Implementing Interventions for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders

A PATH Technical Assistance Package

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

March 1998

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Prepared for:
The Projects for Assistance in Transition from Homelessness Program

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
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March 1998

Prepared under contract to:
Advocates for Human Potential
Sudbury, MA

Acknowledgments

The Center for Mental Health Services Projects for Assistance in Transition from Homelessness (PATH) Program wishes to thank those individuals whose hard work and expertise contributed to completion of this technical assistance package. James T. Winarski, M.S.W., researched the document and prepared and edited the text under contract to Advocates for Human Potential in Sudbury, MA. Fred C. Osher, M.D., Associate Professor and Director of Community Psychiatry at the University of Maryland School of Medicine, reviewed and commented on earlier drafts. Susan Milstrey Wells of Waterford, NY, formatted and edited the final report.

Thanks also to Neal Shifman, M.A., President/C.E.O. of Advocates for Human Potential and Michael Hutner, Ph.D., PATH Director, Center for Mental Health Services, for reviewing and commenting on earlier drafts.

Special thanks to Kelli Pastor, Administrative Assistant at Advocates for Human Potential for assistance with producing the text and her good cheer.

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Introduction

Programs receiving PATH funds represent the first response for people with a myriad of social problems that have been the most difficult for traditional programs to address. PATH providers have identified the treatment needs of homeless individuals with co-occurring mental health and substance use disorders as especially difficult (AHP needs assessment of PATH front-line providers). Problems in assessing the relative contribution of co-occurring disorders to present mood, thought, or behavioral abnormalities, in effectively engaging and preparing clients for treatment and recovery, and in matching appropriate treatment approaches to the varying needs of individual clients present special challenges.

PATH programs serve individuals who are disaffiliated from mainstream culture and who have had negative experiences with service providers. In addition, PATH providers have to respond to the rapidly changing and ever increasing demands of clients while coordinating services in a fragmented and sometimes contentious system of care. The diverse and complex kinds of problems that practitioners encounter at both the program and systems level can be formidable.

In spite of the many challenges, the field has made significant advances in recent years. Models for providing effective services have been developed and tested. Programs have acquired a wealth of practical experience and have begun to document effective approaches to helping some of the most poorly served individuals in our treatment system.

Advocates for Human Potential (AHP) has prepared this technical assistance package to make state-of-the-art research and program information available to front-line practitioners in local PATH programs to help them reach out and provide effective treatment. This package provides a select bibliography, presents information from field-tested models, draws upon the most current

academic literature, and focuses on strategies for overcoming problems that are common to front-line practitioners.

Because PATH programs often serve individuals who are actively using substances and are not engaged in treatment, this package focuses on early intervention strategies common to the engagement and persuasion phases of treatment. These include developing effective helping relationships; creating readiness to make positive changes; providing assessment, treatment planning, and coordination; and implementing critical treatment modalities. The overall goal is to provide up-to-date information and practical intervention strategies to enhance the level of practice in local PATH-funded programs.

Using this Document

This technical assistance document is divided into three major sections that discuss client characteristics, treatment principles, and program planning. Chapter 2 provides background information about the unique attributes of homeless individuals with co-occurring disorders.

Chapter 3 features a summary of service approaches and treatment principles associated with effective responses to the needs of homeless individuals with co-occurring disorders. These theoretical foundations provide the basis for the strategies and interventions described in Chapter 4.

Finally, abstracts and contact information for the Center for Mental Health Services/Center for Substance Treatment dual diagnosis treatment demonstration projects are included in Appendix A.

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Characteristics and Treatment Needs

This chapter provides background information about the characteristics and treatment needs of homeless individuals with co-occurring disorders. It includes

- a summary of epidemiological data on the prevalence of co-occurring disorders;
- classification models for describing the primary relationships between substance use and psychiatric disorders;
- a summary of the unique attributes that distinguish this population and have significant implications for treatment;
- a Checklist of Common Consequences of Substance Abuse in Persons with Severe Mental Illness (© 1995 Robert E. Drake), which highlights areas that require specific intervention strategies; and
- a brief summary of findings from recent government-sponsored demonstration programs that provide a wealth of information about field-tested approaches to serving this population.

Epidemiological Data

Prevalence Rates among the General Population

The National Comorbidity Survey (NCS) (Kessler, et al., 1996) reports that co-occurring mental health and substance use disorders are highly prevalent among the general population. In addition, individuals with either a mental health or

substance use disorder are at increased risk for developing co-occurring disorders. The mental health disorders that are the focus of this survey include mood disorders, anxiety disorders, and antisocial personalities. Schizophrenia spectrum disorders were not included because of the small number of people with this condition in the NCS sample and the extremely high co-morbidity of psychosis with other mental disorders.

The lifetime prevalence rates for co-occurring disorders are remarkable: between 41% and 66% of respondents with a lifetime addictive disorder also have a lifetime history of at least one mental health disorder. Of those respondents with one or more lifetime mental health disorders, 51% also have at least one addictive disorder. The rates for 12-month prevalence were between 33% and 53%, and 15%, respectively. These results compare with the National Institute of Mental Health's 1989 Epidemiological Catchment Area (ECA) Study where 29% of individuals with a lifetime mental health disorder also had an addictive disorder. Of those with a lifetime alcohol disorder, 37% had a co-occurring mental health disorder, and of those with a lifetime drug disorder, 53% had a co-occurring mental health disorder (Regier, et. al., 1990).

Kessler, et al. (1996) explains that the higher prevalence rates in the NCS study are due in part to differences in study design. However, the high lifetime prevalence rates in both studies are far beyond the level of chance and have significant implications for direct service providers. Any person providing care to individuals with mental health or substance use disorders should assume that there is a strong probability of a co-occurring disorder. The data from these studies support the need for routine screening of co-occurring disorders for any client diagnosed with a single disorder, and for accurate assessments that can distinguish key factors related to both disorders.

Prevalence Rates among the Homeless Population

The homeless population presents special methodological challenges for collecting accurate epidemiological information. Consequently, early estimates of prevalence rates for mental health, substance use, and co-occurring disorders varied greatly by study (Fischer and Breakey, 1991). In a more recent methodologically sophisticated study, Lehman and Cordray (1993) report a 30% lifetime prevalence rate of mental health problems, a 60% lifetime prevalence rate for substance use disorders, including a 47% rate for alcohol use disorders and a 34% rate for drug use disorders. The lifetime prevalence rate for co-occurring mental health and substance use disorders among the homeless population was 23%.

