are the five pro-smoking arguments that were found to recur in the study.

- "All things in moderation" cannot hurt you.
- Cigar smoking is actually healthy: it relieves stress.
- Cigarette smoking is bad for your health, but it has not been scientifically proven that cigar smoking is bad.
- Cigar smoking research is flawed.
- Cigar smoking is much less dangerous than other "environmental" dangers.

DeSantis concluded with some recommendations for health promotion interventions that target cigar smokers. He suggested that following the recommendations would help considerably what is currently a weak and vulnerable approach to cigar smoking. DeSantis' approach—an ethnographic one—is a powerful one, as he first learned the perceptions of those in need of a health promotion intervention. This approach goes a long way towards eliminating costly, time-consuming "shot in the dark" substance abuse prevention.

Research Briefs *(continued)*

Smart, J. and Smart, D. (2006) Models of disability: Implications for the counseling profession. *Journal of Counseling and Development, 84,* 29-40. ~ Review by Linda McAuliffe, Mental Retardation

In this study, Smart and Smart provide an overview of four models of disability. The provision of counseling services to people with disabilities is influenced by how counselors conceptualize the experience of disability. The majority of counselors in various specialty areas, such as aging and adult development, community mental health, group counseling, and career counseling lack training and education about the experience of disability. People with disabilities want their social context and experiences to become a valued and acknowledged part of American life.

The first model discussed is the *Biomedical Model*, which is rooted in the scientific method and has a long history in the field of disability. This model views disability as a defect or dysfunction and therefore locates the problem within the individual. This view has perpetuated the notion that the person with a disability has a life that is worth less investment by the counselor. In reaction against this model of disability, two interactional models emerged, the *Functional and Environmental Models*. In these models, disability is redefined in relation to the individual's skills, talents, and abilities. Biological factors are recognized although limitations in society and the environment experienced by people are not considered disabilities. These models suggest that many of the difficulties and challenges faced by people with disabilities are located in the environment and its functional requirements, rather than with the individual. The fourth model, the *Sociopolitical Model*, is also referred to as the *Minority Model of Disability*. This is a fundamental departure from the previous models. This model rejects the dependent and inferior view of disability and defines disability as a social construct and a function of prejudice and discrimination. The hallmarks of this model include self-determination and the drive to achieve full equality under U.S. law.

The authors outline implications for the counseling profession based on this shift in attitudes and beliefs about the experience of disability, including the following:

- Counselors should be aware of the individual's feelings about the experience of disability as well as their own.
- People with disabilities want respect, not sympathy. They want helpful and honest feedback.
- Disability is only one part of a person's identity.
- Counselors should promote full participation and integration of people into their communities.
- Recognize and listen to the individuals' experiences of prejudice and discrimination.
- Counselors should broaden their vision of the experience of disability, recognizing possible gaps in their professional training.
- In order to provide effective services to people with disabilities, counseling professionals in all areas will be required to examine their conception of disability.

Research Briefs *(continued)*

Rush et al. (2006).Bupropion-SR, Sertraline, or Venlafaxine-XR after failure of SSRIs for depression. *New England Journal of Medicine*, *354*, 1231-1242 and Trivedi et al. (2006). Medication augmentation after the failure of SSRIs for depression. *New England Journal of Medicine*, *354*, 1243-1252. ~ Review by Tena Robbins, TREaD

Findings from the second phase of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) clinical trials were published recently in the *New England Journal of Medicine*. Funded by the National Institute of Mental Health, STAR*D is the nation's largest depression study and is part of a *Big Four* research series examining the effectiveness of treatment for major depression, bipolar disorder, adolescent depression, and schizophrenia. STAR*D is part of an overall NIMH effort to conduct practical clinical trials in "real world" settings that address public health issues important to those persons affected by major mental illnesses. This is the first study to examine the effectiveness of different treatment strategies for those who did not become symptom-free after initial medication.

One in three consumers whose depression was resistant to initial treatment using an antidepressant became symptom-free with the help of an additional medication, and one in four achieved remission after switching to a different antidepressant.

One in three consumers whose depression was resistant to initial treatment using an antidepressant became symptom-free with the help of an additional medication, and one in four achieved remission after switching to a different antidepressant. For the 15 to 20% of people who struggle with depression at some time in their lives, the results provide hope by showing that those whose depression is resistant to initial treatment can achieve remission when treated with a secondary strategy that either augments or switches medications. While additional research is needed, the importance of switching or adding different medications underscores the need to preserve broad access to a range of medications.

Interested individuals can read more about the STAR*D study at http://www.edc.pitt.edu/stard/public/index.html. The website contains extensive information for researchers, consumers, and clinicians.

