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ORIGINAL PAPER

Integrated Treatment Group Curriculum for People with Serious Mental Health Conditions Who Use Substances

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Abstract

Without proper treatment, people with co-occurring mental health and substance use problems are at great risk for poor outcomes and high treatment costs in multiple domains. Intermediary organizations can provide support to programs implementing integrated treatment and other evidence-based practices; this includes developing practical tools for programs built to encourage fidelity to a particular practice. In this paper, we describe a group curriculum workbook designed to help practitioners provide integrated treatment with fidelity and a pilot learning collaborative to evaluate whether this workbook is a helpful tool for programs to support people with serious mental health conditions and substance use in identifying and achieving personal goals. Results of the pilot found that nearly all participants demonstrated progress with respect to their identified goals, and group facilitators reported that the workbook was easy to use, that participants enjoyed the material, and that they intended to continue offering the group as part of their regular programming.

Keywords Co-occurring · Wellness · Behavioral health · Mental health · Substance use · Intermediary

Introduction

Without proper treatment, people with co-occurring mental health and substance use problems experience poor outcomes and incur high costs in multiple domains (Drake & Brunette, 1998). Evidence-based integrated treatment for co-occurring mental health and substance use problems, where a single practitioner or team helps the consumer address both mental health symptoms and substance use (SAMHSA, 2009), may mitigate hospitalizations and other risks, reduce treatment costs, and promote individuals' recovery, independent living, and employment (Drake et al., 2004, 2006; Grella & Stein, 2006). Implementing integrated treatment includes programmatic changes and understanding a person's needs to match specific treatments to those needs. This includes screening for both mental health symptoms and substance use problems; conducting an integrated assessment including the interaction between mental health symptoms and substance use; and providing evidence-based interventions matched to specific needs (e.g., motivational interviewing to engage and support motivation to address specific behaviors, medication to treat mental health symptoms or substance use) (Center for Substance Abuse Treatment, 2006; SAMHSA, 2020). Additionally, updating policies and procedures to support integrated treatment, making educational materials around co-occurring disorders available to people, providing staff training around co-occurring disorders, and providing supervision to coach staff in providing integrated treatment are also key to the implementation of integrated treatment (Gotham et al., 2011). While implementing these various components takes time, behavioral health programs can begin to make small changes that incrementally increase their capability to provide integrated care (Minkoff & Covell, 2022).

Intermediary organizations (Franks & Bory, 2015; Proctor et al., 2019) can provide support to programs implementing integrated treatment and other evidence-based practices. The Center for Practice Innovations (CPI) is an intermediary organization funded by the NYS Office of Mental Health to train behavioral healthcare providers working in NYS-run or licensed programs in evidence-based practices and support implementation to sustain improvements over time. One

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of the practices that CPI supports is integrated treatment for people with co-occurring mental health and substance use problems. CPI offers an array of training and technical assistance including: basic technical assistance by building awareness and knowledge through newsletters, website, manuals and workbooks, webinars, and eLearning courses; targeted technical assistance including regional face-to-face meetings, on-site training, remote consultation, learning collaboratives, and coaching in the field by implementation specialists designed to increase staff competency; and intensive technical assistance through ongoing consultation, supervision, fidelity monitoring with performance feedback, practice facilitation, and site visits (Covell et al., 2014; Patel et al., 2022).

In this paper, we describe a group curriculum (workbook) designed to help practitioners provide integrated treatment with fidelity and a pilot learning collaborative to evaluate whether this workbook is a helpful tool for programs to support people in identifying and achieving personal goals. Learning collaboratives (Institute for Healthcare Improvement, 2003) have been used to disseminate evidence-based practices in general medical care and behavioral health care (ØVretveit et al., 2002; Schouten et al., 2008). Common components of learning collaboratives are in-person learning sessions, plan-do-study-act (PDSA) cycles, multidisciplinary quality improvement teams, and data collection to inform quality improvement (Nadeem et al., 2013).