The high prevalence rates of mental health, substance use, and co-occurring disorders among homeless individuals highlights the need to screen for both mental health and substance use disorders and to screen routinely for the

presence of a second disorder. A broad range of treatment options should be available to meet the needs of people with co-occurring disorders.

Homelessness and Co-Occurring Disorders: Defining Key Relationships

Understanding the Social and Cultural Context

Practitioners addressing the problem of co-occurring disorders among the homeless population must recognize both the complex nature, and the broad social and cultural context, of these disorders. Programs need to be responsive to a broad range of psychosocial problems that are significantly complicated by the conditions of poverty, homelessness, and the presence of co-occurring disorders. These problems may contribute to the onset of homelessness, but they may also result from homelessness. For example, serious mental illness may increase a person's vulnerability to losing his/her home. However, homelessness is invariably stressful and may exacerbate the symptoms of a mental health disorder (Drake, Osher, and Wallach, 1991).

Homeless individuals with co-occurring mental health and substance use disorders face the challenge of living with multiple impairments and disabilities, while also struggling to meet immediate survival needs for food, clothing, and shelter. Many of these individuals also experience general medical illnesses, legal problems, histories of trauma, behavioral problems, skill deficits, and a lack of connection to meaningful supports (Fischer, 1990).

These unstable conditions severely compromise efforts to recover from illnesses and/or addictions. Indeed, it is not realistic to think that we can provide fully adequate mental health and substance abuse treatment to people who are without a home (Drake, Osher, and Wallach, 1991). Yet these individuals have an urgent need for treatment services and supports. Programs serving this population play a vital role in helping these vulnerable individuals develop meaningful connections to the people and institutions that provide critical assistance. They also offer direct services that promote recovery and support the journey back to a vital and dignified life.

Defining Co-Occurring Disorders

The term co-occurring disorders describes the coexistence of two independent but intertwined disorders and includes a wide range of mental health and substance use disorders. Co-occurring disorders are the combination of mental health disorders such as schizophrenia and other psychotic disorders, major affective disorders, and personality disorders with substance use disorders related to the ingestion of alcohol and other drugs. The term implies the need for an integrated response to two or more disorders. It does not assume the primacy of one disorder over the other (CSAT, 1994; Bassuk, 1994).

Co-occurring mental health and substance use disorders vary along the dimensions of severity, chronicity, and degree of impairment in functioning. Both disorders may be severe or mild, or one may be more severe than the other. Either or both disorders may reflect episodes of acute symptom exacerbations or a chronic condition and may change over time. Levels of disability and impairment in functioning may also vary. Some common examples of co-occurring disorders include major depression with cocaine addiction, alcohol addiction with panic disorder, alcohol and polydrug addiction with schizophrenia, and borderline personality disorder with episodic polydrug use (CSAT, 1994).

The treatment needs of people with co-occurring mental health and substance use disorders differ significantly from the treatment needs of individuals who have a mental health or substance use disorder by itself. There are several possible relationships between mental health and substance use disorders that are essential to consider when providing services to these individuals. The primary relationships between substance use and psychiatric disorders are described in the following classification model (Meyer, 1986):

- Substance use can cause psychiatric symptoms and mimic psychiatric disorders.
- Substance use can initiate or exacerbate a psychiatric disorder.
- Substance use can mask psychiatric symptoms and syndromes.
- Withdrawal from substances can cause psychiatric symptoms and mimic psychiatric syndromes.
- Psychiatric and substance use disorders can coexist independently.
- Behaviors related to psychiatric symptoms can mimic substance use problems.

More recently, Lehman (1996) described the different groupings of disorders that are often presented by clients in service delivery settings. These are outlined below.

Substance Use Disorders with Substance Induced Disorders

Practitioners need to recognize that what appears to be a co-occurring disorder can be attributed primarily to the symptoms induced by substance use. In these instances, psychiatric symptoms clear when the substance use is stopped. Different substances have the potential to produce a variety of psychiatric side effects.

Substance Use Disorders with an Independent Mental Disorder

Individuals with mental disorders and co-occurring substance use disorders need integrated interventions for both problems. An inaccurate diagnosis can result if the symptoms of the mental disorder overshadow the evidence of substance use. A period of abstinence from substances is required to make an accurate determination.

Substance Use Disorders with Axis II Personality Disorders

Because personality disorders commonly co-occur with substance use, practitioners need to be especially aware of the implications for treatment. The interpersonal difficulties that define character disorders contribute to drug use and interfere with engagement. Accurately determining the character disorder allows practitioners to anticipate the treatment problems common to these individuals and to make the necessary adaptations. In addition, behaviors associated with substance use, such as illegal activities, can inaccurately be perceived as being the function of a character disorder. For these individuals, substance abuse treatment can reduce disruptive and maladaptive behaviors.

Co-Occurring Mental Health and Substance Use Disorders with Associated Medical Problems

Substance use disorders can lead to major medical problems such as HIV infection. The presence of an HIV infection may impact the person's motivation to seek treatment for mental health, substance use, or both disorders. Co-occurring disorders may impair the person's capacity to understand and comply with medical treatment. Some of the other major medical problems that may impact treatment for co-occurring mental health and substance use disorders include pancreatitis, liver disease, tuberculosis and other infectious diseases, anemia, organic brain disorders, and stroke.

Co-Occurring Mental Health and Substance Use Disorders with Associated Social Problems

Social problems significantly complicate the assessment process for individuals with co-occurring disorders. Legal problems related to substance use, the conditions of homelessness and/or unemployment, and incarceration require direct attention and pose major challenges to providing effective treatment. Experiences of deprivation and abuse, and a lack of access to adequate sources of care common among people living in extreme poverty, also create complications. All of these factors can compromise the practitioner's ability to engage the person, collect accurate information, and provide adequate care.

To clearly distinguish the complex interaction between and among mental illnesses and substance use disorders requires the skilled interpretation of accumulated evidence; ultimately, this must include the analysis of a skilled clinician in a controlled setting, such as a hospital. Making accurate discriminations about these relationships in unstructured settings, such as the streets or shelters, is especially difficult. However, it is essential for providers serving homeless people to understand these relationships. The information collected about the signs and symptoms related to the person's biological, psychological, and social levels of functioning over time are a critical part of making an accurate diagnosis and providing effective treatment.