Research Briefs *(continued)*

Hopkins, M., & Ramsundar, N. (2006). Which factors predict case management services and how do these services relate to client outcomes? *Psychiatric Rehabilitation Journal*, *29*(3), 219-222. ~ Review by Tena Robbins, TREaD

A central tenet of case management is that service provision be based on individual needs. Previous studies, however, have failed to show a relationship between status characteristics (e.g., client functioning) and amount of case management services provided. Given this finding, it is important to determine which other factors predict case management activity. This study explored two key questions: (1) what factors predict the intervention a case manager provides to individuals with serious mental illness over the course of 1 year? And (2) which aspects of the intervention—including working alliance and the amount, location, and content of support—predict community functioning outcomes?

Thirty (N=30) consumers with schizophrenia, 70% of which also had substance use issues, participated in the study. Case managers completed the Multnomah Community Ability Scale which assesses different aspects of community functioning and the Working Alliance Inventory which measures aspect of the therapist-consumer relationship, at program entry and again 1 year later. They also completed a daily contact log that captured the *amount of support* (minutes spent with consumer), *amount of indirect support* (number of telephone contacts with other stakeholders involved in care of the consumer), *location* of support (frequency of community visits), and *type* of support (content of support such as housing, vocation, social, medication, etc.).

Findings related to the first research question revealed that stronger working alliances, as perceived by the case manager at enrollment, predicted more support, more visits in the community, and a greater focus on activities of daily living and social skills. Results related to research question two found that improvements in community functioning were associated with stronger working alliances and the frequency with which housing and medication were discussed. Given the small sample size, these findings should be viewed as preliminary; however, they do suggest that stronger working alliances predict improved community functioning.

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Stronger working alliances predict improved community functioning

Research Briefs *(continued)*

Among the best predictors of youth outcomes were counselor interpersonal skills, therapist direct influence skills, youth willingness to participate in treatment, parent willingness to participate in treatment, youth participation in treatment, and parent participation in treatment.

Karver, M., Handelsman, J., Fields, S., & Bickman, L. (2005). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, *26*(1), 50-65. ~ Review by Tena Robbins, TREaD

Recently there has been an increasing emphasis in the youth and family mental health treatment literature on the use of empirically supported treatments (ESTs). In contrast there has been scant attention paid to more universal aspects of the therapy process that may have even greater impact upon therapy outcomes. According to the authors, it is likely that the success of the techniques proposed by ESTs may depend on the presence of common process factors. Extending their previous work describing a theoretical model linking common therapeutic relationship variables to youth outcomes, Karver and his colleagues conducted a meta-analysis of 49 youth treatment studies examining associations between therapeutic relationship variables and the extent to which they account for variability in treatment outcomes. Correlations between therapeutic relationship variables ranged from modest to strong. Among the best predictors of youth outcomes were counselor interpersonal skills, therapist direct influence skills, youth willingness to participate in treatment, parent willingness to participate in treatment, youth participation in treatment, and parent participation in treatment. This paper represents the most comprehensive analysis of therapeutic alliance in the youth treatment literature.

Solomon, L.J., Higgins, S.T., Heil, S.H., Badger, G.J., Mongeon, J.A., & Bernstein, I.M. (2006). Psychological symptoms following smoking cessation in pregnant smokers. Journal of Behavioral Medicine, 29(2), 151-160. ~ Review by Tena Robbins, TREaD

This study examined the relationship between smoking status and psychological symptoms in pregnant women across pregnancy. Participants were 45 women who quit smoking early in pregnancy (early quitters), 22 who quit later in pregnancy (later quitters), and 84 who smoked throughout pregnancy (never quitters). Assessments of smoking status and psychological symptoms (Brief Symptom Inventory and Beck Depression Inventory) occurred near first prenatal visit, second visit, and end of pregnancy. Results indicated that scores on the Global Severity Index of the Brief Symptom Inventory, several Brief Symptom Inventory subscales, and on the Beck Depression Inventory were highest among never quitters, lowest among early quitters, and intermediate for later quitters. Scores decreased across pregnancy, especially between first and second assessments. The study found no evidence that quitting smoking increased psychological symptoms either in the immediate post-withdrawal period or later in pregnancy. These findings should temper concerns that quitting smoking may have detrimental psychological consequences during pregnancy.