Group Curriculum

Wellness Self-Management (WSM), an adaptation of the practice known nationally as Illness Management and Recovery (Mueser et al, 2002) is a recovery-oriented, curriculum-based group designed to help people with serious mental health conditions make informed decisions, set goals, and take "action" steps toward recovery (Salerno et al., 2011). CPI was awarded a SAMHSA Science and Service award for the development of WSM in 2010. The curriculum is organized into 57 lessons, each of which follows a specific format that promotes consistency and fidelity across group facilitators. Specifically, following the ROPES format—Review, Overview, Presentation, Exercise, Summary (Cohen et al, 1985), each lesson begins with a review of the prior lesson and discussion of any action steps taken, a discussion with group members around a new topic and why it is important, a personalized worksheet related to the topic, specific action steps related to the topic, and a summary of the lesson and discussion. This format incorporates important information about each topic with motivational, educational, and cognitive-behavioral approaches so that, by simply following each lesson's structure and content, practitioners are using these competencies and providing essential knowledge. Each group participant has their own workbook that they use to identify personal goals (see Measures below) and self-directed action steps. While the workbook does not dictate how often the group should meet, most facilitators offer the group weekly for one-hour for 57 weeks (sometimes longer if a topic is better covered across multiple groups) (Salerno et al., 2011).

In response to high levels of interest across NYS, the authors worked closely in 2009/2010 with experts from the New York State Office of Mental Health and New York State Office of Addiction Services and Supports (OASAS) to develop a version of WSM that is designed for individuals who are simultaneously managing mental health symptoms and substance use. This program is called Wellness Self-Management Plus (WSM+) and it consists of revisions of WSM's 57 lessons that reflect an emphasis on dual recovery. For example, "Visions of Recovery" was revised to include quotes/descriptions from individuals with substance use issues as well as mental health difficulties; "Using Self-Help and Peer Support" was revised to include 12-step programs; and a series of WSM lessons entitled "Practical Facts about Mental Health and Mental Illness" became "Practical Facts about Mental Health and Substance Use Problems". As with WSM, this format incorporates important information about each topic with motivational, educational, and cognitive-behavioral approaches so that, by simply following each lesson's structure and content, practitioners are using these competencies and providing essential knowledge. Anecdotal reports from group leaders indicated that even group leaders without extensive expertise with substance use disorders or prior training in motivational, educational, and cognitive-behavioral approaches, were able to lead groups with competence and confidence. In July 2020, the authors worked with OASAS and internal subject matter experts to update the workbook to include tobacco as an addiction and to update language (e.g., changing substance abuse to substance use or substance misuse). Topics include (but are not limited to): "Recognizing and Using Your Personal Strengths to Support Recovery"; "Understanding the Connection between Mental Health and Substance Misuse"; "Exploring Your Personal Life Goals; Understanding Barriers that Get in the Way of Achieving Goals"; "Understanding How Substance Misuse and Addiction May Harm Your Mental and Physical Health"; "Understanding Pros and Cons of Substance Misuse"; "Making Important Decisions: Knowing your Personal Readiness to Change"; "How Your Cultural, Religious, and Family Background Affects the Decisions You Make about Mental Health and Addiction Treatment"; "Using Self-Help and Peer Support"; "Practical Facts about Mental Health Problems, Substance Misuse and Addictions"; "Understanding and Preventing a Relapse"; "Developing Your WSM+ Plan"; "Healthy Lifestyle, Tobacco Use, E-cigarettes/vaping and Recovery". The WSM+ workbook is available for free download in

English and Spanish from CPI's website (https://practiceinnovations.org/products/outside-new-york#FeaturedCoursesList).

To explore whether the WSM+ revised workbook produced similar outcomes to previously reported findings for the WSM workbook (i.e., that it was a helpful tool for programs to support people in identifying and achieving personal goals; Salerno et al., 2011), we facilitated a learning collaborative with 15 community-based psychosocial rehabilitation programs to support them in initiating and running Wellness Self-Management Plus (WSM+) groups at their program.

Methods

Participating Programs

In February 2020, we invited community-based Personalized Recovery-Oriented Service programs (PROS) to join a learning collaborative to support them in initiating and using the Wellness Self-Management Plus (WSM+) curriculum in their integrated treatment groups. PROS programs are comprehensive recovery-oriented psychosocial rehabilitation programs for people diagnosed with serious mental illness, the majority of whom also use at least one substance, including tobacco. These programs aim to integrate treatment, support, and rehabilitation activities to facilitate a person's recovery. PROS programs offer people in-person day-long services focused heavily on group treatment. PROS programs receive a monthly base rate per person served. If a person receives integrated treatment during a month, including stage-based groups, the program also receives an additional payment for that person as an add-on to that person's monthly base rate. Specifically, these programs offer groups for people in earlier stages of change (motivation groups) and for those who are in later stages of change (active treatment/relapse prevention groups). The WSM+ curriculum is ideal for people who are currently using one or more substances and are in an earlier stage of change for at least one substance (motivation groups). In earlier stages of change, it is often helpful to have people identify personal goals and the ways in which mental health symptoms and substance use may be getting in the way of achieving those goals. The WSM+ curriculum lessons are designed so that people can identify goals, steps toward achieving those goals, and any ways in which mental health symptoms and/or substance use might be getting in the way. The curriculum also includes a lesson specifically about stages of change that includes an activity for a person to identify their stage of change. The group then discusses how making a change might help them achieve their goals. While we encouraged programs to offer this group to people who were using one or more substances, including tobacco, some programs allowed people who did not use substances to join if they expressed an interest (e.g., because they had people they cared about who were using substances or to learn more about how substances might impact their life if they started to use alcohol, tobacco, or other drugs).