The Unique Attributes of Individuals with Co-Occurring Disorders

The treatment needs of individuals with co-occurring mental health and substance use disorders are more complex than those who suffer from either disorder alone. These individuals are part of a diagnostically and functionally heterogeneous group with a broad and diverse range of treatment needs. The following attributes are unique to this population and have significant implications for developing treatment strategies (Drake and Wallach, 1989).

More Complex Needs

The combination of mental illnesses and the use of alcohol and other substances creates a unique interactive effect that makes these individuals more vulnerable at the biological, psychological, and social levels. Although both mental health and substance use disorders require treatment, it is difficult to manage the mental illness unless the substance abuse is stabilized. This is especially true for individuals who require psychotropic medication. In addition, people with co-occurring disorders may lack understanding about the impact of their substance abuse.

People with co-occurring disorders often are housed precariously and are especially vulnerable to becoming homeless. Homelessness significantly compromises the chances of recovery from either or both disorders, and it may contribute to the exacerbation of symptoms and substance use.

More Disruptive and Noncompliant Behaviors

People with mental illnesses are more vulnerable to the effects of chemical substances and experience more severe symptoms and disturbances in behavior. They also experience greater difficulty in adapting to the behavioral requirements of both treatment and housing environments. As a result, clients with co-occurring disorders often are noncompliant with treatment or not in treatment at all. However, it is important to note that many of these individuals are not prepared to adapt to the structure and behavioral regimens of programs that require abstinence (Drake, et al., 1996).

Poor Self-Care

The combined effect of psychiatric symptomatology and addiction can influence the person's capacity to attend to self-care needs. In addition, attention to self-care is not a high priority for homeless individuals who must also attend to issues of basic survival.

Poor Physical Health

Homeless individuals suffer from higher rates of both acute and chronic medical problems compared to the general population (Institute of Medicine, 1988). Common physical problems include skin diseases and infections, liver and cardiac diseases, and tuberculosis (Wright & Weber, 1987). Individuals with co-occurring disorders are especially vulnerable to contracting the HIV virus and are at greater risk for suicide.

Longer and Slower Course of Treatment/Frequent Symptom Exacerbations

The course of treatment for individuals with co-occurring disorders is longer than for individuals with only one disorder. The complexity and long-term nature of these disorders highlights the need for a longitudinal approach to assessment, treatment, rehabilitation, and social support. The increased frequency of symptom exacerbations requires a capacity to respond to acute episodes throughout each stage of treatment.

Consequences of Substance Abuse in Persons with Severe Mental Illness

The checklist that follows (used with permission of the author) is part of a package for client evaluation, but it also provides a valuable perspective on the types of problems that need to be addressed in any program serving homeless individuals with co-occurring disorders (Mueser, Drake and Clark, et al., 1995).

Table 1
Checklist of Common Consequences of Substance Abuse in Persons with Severe Mental Illness (© 1995 Robert E. Drake)

Consequence	*Example*
Housing instability	Getting evicted from apartment, group home, family
Symptom relapses apparently unrelated to life stressors	Increases in psychotic symptoms, worsening of depression, mania
Treatment noncompliance	Failing to attend medication or other clinic appointments
Violent behavior or threats of violence	Getting into fights, throwing objects, cursing at others
Sudden, unexplained mood shifts	Depression and hopelessness, anger, euphoria, anxiety, expansiveness
Cognitive impairments	Increased confusion, memory problems, difficulty planning ahead not related to a stress-induced symptom relapse
Difficulty budgeting funds	Frequent attempts to borrow money, stealing money, pawning one's own or others' possessions
Prostitution	Trading sex for money, food, clothing or drugs/alcohol
Social isolation	Increased avoidance of others
Social difficulties	Frequent arguments with family, friends
Employment difficulties	Frequently tardy or absent, arguments with employer or other employees, having pay docked, job loss
Hygiene and health problems	Deterioration in personal hygiene and grooming, medical problems, weight loss

Legal problems	Arrests for disorderly conduct, drunken driving, possession of illicit drugs, shoplifting

Findings from Demonstration Programs

Center for Mental Health Services/Center for Substance Abuse Treatment Collaborative Demonstration Program for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders

The Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) collaboratively funded demonstration programs to document innovative interventions for homeless individuals with co-occurring disorders. The program was implemented in two phases. The first phase documented interventions and developed evaluation plans for the most promising approaches to the treatment of alcohol, drug abuse, and mental illnesses among the target population. Sixteen programs were selected to develop manuals of their interventions. The second phase supported the detailed evaluation of six of these interventions and is currently in the final stage of data collection. The ultimate goal was to create documents that could inform and advance the field of applied programs for homeless people with co-occurring mental health and substance use disorders.

The 16 demonstration programs represent six major types of service currently provided to this population: outreach, detoxification, case management, day treatment, residential treatment, and system-wide service coordination. The programs cover a demographic and geographic range that represent a cross section of the nation and are located in twelve states. They are based in the following cities.

- Anchorage, AK
- Bakersfield, CA
- Berkeley, CA
- San Diego, CA
- San Francisco, CA
- Dorchester, MA
- St. Louis, MO
- Lincoln, NE
- Brooklyn, NY
- New York, NY

- Thorton, CO
- Bridgeport, CT
- Miami, FL
- Portland, OR
- Pittsburgh, PA
- Alexandria, VA

Each program site described both the theoretical foundation and the process for implementing interventions as part of a 50-page manual that includes (1) logic models that graphically depict the causal connection among theoretical and operational program components, (2) a detailed description of the structure and process of the intervention, and (3) a plan for evaluation.

Five common themes emerged for developing a programmatic response to this population relative to critical client characteristics and program/practitioner responses (Winarski and Dubus, 1995). These are highlighted in Table 2.

Table 2
Common Themes from CMHS/CSAT Demonstrations for Working with Homeless People Who Have Co-Occurring Disorders

Client Characteristics	*Program/Practitioner Responses*
Disaffiliation	Develop relationship
Multiple, complex needs	Respond to hierarchy of needs as part of a comprehensive approach
Impoverished environments	Develop positive support network
Effects of illness and addiction	Provide treatment, rehabilitation, support, and education
Low motivation for change/low self-esteem	Develop readiness

Details about specific interventions are available from individual programs. See Appendix A for a brief summary of each program and contact information.

McKinney Demonstration Programs

In 1990, CMHS awarded funds to mental health researchers through the Stewart B. McKinney Homeless Assistance Act to test the effectiveness of a variety of approaches to providing mental health treatment, housing, and related services to homeless adults who have severe mental illnesses. Five projects were conducted--one each in Boston, Baltimore, and San Diego, and two in New York City. These projects are among the first longitudinal, experimentally designed

studies of housing and service interventions for homeless people with severe mental illnesses.