Research Briefs *(continued)*

Shaw, D.S., Dishion, T.J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: Two-year effects of the Family Check-Up in early childhood. *Journal of Consulting and Clinical Psychology*, *74*(1), 1-9.
~ Review by Tena Robbins, TREaD

Despite recent research indicating that the toddler period is one of the pivotal times for identifying pathways to early conduct problems, few family-based preventive interventions have been specifically designed to modify child disruptive behavior during this age period. This randomized trial tested the effectiveness of the Family Check-Up in sustaining maternal involvement and preventing the exacerbation of child conduct problems among 120 at-risk toddler-age boys, half of whom were randomly assigned to a treatment condition. The Family Check Up was associated with reductions in disruptive behavior and greater maternal involvement and was particularly effective for children at greater risk for a persistent trajectory of conduct problems.

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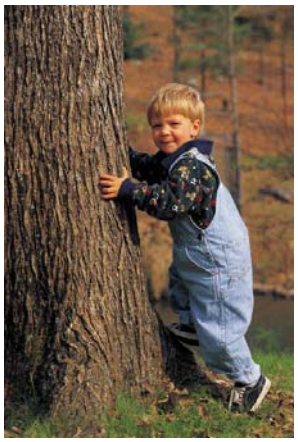

KENTUCKY BEHAVIOR INSTITUTE 2006: FROM RISK TO RESILIENCE
June 26-28, 2006, Lexington Convention Center, Lexington, KY
Registration Information at http://www.state.ky.us/agencies/behave/misc/bi01.html

MENTAL HEALTH ASPECTS OF INTELLECTUAL DISABILITY: DIAGNOSIS & TREATMENT
June 1 & 2, 2006, at Spalding University, Louisville, KY

For Registration Information, contact:
Becky Wolf-Klein or Bonnie Thorson Young at (502)459-5292 or
via email at rklein@sevencounties.org or byoung@sevencounties.org

REGISTRATION DEADLINE: MAY 19, 2006

"It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts."

Sir Arthur Conan Doyle
British mystery author & physician (1859 - 1930)

Policy Changes as Best Practice to Reduce Substance Abuse

~Contributed by Stan Hankins, Substance Abuse Prevention

Research on effective strategies to reduce substance abuse and related problems indicates that regulation and policy changes are among the most successful and cost efficient. Policy changes are effective for several reasons, assuming they are supported and consistently followed.

First, they limit the availability and accessibility of substances and opportunity for use. When there are deterrents to obtaining alcohol and other drugs accompanied by meaningful consequences for their use, *using behavior* generally declines significantly.

Second, policy changes send a message from the governing entity that this behavior is not acceptable; over time, this can impact prevalent attitudes towards substances and their use. Consider the impact of tobacco laws and policies over the years: they have been a significant factor in changing the nation's overall views of tobacco use.

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Third, regulation/policy changes are global in their reach. The change typically affects the entire organization or population. Finally, policy changes, once put into effect, are usually longstanding if not permanent, though they may be amended or modified on occasion.

When regulation and policy change is in the context of the workplace, the goal is to help bring about a solution – healthier, drug-free workers and a safe work environment. Policies calling for immediate termination of an employee that fails a drug test or violates a substance abuse policy may alleviate the problem for the company, but not necessarily for the employee and others. If this person is uninformed about the risks of substance use/abuse and is not assessed to determine if s/he has a possible abuse/dependency problem and then referred to an education or treatment program as needed, there is a high probability that the problem will persist and worsen. This person could move from job to job and continue to be a liability for the employer in terms of decreased productivity, continued rule/policy violations, and compromising the safety of the work environment. Therefore, we recommend policies that include provisions for education of employees about substance abuse and dependency, assessing those who either fail drug tests or violate a substance policy for substance abuse/dependency, and referral to either an early intervention program such as the Prevention Research Institute's Prime for Life program, or an appropriate level of treatment. State DUI laws that have requirements for first-time and repeat offenders are excellent examples that companies can follow for guidance in creating or upgrading their substance abuse policies.

Of course, in order for these policies to take hold and be effective, owners and administrators need to buy in to this concept and take ownership of creating and enforcing these policies. There is debate about who is responsible for the problems created by an individual's substance abuse, and it is easy to point fingers elsewhere. In reality, it is everyone's responsibility to confront and try to address a substance abuse problem they encounter, even though ultimately it is the individual who must decide whether or not to change behavior. The error is to take the position that it is somebody else's problem. This too is what employers need to understand.