Measures

Programs submitted monthly performance indicators from January 2021-July 2022 via an online Qualtrics form. (While the learning collaborative meetings ended in December 2021, programs agreed to provide ongoing group information for an additional seven months.) Programs responded to the following questions (if programs facilitated more than one WSM+ group they answered the questions for each group): (1) Did you offer at least one WSM+ group in the past month?; (2) WSM+ group name; (3) Lessons covered; (4) Average number of people who attended the group; (5) How many times did the group meet last month?; (6) Group Delivery Method (in person, remote, or both); and (7) If anyone joined remotely, please indicate how they joined (video, phone, or both).

During spring and summer 2021 participating programs also provided deidentified information about group members' personal goals. Members completed a worksheet from the WSM + workbook (Appendix A: Quality of Life Goals Progress Checklist) or informed their group facilitators verbally of their goals, and group facilitators provided the information via an online Qualtrics form. The "Quality of Life Goals Progress Checklist" includes goals such as "Working towards a diploma or academic degree, continuing my education, or learning a trade in school", "Socializing with friends (spending enjoyable time with others) in relationships that are healthy", "Contributing to my community in a useful way (e.g., volunteering, joining a self-help or peer advocacy group)", and "Being confident that I can handle my mental health and substance misuse problems and not relapse." In December 2021, we reached out to group facilitators for updates on group participant's initial goals; the checklist includes three options, "No Improvement," "Improvement," or "I've Achieved This." Group facilitators asked participants to provide a self-reported update and/or reviewed people's medical records for evidence of improvement. Staff members' attendance at learning collaborative meetings was captured through CPI's learning management system (LMS).

Procedures

In September 2020, we held a kickoff meeting for participating programs. During this meeting, participating programs committed to having their WSM+ group

facilitators and a supervisor or program director take part in all LC activities including an initial training in WSM+, attending monthly 1-hour LC meetings, and submitting monthly performance indicators. In addition, programs agreed to provide at least one WSM+ class each week, starting no later than January 2021, using the WSM+ workbook. Following the kickoff, CPI staff convened group facilitators and program leadership in smaller training groups (3–8 people; 7 groups in September and October 2020) to review the WSM+ workbook, the ROPES method for facilitating groups, and role play facilitating a WSM+ lesson. After watching an experienced CPI expert model the leading of a group, each participant "played" the group facilitator for 10–15 min and then received feedback from the group and CPI. This was followed in November 2020 by an implementation planning meeting where participating programs were encouraged to use an implementation guidance document to plan the rollout of WSM+ groups at their programs.

Monthly Learning Collaborative meetings began in December 2020 and continued through September 2021. In October and November 2021, programs requested that we meet with each participating program individually for more targeted technical assistance. To provide more individualized attention and a better experience, the group of 15 PROS programs was divided into two cohorts that each met monthly following the kickoff and initial training. CPI led the online meetings, providing tools (e.g., group facilitator one-page guide) and consultation to support implementation of WSM + groups and facilitating discussion of progress and challenges in starting groups, engaging group participants, navigating technology (due to not meeting in-person), and other challenges raised by group facilitators. CPI encouraged program-to-program interaction in the online meetings through features such as polling questions, a chat box, role playing, and open discussion.

Analysis

Using SPSS, we applied descriptive statistics to characterize participation among programs, attendance at the WSM+ groups, and participant goals. The New York State Psychiatric Institutional Review Board determined that this evaluation did not meet the definition of human subjects research.

Results

Program Characteristics and Participation

Eighteen PROS programs volunteered to participate in the Learning Collaborative scheduled to begin in Spring 2020. The Learning Collaborative (LC) was originally designed as a blended in-person and virtual yearlong activity. However, due to the COVID-19 pandemic and consequent shift in services and priorities, the Learning Collaborative was postponed until Fall 2020 and shifted to a fully virtual format. Fifteen (83%) of the 18 PROS programs that initially volunteered joined the Fall 2020 learning collaborative.