The projects served homeless individuals who had varying levels of connection to mental health services, ranging from a moderate though somewhat unsuccessful connection, to street dwellers who had little or no connection to mental health treatment. Each program was required to implement a comprehensive set of mental health treatment, housing, and support services. The programs shared goals and measures, but varied in degrees of client engagement, levels of case management, and types of housing.

A report of the preliminary findings and a detailed description of each project has been published by CMHS (1994). It concludes that homeless adults who have severe mental illnesses can be reached, are willing to accept mental health, housing, and other services, and can remain in community-based housing with appropriate support. This is encouraging news for programs that provide services to this population, and it clearly supports the need for programs such as PATH that provide outreach, treatment, and support to these individuals. The report includes the following summary points that have significant implications for providers of services to homeless persons with severe mental illnesses:

- Homelessness among persons with severe mental illnesses cannot be addressed without providing substance abuse treatment directly and routinely within the context of mental health care. Mental health and substance abuse treatment must be integrated, and substance abuse treatment must be widely available.

- Many homeless persons with severe mental illnesses are willing to use mental health services that are easy to access and designed to meet their needs as they perceive them. In addition, homeless persons with severe mental illnesses can be effectively treated in the community. This reduces their use of more expensive inpatient settings.

- Securing housing is an attainable goal for nearly all homeless persons with severe mental illnesses. With appropriate levels of support, particularly during the critical transition from homelessness to residential stability, many can live successfully in independent, community-based housing.

- More research is needed to determine effective interventions for more disabled subgroups among the homeless mentally ill population. In particular, there is a need to learn what level of services are necessary and for how long.

Summary

The high prevalence rates of mental health, substance use, and co-occurring disorders among homeless individuals, and the numerous and complex problems that result, require a comprehensive, coordinated response to treatment. Federal programs have demonstrated that such approaches can be successful. Some important principles that underlie these strategies are discussed in Chapter 3.

3

Theoretical Foundations

This chapter features a summary of service approaches and treatment principles associated with effective responses to the needs of homeless individuals with co-occurring disorders. It includes

- a summary of three major service approaches;
- a review of principles for providing effective care;
- a conceptual framework for providing treatment, including a discussion of the factors that impact an individual's motivational state; and
- a description of a concept of recovery that emerged from the CMHS/CSAT Collaborative Demonstration Program.

Overview of Three Major Service Approaches

Because homeless individuals with co-occurring mental health and substance use disorders have complex needs, they usually require the services of numerous programs from within the community's system of care. The Federal Task Force on Homelessness and Severe Mental Illness (Interagency Council on the Homeless, 1992) has recommended that an integrated system should include health care, mental health services, substance abuse treatment, social services, income support, legal services, housing, and rehabilitation and employment services. However, most communities lack the administrative structures and systems of accountability to coordinate this vast array of services.

Concerns about limited resources and separate funding streams also inhibit coordination. In addition, the mental health and substance abuse treatment

fields have a long history of separating services, reinforced by philosophical differences and separate administrative structures (Osher and Drake, 1996). As a consequence, fragmented service delivery systems have emerged as one of the greatest obstacles to providing effective services. Rigid and unresponsive program applications and turf battles among providers have resulted in clients receiving insufficient and/or inadequate treatment, partial treatment, or no treatment at all. The availability of a range of programs and services in the community does not guarantee that services are coordinated, accessible, or designed to meet the needs of consumers.

Three major models for delivering services have emerged as a response to the needs of individuals with co-occurring disorders: the parallel model, the linkages model, and the integrated model. Each model has advantages and disadvantages, but integrated models are beginning to demonstrate greater success in both engaging and retaining clients in treatment and achieving more positive treatment outcomes (Osher and Drake, 1996).

The Parallel Model

In the *parallel model*, individuals with co-occurring disorders are referred to both mental health and substance abuse programs to receive treatment concurrently or sequentially. The primary advantage is that it utilizes existing programs in both fields and can be flexible in responding to different levels of disability, motivation, and addiction. A variety of services can be matched to the individual's need as he/she advances in recovery. The major disadvantage is the "enormous burden placed on case manager and clients to maintain continuity through multiple episodes of treatment in diverse programs in a distinct system of care" (Minkoff, 1991). It also places the burden of coordination on individuals who, because of their disabilities, are the least capable of doing so.

The Linkages Model

The *linkages model* is used from within the mental health system and combines aspects of the parallel and integrated models within the context of a clinical case management approach (Kline, et al., 1991). Clients receive a continuum of residential services, psychosocial rehabilitation programs, and a complete array of clinical services as part of an integrated approach, with the exception that substance abuse services are not provided in-house. Case managers refer clients to traditional substance abuse programs that promote abstinence by using such approaches as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The case managers monitor and coordinate the link between the mental health and substance abuse systems and provide direct services, as necessary.

If there are adequate substance abuse services available in a community, the linkages model offers clients the advantage of a strong helping relationship and an emphasis on flexible programs and treatment advocacy. However, establishing links between the mental health and substance abuse systems remains a formidable task. Even with the most aggressive case management, individuals with co-occurring disorders can be denied access to adequate treatment.

The Integrated Model

The *integrated model* provides psychiatric and substance abuse treatment within one hybrid program, where administrative, supervisory, and clinical functions are conducted under one management structure. Integrated programs utilize group interventions that are specific to the needs of clients in the engagement, persuasion, active treatment, and relapse prevention phases of treatment (Kline, et al., 1991). Clinicians integrate both case management and direct service functions to provide the full spectrum of basic support and clinical services from within the context of an ongoing helping relationship. It is important to note that integrated programs do not employ a new treatment technology for people with co-occurring disorders, but rather use a method for applying existing mental health and substance abuse technologies concomitantly (Ridgely, 1991).

Principles for Providing Effective Care

Reviews of demonstration programs and clinical research have identified several emerging principles of treatment that address the scope, pace, intensity, and structure of programs serving people with co-occurring mental health and substance use disorders (Drake, et al., 1993). These principles represent some of the elements that are common to successful programs and are useful to consider in planning and implementing services for this population.