While policy change is recognized as a proven strategy to reduce substance abuse and related problems, it should be noted that this is only effective when combined with other strategies, such as media campaigns to raise awareness about a substance abuse issue and programs to increase an individual's knowledge about risk and consequences of substance abuse. Substance abuse behavior and causal factors are complex, thus requiring comprehensive and often complex solutions. Also realize that prevention is a perpetual endeavor with desired results realized slowly and gradually, and that to some extent substance abuse, alcoholism and drug addiction will be with us no matter how comprehensive and effective our efforts are in the realms of prevention, intervention and treatment. Fortunately, the field of knowledge continues to grow, and we now know of evidence-based strategies and best practices that do work in reducing the risks of substance abuse, and policy strategies are among the most effective.

CHECK THIS OUT.....

CO-OCCURRING DISORDERS SERVICES ENHANCEMENT TOOLKIT

ZiaLogic is in the process of developing a complete array of implementation toolkits for behavioral health services. The company uses a network of qualified contractors to work with systems of all complexities, including state (provincial) agencies, networks, counties, and local agencies, programs, and provider associations. are available to systems, programs and clinicians to assist with system change initiatives and clinical development activities. Toolkits will be available to systems, programs and clinicians to assist with system change initiatives and clinical development activities.

The Co-Occurring Disorders Services Enhancement Toolkit is in production and specific tools are available for purchase through a non-exclusive license agreement and terms. This toolkit is designed to support the implementation of integrated services for individuals with comorbid psychiatric and substance use disorders.

Find out more at http://www.zialogic.org/Toolkit_1.htm

Lessons Learned from the Kentucky Medication Algorithm Project (KYMAP)

A retreat was held on March 7, 2006, in Louisville to discuss "lessons learned" from implementation of the Kentucky Medication Algorithm Program (KY MAP) at Central State Hospital (CSH), in conjunction with Seven Counties Services and Kentucky River Community Care. Modeled after the Texas Medication Algorithm Project, KY MAP is an evidence-based practice that provides treatment guidelines (an "algorithm") for prescribing medications based on the major diagnostic categories of schizophrenia and major depression. CSH was awarded three years of funding from SAMHSA to assess the usefulness of the *Medication Management Approaches in Psychiatry Toolkit* in a public mental health system. The "Lessons Learned" retreat focused on seven major topics: (1) Training; (2) Evaluation of training; (3) Implementation; (4) Fidelity; (5) Consumer Education; (6) Outcomes; and (7) Finance.

During the morning session, partners involved in grant implementation provided an overview of progress during the first 30 months of the grant. Each organization had a specific role in grant implementation. In addition to the service sites (Central State Hospital, Seven Counties Services, Kentucky River Community Care), other partners include the University of Kentucky College of Nursing (assessing fidelity of implementation), the University of Louisville Kent School of Social Work (evaluation), University of Louisville Department of Psychiatry (training), and Bridgehaven / Seven Counties Services (consumer education). The afternoon session focused on identification of strengths and weaknesses of the implementation effort. Major findings include:

Strengths identified by meeting participants:

- Introduced evidence-based practice language into the culture
- Use of objective measures (e.g., in describing medication responses) improved communication between clinicians and consumers
- Consumers provided positive feedback about the consumer education piece of the initiative
- Evidence-based practices helped demonstrate medical necessity
- Algorithm process may sharpen diagnoses
- Sharpened treatment planning goals support a recovery focus
- Created a baseline (e.g., outcome measures) where ones did not previously exist

Weaknesses identified by meeting participants:

- There was not full buy-in from all partner sites from the start of the project
- Prior authorization (for medications) can be an impediment to use of the algorithm
- Documentation required under the project did not mesh well with everyday outpatient clinic work flow
- Problems with the web-based application led to duplication of documentation (working with paper forms that then needed to be entered into the web-based format)
- Grant goals and timelines may have been too ambitious
- Training was costly and time intensive

The results of the retreat will be used (along with other documentation) to develop a case study of the overall implementation effort. R.E.A.C.H. of Louisville, Inc. will work with the Department to craft a report that will be used to move forward with implementation of KYMAP in other parts of the mental health system. The Evidence-Based Practices Advisory Group will assist in

(Continued on page 13)

(Continued from page 12)

assessing the effort and "lessons learned" and providing feedback to the Department. Recommendations for implementation of KYMAP at other service sites will be developed over the next several months and used to inform the next phase of implementation.

To learn more about KYMAP and related initiatives, please contact Louis Kurtz, Best Practice Coordinator, at Louis.Kurtz@ky.gov or (502)564-4860.