The 15 programs participated from 11 agencies spanning 4 of 5 New York State regions. Of the 15 participating programs, 14 (93%) were considered primarily urban, with the remaining program considered a "metropolitan area with high commuting of 30% or more to an urban area" (https://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx). Of the 15 participating programs, 14 (93%) provided summary demographic data for service recipients for the period of 1/1/2021–12/31/2021 (available from the NYS OMH website: https://my.omh.ny.gov/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPROS%2F_portal%2FPROS&Page=Home&nquser=BI_Guest&nqpassword=Public123#reports). The 14 programs with data served predominately men (average percentage of men served was 66.6% (SD = 17.8%; range = 45.5% to 100%). Service recipients were most often identified as White (48.6%, SD = 17.4%), followed by Hispanic (27.0%, SD = 23.6%), Black (25.1%, SD = 11.1%), Unknown (8.7%, SD = 0.6%), Other (8.6%, SD = 4.6%), and Asian (5.8%, SD = 2.4%). Programs participated in an average of 78% of learning collaborative meetings (SD = 16%, median = 80%, mode = 90%).

WSM+ Group Attendance

Of the 15 programs that joined the pilot learning collaborative, 14 (93%) were able to offer the WSM+ group in 2021. The remaining program was unable to offer the group when a temporary relocation to accommodate building reconstruction was delayed due to the pandemic. This program continued to regularly attend collaborative meetings and planned to begin offering the WSM+ group once they were able to return to their building. Most programs were able to offer weekly WSM+ groups for at least 10 of the 12 months during the pilot learning collaborative (Table 1). Programs varied in their ability to offer groups virtually (members could attend with or without a camera) or in-person, largely due to the COVID-19 rates in their communities. Even those who were able to offer programs in-person had to significantly restrict the number of group attendees due to distancing requirements related to COVID-19 guidelines. Four (29%) were only able to offer the group virtually, three (21%) were able to offer all groups in-person, and the remaining seven (50%) offered groups virtually or hybrid at first, transitioning to in-person groups once it was safe for people to return

Table 1 Wellness self-management plus group performance indicators

Program	N monthly groups N out of 12)	Typical number of group Participants	Format (N)
1	11	1–2	Virtual (11)
2	12	8–10	Hybrid (3), In-Person (9)
3	5	4–7	In-Person (5)
4	10	3–6	In-Person (10)
5	10	5–8	In-Person (10)
6	10	2–3	Virtual (10)
7	3	5–7	Virtual (2), In-Person (1)
8	12	2–5	Virtual (2), Hybrid (9), In-Person (1)
9	11	3–4	Virtual (6), In-Person (5)
10	12	6–9	Virtual (7), In-Person (5)
11	12	2–4	Virtual (3), Hybrid (9)
12	9	3–4	Virtual (9)
13	12	2–8	Virtual (4), In-Person (7), Hybrid (1)
14	11	2–4	Virtual (11)

Hybrid groups were offered so that participants could join either virtually or in-person

to the site. Program 7 offered a few groups virtually at the beginning of the collaborative, took a pause for 8 months, and then re-started the group in-person in the final collaborative month.

Group format played a role in how well the WSM+ group was attended. Virtual-only groups averaged 2–3 people per session, whereas in-person-only groups averaged 5–6 people. Group leaders reported that it was harder to engage members virtually and some members did not have access to or were not able to use the technology needed to access the group. Independent of format, group leaders used a range of strategies to broaden the group's appeal and attendance. These strategies included developing a group name that was engaging and inviting; sending welcoming letters to new registrants; mailing workbooks to participants; assisting with technology (e.g., installing a video platform on people's phones and teaching them how to use it); outreach when people did not attend, including follow-up with a person's clinician; adjusting the time of the group to maximize attendance; opening the group to new members (versus running a closed group); offering in-person groups outside; empowering members to select group topics and order of topics; adding additional topics that people wanted to address (e.g., gambling, food addiction, holiday stress); and inviting guest speakers for some topics (e.g., nurse for the lesson entitled, "Getting Help for Your Physical Health Problems").