Integration

Open clinical trials have found integrated treatment programs that provide both mental health and substance abuse services concurrently and in the same setting to be most effective. Treating only one disorder or treating two disorders in sequence is problematic because the disorder not being treated may have a destabilizing influence on the targeted disorder. Treating both disorders concurrently in two separate systems creates barriers to client access and retention. Homeless individuals are especially vulnerable to being lost between

the two systems. Integrated programs reduce the potential for miscommunication in treatment planning and can be more easily modified to meet the specific needs of individuals with co-occurring disorders.

Comprehensiveness/Individualized Treatment

Homeless individuals with co-occurring disorders experience a broad and diverse range of needs, including problems that can place basic survival in jeopardy. Consequently, programs need to provide a comprehensive response to a wide range of psychosocial issues, as well as address the manifestations of specific disorders. Ideally, an integrated system should include health care, mental health services, substance abuse treatment, social services, income support, legal services, housing, and rehabilitation and employment services (Interagency Council on the Homeless, 1992). Recovery from both mental health and substance use disorders requires that individuals develop skills and utilize supports that are required for long-term success in living and vocational environments.

Assertiveness

Homeless individuals with co-occurring disorders often have long histories of being disaffiliated from families, friends, and professional sources of support. Histories of negative experiences with service providers and noncompliance with treatment are not uncommon. Successful programs have taken an active approach to establishing helping relationships and providing critical supports and services. Assertive interventions include outreach services that engage individuals on the street, in shelters, or wherever they may live, and approaches that involve natural supports such as family members, employers, landlords, and friends.

Close Monitoring

Close monitoring refers to intensive supervision and management of clients who express negative behaviors, especially individuals with poor insight and judgment who are self-destructive and/or who require external structure to achieve goals related to treatment, rehabilitation, and recovery. Examples of monitoring interventions include random urine drug tests, the use of representative payees to prevent public entitlements from being used to purchase alcohol and other drugs, and highly structured residential programs. The goal of these activities is to promote sobriety and to create conditions that are conducive to recovery. The challenge is to provide the kind of monitoring and external structure that develops the person's internal volitional control and level of independence.

Stable Living Environment

Homeless people often live in conditions that are among the most impoverished in our communities. Individuals struggle to meet basic survival needs and are at high risk for violent victimization, while alcohol and other drugs are readily available and remain a prominent feature of street culture. Recovery from both mental health and substance use disorders is difficult if not impossible in these environments. People with co-occurring disorders need to have access to a range of safe and affordable housing options that provide required emotional and material supports and freedom from the continuous presence of alcohol and other drugs.

Flexibility and Specialization

To develop expertise in treating co-occurring disorders, successful programs in both the mental health and substance abuse fields have modified previous beliefs, learned new skills, and tested new approaches. They teach us that we do not need to develop a new specialty. Rather, they focus on modifying the attitudes, knowledge, and skill levels of existing staff to meet the unique needs of individuals with co-occurring disorders.

Stages of Treatment

The stage model described by Osher and Kofoed (1989, see the section that follows) conceptualizes substance abuse as a chronic, relapsing disorder that is to some extent independent of the mental illness, but that is treatable with integrated and comprehensive approaches. Conceptualizing treatment interventions along a continuum of client readiness for treatment allows a better matching of specific interventions to achieve desired outcomes. Though the course of recovery rarely follows a linear track, these stages highlight the need to provide a range of treatment options that are responsive to the unique needs of each individual.

Cultural Sensitivity/Consumer Focus

Culture has a significant impact on how people develop relationships, perceive offers of assistance, and utilize services. Successful programs develop practitioner competency in responding to the factors that influence an individual's response to treatment, including language, family, and ethnic background. Strategies may include hiring staff who share the language and culture of the people being served in the program, providing staff with education about cultural issues, creating interventions that include peer support, and developing flexible

program structures that respond to cultural diversity. The perspective of the consumer needs to be the driving force for planning and conducting interventions.

Longitudinal Perspective

Treatment of both severe mental illnesses and substance abuse usually occurs over a period of years rather than days or months. Treatment should be continuous and not merely a response to acute episodes. Programs serving homeless individuals with co-occurring disorders demonstrate that the engagement and persuasion stages alone may take a period of months or even years before the person is ready to commit to an active treatment program that stresses abstinence. Programs emphasize the need to recognize small increments of progress over a long term course of recovery that may include numerous set- backs.

Optimism

The challenges of providing care to people with chronic disorders understandably can discourage consumers, families, and treatment providers. Programs often serve people who feel trapped by their circumstances and powerless to do anything to improve them. However, maintaining hope for recovery is an essential feature in successful programs serving homeless individuals with co-occurring disorders. Recognizing motivation as an emotional state rather than a fixed personal attribute provides the foundation for developing strategies to empower consumers and enhance their readiness to benefit from treatment. Regular supervision, training, and support groups are also valuable in helping clinicians to achieve competence and mastery in critical areas, while supporting a genuine experience of hope and optimism (Osher, 1996).

Conceptual Framework for Providing Treatment

Four Phases of Treatment

Osher and Kofoed (1989) outlined a conceptual model for treating individuals with co-occurring psychiatric and substance use disorders that consists of four treatment phases: engagement, persuasion, active treatment, and relapse prevention. This model has provided a useful framework to guide both the development and implementation of integrated programs for people with co-occurring disorders and is widely used in the field. All of the 16 programs in the CMHS/CSAT Collaborative Demonstration Program representing both the

mental health and substance abuse fields referred to this model as part of the theoretical development of their programs (Winarski and Dubus, 1995).

This model was developed in response to the unique challenges of providing integrated treatment to this population. Both severe psychiatric and addictive disorders follow a chronic course with frequent relapses. Consequently, clients in an integrated program are likely to be in different phases of recovery, in addition to presenting with unique treatment histories and varying capacities to form treatment relationships. The four phases provide a basis for differentiating clients relative to the stability of their psychiatric disorder and their readiness to engage in substance abuse treatment (Osher and Kofoed, 1989).

This model is especially relevant for programs serving homeless individuals with co-occurring disorders, who present with an especially broad and diverse range of needs. The following description of the four-phase model includes discussion of using the phases as a guide to help match service activities to the needs of individual clients.

Phase 1: Engagement

Engagement involves the process of convincing the person that participating in service activities can be desirable and beneficial. Engaging homeless people who need treatment can present special challenges. These individuals may be socially isolated and have fragmented relationships. Histories of being rejected by family, friends, and service providers are more often the rule than the exception. They also may be suspicious about the intentions of anyone offering assistance.