FAST FACTS

Treatment Admissions for Substance Abuse among Clients with Co-Occurring Disorders in Kentucky Treatment Episode Data Set (TEDS): 1998-2004*

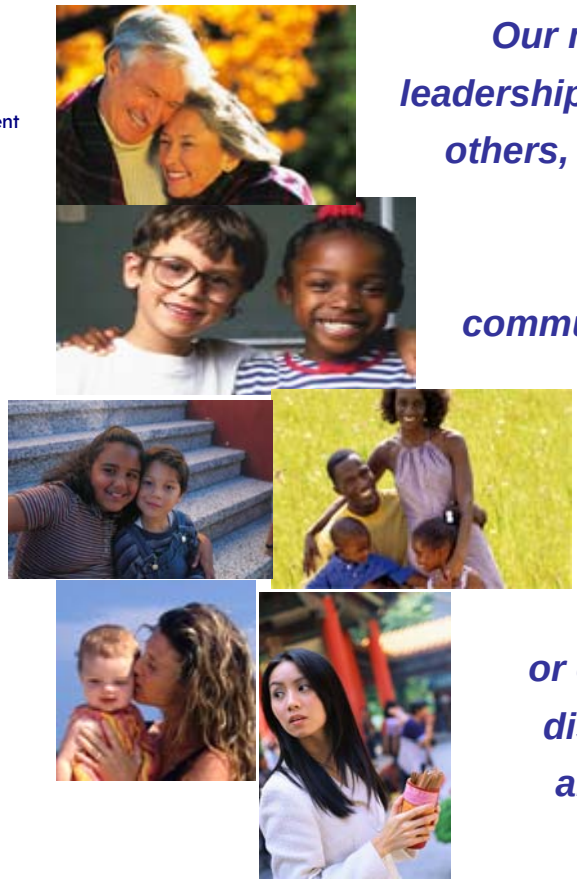
- From 1998 to 2004, treatment admissions for co-occurring disorders (substance abuse and a psychiatric problem) in Kentucky's Community Mental Health Centers increased by 5% (from 9,874 to 10,367); while, treatment admissions for substance abuse problems alone sharply increased by 77% (from 5,654 to 10,021).
- Between 1998 and 2004, female admissions were likely larger for co-occurring disorders (37 and 46%) than for substance abuse problems alone (24 and 30%); contrarily, male admissions were likely smaller for co-occurring disorders (63 and 55%) than for substance abuse problems alone (76 and 70%).
- The average age at admission was likely to be slightly one year older for co-occurring disorders than for substance abuse problems (average age of 33.9 vs. 32.6 in 1998 and 35.1 vs. 32.9 in 2004, respectively).
- From 1998 to 2004, alcohol was the most common primary substance of abuse among admissions for co-occurring disorders and for substance abuse problems, followed by marijuana, and cocaine.
- Older age was associated with a larger proportion of alcohol admissions.
- Clients who had co-occurring disorders at younger ages (under 18 and 18 to 24) were likely to have larger marijuana admissions than other age groups.
- Clients who had co-occurring disorders were more likely to seek treatment themselves than those who had substance abuse problems alone; whereas, those who had substance abuse problems alone were more likely to be referred by the criminal justice system.

*From the report of "Treatment Admissions for Substance Abuse among Clients with Co-Occurring Disorders in Kentucky TEDS: 1998-2004"

For more information, contact Hoa Van Le, Data Analyst, at Hoa.Le@ky.gov or (502)564-4860.

Department for MH & MR Services
Division of Administration & Financial Management
Training, Research, Evaluation, & Dissemination
100 Fair Oaks Lane, 4E-A
Frankfort, KY 40621-0001

Phone: 502/564-4860
Fax: 502/564-3844
TTY: 502/564-5777



Our mission is to provide leadership, in partnership with others, to prevent disability, build resilience in individuals and their communities, and facilitate recovery for people whose lives have been affected by mental illness, mental retardation or other developmental disabilities, substance abuse, or an acquired brain injury.

Visit our website at http://mhmr.ky.gov/kdmhmrs/

Best Practice Resource Corner

From Study to Action: A Strategic Plan for Transformation of Mental Health Care (February 2006) is based on the notion that by weaving together the findings and recommendations of four key policy reports (Institute of Medicine's *Quality Chasm*, President's New Freedom Commission Report, SAMHSA's *Federal Action Agenda*, and the Institute of Medicine's Improving *the Quality of Health Care for Mental and Substance-Use Conditions*), the mental health and substance use fields have at hand the consensus framework and tools required to develop a more coherent, coordinated and effective national plan and strategy for systems transformation that is responsive to the concerns and responsibilities of all stakeholders. The monograph is publicly available at www.healthcarechange.org

Best Practice Implementation in Kentucky's Public Mental Health & Mental Retardation System (March 2006) is now available for download at http://mhmr.ky.gov/kdmhmrs/