Participant Goals

Of the 14 programs that offered WSM+ groups, 12 (86%) submitted information about participant goals. Across programs, 109 Participants listed an average of 3.65 goals (SD = 1.95, median = 3, mode = 2, range = 1 to 12). Across participants, the top five goals were improving physical health (n = 52, 48%), having a good relationship with one or more family members (n = 46, 42%), socializing more with friends (n = 43, 39%), stopping or reducing substance use (n = 40, 37%), and working at a paid job (n = 36, 33%). Of these 109, we received updates for 34 (31%) people. Of those, 33 (97%) showed improvement toward or achieved at least one goal, including 8 (24%) who achieved at least one goal. The remaining person had stopped attending the group after the first few meetings.

Discussion

The purpose of this paper was to describe a group curriculum, WSM+, designed to help practitioners provide integrated treatment for people with serious mental health conditions and substance use with fidelity. Further, we planned to explore whether applying it in practice would yield outcomes similar to those reported for the WSM workbook (Salerno et al., 2011). In the current pilot study, 97% of participants for which we had follow-up data demonstrated progress with respect to their identified goals, which compares favorably to the 75% reported by Salerno et al. (2011). Group facilitators reported that the workbook was easy to use (including those without prior specialized substance use disorder or integrated treatment training), that participants enjoyed the material, and that they intended to continue offering WSM+ groups as part of their regular programming.

One important finding was that most of the top goals for participants included areas not specifically associated with behavioral health symptoms: these included health,

relationships, and employment. When people are in earlier stages of change, understanding their goals and values is an important first step in engaging people in conversations around recovery. When mental health symptoms and/or substance use begin interfering with these goals, people are more motivated to make changes to address symptoms and/or reduce substance use. The WSM+ curriculum both allows facilitators to understand what people value and helps people see their mental health symptoms and substance use as potential barriers to achieving those goals. These findings are also consistent with a recent survey of about 4,000 recipients or providers of behavioral healthcare throughout New York State that found people prefer integrated person-centered care focused on wellness, recovery, empowerment, and person-centered (individualized) goals including health, finding meaningful work, building supportive relationships, and community inclusion (The New York State Office of Mental Health Training and Technical Assistance Huddle, 2021).

Another observation is that despite the challenges presented by the COVID-19 pandemic, sites made great efforts to adapt their implementation of this curriculum and continue to offer the WSM+ group program. As noted previously, sites differed in their use of remote, hybrid and in-person service delivery. The material was valued to such an extent that most sites continued to offer WSM+, even as the pandemic continued, and many recipients continued to participate in the groups offered.

That said, the most significant challenge and limitation for the pilot study was how the COVID-19 pandemic impacted the WSM+ groups. It is unclear whether the groups would have attracted more participants if offered in a setting similar to pre-pandemic conditions. Even programs that were able to provide in-person groups did so within pandemic protocols which typically limited the number of group participants, required masking, and required social distancing between group participants. Programs reported that it was particularly challenging to engage clients in treatment during the pandemic which may have impacted both the attendance numbers and the number of people with updates around their personal goals. Even so, the data do suggest that, even with these challenging circumstances, some people were able to make progress toward or achieve important personal goals. Further, having the WSM + group available during the pandemic was particularly helpful, because people with co-occurring substance use and mental health symptoms lost many sources of support, and there was a demonstrable increase in mental health symptoms, substance use, and suicidal ideation during the pandemic (Czeisler et al., 2020, 2021). Clearly, future research is needed to further test the WSM+ workbook in fully operational programs.

The pilot study had some additional limitations worth noting. First, the small number of self-selected programs limit generalizability. Future research is needed with a larger number of programs and program types. Second, we did not include measures of group facilitator skills. While the workbook is designed so that following the structure ensures fidelity, it would be helpful if future studies assessed this directly. Third, some of the group facilitators left during the course of the learning collaborative year. While we met with new group facilitators to provide some additional support, it is unclear what impact this turnover may have had on the groups. Fourth, outside of the workbook goals, we did not collect group participant measures such as stages of change for mental health and substance(s) used, mental health diagnoses and which substance(s) they used or other demographic characteristics. Future studies should include these client-level measures to help refine the understanding of outcomes. Finally, it is possible that the people for whom we had goal updates were systematically different from the larger sample. Future studies should include strategies to encourage more systematic follow-up with group members.

In conclusion, data from this pilot learning collaborative suggest that the WSM+ workbook is acceptable to both group facilitators and group members and, even in difficult circumstances, facilitates a process whereby people can set and work toward meaningful recovery goals.

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Declarations

Conflict of interest The authors have no relevant financial or non-financial interests to disclose.

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