The service activities during the engagement phase focus on aggressive outreach, developing trusting relationships, and providing assistance in areas that are of immediate concern to the person, such as food, clothing, access to entitlement programs, shelter, and health care. Readiness to commit to programs requiring abstinence varies considerably among individuals. Escaping the pain of street life or avoiding legal problems is sometimes a motivating factor. Admissions to detoxification programs also can provide the opportunity to develop a meaningful relationship to the human service network. More often it is necessary to establish a relationship over time and to conduct activities that help to increase motivation and develop readiness to make positive changes (Miller and Rollnick, 1991).

Phase 2: Persuasion

Persuasion is a process of helping the person to recognize substance abuse as a problem and to accept active treatment interventions that typically require a commitment to abstinence from alcohol and other drugs. The fundamental challenge is to overcome the denial and lack of insight that are common to people who abuse substances. Individuals with co-occurring disorders also may have an impaired ability to process information that further compromises their capacity to develop insight and to recognize the negative consequences of self-destructive behaviors. The stress and trauma related to homelessness, the ready access to drugs, and the pervasiveness of drug culture on the streets present further challenges.

The critical service activities during the persuasion phase include individual counseling, psychoeducation groups, and pretreatment or "active use" groups (Kline, et al., 1991). All activities during this phase are based on an understanding of client motivation as an emotional state, rather than a fixed character trait. An emotional state can be influenced by service interventions, while the character traits of a person are often subject to labels and thought to be unchangeable. The goal is to facilitate insight about the negative consequences of substance use and to offer desirable alternatives that reflect the client's wants and needs (Miller and Rollnick, 1991).

The primary challenge for practitioners during this phase is to help the person develop a genuine commitment to changing substance abusing behavior and to following a plan for the management of psychiatric symptoms. For homeless individuals with co-occurring disorders, drugs may provide a source of pleasure and an escape from emotional and physical pain and boredom. In contrast, psychotropic medications carry the stigma of mental illness and often have unpleasant side effects. Promoting abstinence from alcohol and other drugs can be facilitated by contrasting the immediate pleasures with the long-term damaging consequences.

Demonstrating the long-term benefits of psychotropic medication can be especially challenging and often requires several trials as the person comes to terms with the reality of mental illness. Hospitalizations often are ideal opportunities for conducting persuasion activities because of the structure provided by the treatment milieu, the availability of supports, and the focus on treatment needs. Practitioners should avoid attempts to engage clients in treatment activities unless a sufficient level of readiness is developed. Forced or premature participation usually will lead to frustration for the practitioner and client and often is not successful.

Phase 3: Active Treatment

The active treatment phase focuses on helping the person develop the attitudes, knowledge, and skills necessary to support abstinence and to engage in treatment and support activities. Some of the most critical activities for homeless individuals with co-occurring disorders include abstinence support groups that focus on developing essential coping skills, case management services that include planning for residential placement, family involvement, and one-to-one counseling. Medical and behavioral interventions also are important, as are psychiatric services that deal with medication and symptom management. Programs also may adapt the pace and intensity of interventions based on an assessment of the particular strengths and deficits of the client. For example, clients in psychoeducational groups with cognitive deficits may require a slower pace and less confrontation. However, an expectation of abstinence remains essential, even for the most disabled individuals. Self-help support groups such as AA and NA also can play a significant role in supporting long-term abstinence.

Phase 4: Relapse Prevention

Both psychiatric and substance use disorders follow a course in which a return to negative patterns of thinking or behavior, exacerbations of symptoms, and relapses to substance use should be anticipated. The clinical response to relapses has a critical impact on the client's long-term abstinence and overall recovery. Supporting the attitude and skill development that took place during the period of initial commitment to abstinence is of primary importance. The person needs to integrate these learnings into an overall healthy pattern of living. A long-term connection with a service and support network is critical, especially when the initial enthusiasm about maintaining sobriety is replaced by the realities of routine daily life. Relapses should be recognized as opportunities for learning, and should provide the chance for the person to develop new coping skills and supports for adapting to future challenges . For homeless individuals especially, maintaining long-term abstinence is one of the many significant tasks of reintegrating into mainstream culture and working toward recovery.

For homeless individuals who have suffered numerous losses and often have multiple disorders, the progression through these phases can take many months or even years. In addition, the course of growth and recovery is not always linear. Individuals who had achieved some period of sustained abstinence may again need engagement and persuasion interventions at some later date. The four-phase model provides an effective framework for matching interventions to the needs of the individual as part of an integrated approach to treatment.

Developing Readiness to Make Changes

Programs serving homeless individuals with co-occurring disorders often site a lack of motivation and low self-esteem as significant obstacles to engaging people in treatment (Winarski and Dubus, 1995). Many homeless clients have difficulty accessing services, have had negative experiences with service providers, and have been labeled as "noncompliant," "treatment resistant," and "not ready for treatment" by service providers. Often, individuals feel "stuck" in very difficult circumstances and are unable to take steps that can lead to positive change. In addition, some mainstream providers have become part of the cultural trend of assigning blame and casting judgment on people who have had difficulty moving out of poverty.

Recognizing the factors that influence a person's readiness to make changes is essential for all practitioners working with this population. Miller and Rollnick (1991) describe the factors that contribute to shaping the person's internal perceptions about change and overall motivational state. The following description examines the relationships among these factors and highlights the unique needs of homeless individuals with co-occurring disorders.

Perception of Need

No lasting change in human behavior is possible unless the person feels the need to change from within. Motivation for change is enhanced when the person perceives a discrepancy between his/her current behavior and important personal goals (Miller, 1985b). Avoiding pain is a prime motivator for behavior change. Practitioners in the field have noted that some persons must "hit bottom" before denial can be overcome. A traumatic experience may lead the person to change behaviors that have caused severe distress.

The long histories of deprivation and abuse that are common to homeless individuals have a significant impact on how they perceive pain and on the kinds of actions they will take to alleviate discomfort. People who live in conditions that are perpetually distressing learn to be tolerant of even extremely uncomfortable conditions. The desire to escape painful experiences can produce a heightened state of motivation. However, if hopes for improvement are not realized after a period of many months or years, hope itself can become a great source of pain. Rather than taking actions, individuals who feel trapped may relinquish hope as a means of emotional survival.

People who have been chronically deprived and/or abused need to experience a sense of security and stability that allows them to explore the potential for future improvement. The challenge for practitioners is to help individuals build a foundation from which to renew their hopes.

Belief that Change is Possible and Can Be Positive

Individuals feel little motivation to change behaviors unless a positive outcome is perceived as achievable within a reasonable period of time. Most people who are homeless have experienced change as a negative force: histories of unstable housing and work experiences and disruptions in key relationships are common. People who perceive change as a threatening and negative experience may be reluctant and uncomfortable with practitioners who suggest strategies for change. In addition, if the desired outcomes of these changes appear to be unlikely or possible for only the distant future, commitment will not be sustained.

Practitioners need to be aware of the person's recent experiences with life changes. This is especially important for homeless individuals with co-occurring disorders living in unstable conditions. Strategies for behavior change need to include a supportive relationship and should begin by targeting achievable, short-term goals.

Sense of Self-Efficacy

Self-efficacy is essentially an internal belief by the person that he/she can take an action to make a change. The person's sense of self-efficacy is directly related to his/her perception about both the size and the locus of the obstacles to change. People are more willing to make changes if the obstacles are not overwhelming and if the locus of control is internal rather than external. Homeless individuals with co-occurring disorders have lost control over their living environments and may view themselves as being acted upon by external forces. In addition, for people who have suffered many losses, the obstacles on the road to recovery can seem overwhelming.

Homeless individuals with co-occurring disorders often need support to regain a sense of their own ability to effect positive changes. Practitioners should create experiences that provide opportunities for success and that develop confidence. In addition, providers should ensure that the person is involved with developing treatment plans and that the pace and intensity of interventions are sensitive to the person's ability.

A Stated Intention to Change

Any statements that the person makes relative to the need to change are an important indicator of a developing readiness to take action. Practitioners should acknowledge these statements and be prepared to explore their significance with the individual. It is not uncommon for practitioners to ignore these statements,

especially if the person has stated intentions previously without following up on a plan for taking action.

For example, a person with a drug addiction may make many impassioned statements about an intention to be abstinent and to adhere to a program regimen, but not take even the first step to become involved in the program. This discrepancy between the person's word and actions do not necessarily mean that the person is not sincere or simply "manipulating" the practitioner. They are an indication of an emerging awareness of a discrepancy between present conditions and wishes for the future. Statements of intention to change should be considered prime opportunities to explore this discrepancy and to begin considering possible courses of action.

Recovering from Mental Health and Substance Use Disorders: A Unifying Concept

Recovery has for many years been a common topic of discussion among consumers of human services who have lived with serious and long-standing mental or physical illnesses and/or addictions (Deegan, 1988). Among professionals, it has perhaps been more common to the substance abuse field, but has recently become a prominent part of the dialogue within the mental health field as well (Anthony, 1991). Though clinical perceptions of recovery focus on the person gaining control over symptoms and/or addictions, consumer literature has promoted a broader view that includes the "real life" experience of regaining a new sense of self and purpose as individuals overcome the challenges of long-term disabilities. This more holistic perspective can enhance our understanding of the profound and often mysterious process of recovery.

The recent demonstration program supported collaboratively by the Center for Mental Health Services and the Center for Substance Abuse Treatment documented the interventions of 16 programs that serve homeless individuals with co-occurring disorders (Winarski and Dubus, 1995). These programs exemplify most of the major types of service delivery currently provided to this population and represent a cross-section of demographic and geographic areas. Despite differences in geographic, cultural, and institutional influences, the concept of recovery was central to both the theoretical and operational development of each program. These programs provide valuable insights about understanding and facilitating the process of recovery. See Appendix A for a brief description of the 16 programs.

Understanding Recovery

The programs in the collaborative demonstration provided three critical insights, outlined below, that can considerably enhance our understanding of the recovery process.

Recovery Occurs for all People

The programs challenged the belief that the person is not in recovery until he/she can meet the admission requirements of active treatment programs. Rather, recovery is described as including the broad spectrum of human experience. Steps in the process of recovery may include being in a state of denial about a problem, taking a step forward only to take two steps backward, or "hitting bottom."

What appears to the outsider as denial, indifference, or even contempt can be a critical part of the person's struggle for growth. It is also an important sign to providers to change strategies. Programs describe recovery as a cyclical process of loss and reclamation that is intrinsic to the human experience. It includes but also goes beyond experiences with illness and addiction. Recovery is described as a distinct force that strives toward reintegration and healing, even among individuals with severe disabilities and addictions. Practitioner responses to people in the earliest stages of recovery can be critical to determining success with a large proportion of homeless individuals who have co-occurring disorders.

Recovery Occurs at Multiple Levels and at Variable Rates: The Centrality of Loss

Homeless people typically have suffered multiple losses, extreme deprivation, and abuse, in addition to experiences with illness and addiction. The demonstration programs describe case histories where loss is the central theme, and the process of recovery is occurring on many levels simultaneously. In addition, rates of recovery can vary significantly both within and between individuals.

The profound and pervasive nature of these losses for each individual is impossible to calculate, but we do know that for each loss, the person will experience a grief response as part of the process of reclamation and recovery. The effects of one loss or disorder will impact the process of recovery from others. Each individual will recover from different losses in his/her own way and time. Programs serving this population need to recognize that recovery from mental health and/or substance use disorders is inextricably linked to recovering from these other losses, and that responses should be sensitive to differences among individuals.

Recovery Follows a Non-Linear Course

The programs within the collaborative demonstration all refer to a process of recovery that typically does not progress along a straight line and often includes setbacks. A return to negative patterns of thinking or behavior, exacerbations of symptoms, and relapses to substance use are common experiences on the road to recovery. Programs emphasize the importance of using these experiences as a source for learning rather than an indication of failure. The challenge for providers serving this population is to implement programs that facilitate progress and prevent relapse, while also meeting the needs of people who experience setbacks.

Facilitating Recovery

The lessons learned in these demonstration programs have their roots in field-tested treatment strategies and should be considered when planning interventions for this population. One of the critical challenges for programs serving homeless individuals with co-occurring disorders is to conduct interventions that are sensitive to the client's level of motivation and readiness to progress in the recovery process. Each individual ultimately must become involved in his/her own process of recovery. Though the demonstration programs served clients at different stages of recovery, six common elements emerged as critical to facilitating this process (Winarski and Dubus, 1995).

Create Environments that are Conducive to Recovery

Homeless people often live in environments that are dangerous, stressful, and drug-infested, and where basic survival is a daily struggle. Many individuals have become disaffiliated from social supports. Recovery from disorders, addictions, and other losses is difficult if not impossible in these impoverished conditions.

Programs in the collaborative demonstration created and provided access to environments that were free from crisis and danger, as well as alcohol and drugs. The goal is to help the person make the transition from vigilant attention on survival to an internal experience of security that allows healing and recovery to begin. A safe environment provides the foundation for this difficult work. When a person feels safe, he/she will be better able to handle the demands required by more intensive interventions.

Attend to Motivational States

The demonstration programs describe low motivation and a lack of readiness to enter treatment programs as significant obstacles to assisting homeless individuals with co-occurring disorders. They describe people who often feel trapped by circumstances and powerless to take steps toward improvement. Developing strategies to increase motivation, build self-esteem, and enhance the person's readiness to take the steps necessary for positive change were considered critical for success. Providers emphasized the need to replace notions of "compliance" and "treatment resistance" with motivational strategies that appreciate the struggles common to the very earliest stages of recovery (Miller and Rollnick, 1991).

Respond to Mental Health and Substance Use Disorders Simultaneously

The interactive effects of drug use and psychiatric symptoms, and the influences of numerous psychosocial variables, create a complex picture that usually requires many contacts over time to decipher fully. Questions about etiology and the primacy of disorders have important implications for both diagnosis and treatment, but they need not be an impediment to addressing the presenting signs, symptoms, and behaviors. Programs in the collaborative demonstration focused on the needs presented by both disorders throughout each stage of the recovery process.

Create Community

The documented accounts of client progress from the collaborative demonstration programs all suggest that recovery does not occur in isolation. People need to develop meaningful relationships that provide the opportunity to both give and receive emotional support. This reintegration into an experience of community is closely linked to the process of recovery, especially for homeless individuals who have lost connection to nurturing relationships. The meaning and dynamic of community may vary for individuals, but the need for belonging and meaningful contact apply to all. Successful programs provide services from within the context of supportive relationships that focus on including the person in a meaningful experience of community.

Define Expectations

People who are homeless may not be comfortable with, or aware of, the behavioral expectations that are common to service and support settings, especially among mainstream programs. In addition, individuals who have mental illnesses and/or addictions may not be capable of navigating through the many formal and informal rules for interacting that are critical to success in any housing, work, or treatment environment. The demonstration programs emphasized the need to define expectations clearly and to provide positive role models.

Defining expectations helps ensure that the person understands how the practitioner intends to help, and may include a verbal and/or written description of the practitioner's role within the agency as it relates to working with clients. In addition, expectations for behavior are made explicit, with a focus on behaviors that are expected as well as those that are not acceptable. Matching behavioral expectations to the person's stage of recovery and communicating these expectations clearly are critical to promoting recovery.

Programs also identified the need to establish a positive expectation, i.e., a way to demonstrate that recovery can occur. This is best accomplished through the use of peers who have progressed in recovery and can serve as models for individuals at earlier stages of the process. In addition to providing evidence of positive outcomes, successful peers can share personal experience about the ups and downs of recovery and help prepare the person for future challenges.

Use Setbacks as Opportunities for Learning

Because setbacks are a common part of recovering from both substance use and mental health disorders, each of the demonstration programs developed strategies to respond to these difficult periods. Rather than being an indication of failure for the client or the practitioner, a return to substance use and/or the re-emergence of symptoms or negative behaviors provided the opportunity to re-evaluate treatment goals and strategies. The primary goal is to prepare the person to deal with the many obstacles that occur throughout the process of recovery.

Summary

The complex needs of homeless people with co-occurring disorders require a comprehensive, integrated approach that is focused on the consumer's needs and is tailored to the individual's ability and readiness to embrace recovery. Chapter 4 outlines some guidelines for putting these principles into practice.

4

Effective Services and Programs

This chapter provides information and strategies for conducting critical program activities. It features sections on

- *outreach/engagement*, including an outline of critical helping skills;
- *assessment*, with a focus on the specific needs of this population, a discussion of critical assessment information, and a description of some common assessment instruments;
- *building motivation for change*, including strategies for helping individuals make positive changes;
- *critical program components* needed to meet the needs of people with co-occurring disorders; and
- *treatment planning/coordination and client advocacy*, with a description of three case management models that have been used to coordinate services for this population.

The Foundation for Outreach and Engagement: Developing Effective Helping Relationships

Outreach is the initial step in developing relationships with some of the most disenfranchised people in our communities. The Federal Task Force on Homelessness and Severe Mental Illness has recognized outreach as the first

and most critical component of any program serving a homeless population (Interagency Council on the Homeless, 1992). For people with co-occurring mental health and substance use disorders, the need to establish human connections is especially urgent and often critical for survival.

Fear and mistrust of service providers is common among homeless people and often based on previous negative experiences. Clients frequently have histories of broken relationships with family and friends and have experienced numerous losses. Flagrant psychiatric symptoms and behaviors related to intoxication and withdrawal create significant interpersonal barriers. Poor physical health and the demands of street survival can compromise the person's capacity to relate meaningfully to others. Consequently, it may be necessary for practitioners to spend many weeks, months, or even years in developing a relationship as part of the outreach process.

The human relationship is the linchpin to any effective helping process (Carkhuff, 1969). By focusing on individual strengths and preferences, practitioners can move beyond merely diagnosing, prescribing, and treating the patient and come to understand the person beneath the illness/addiction. Recognizing that our humanity binds us to clients rather than separates us, we can gain the courage to be warm, empathic, and genuine, even in the face of rejecting behaviors (Kisthardt, 1992).

The section that follows focuses on strategies that are fundamental to outreach and engagement efforts, but that also are applicable throughout the entire course of treatment. This discussion includes an exploration of important characteristics of the helping relationship, a description of critical skills for developing and maintaining a relationship, and keys for ensuring safety during outreach interventions (Birk, Bassuk, and Kisthardt, 1994).

Key Characteristics of the Helping Relationship

Trusting and Respectful

One of the most important characteristics of an effective helping relationship is mutual trust and respect. The practitioner needs to trust the client's intention to improve and to tolerate apparent backsliding and relapses. The client needs to trust that the practitioner will be available, will be knowledgeable about providing services or making referrals, and will be nonjudgmental. The helping relationship is defined by its ability to produce results in an atmosphere of collaboration and cooperation. The following steps contribute to creating a trusting and respectful relationship.

- *Gather information about the client's past history* of relationships with family, friends, and service providers. Recognize that rejecting

behaviors may be a function of the person's pattern of relationships, previous negative experiences with service providers, symptoms of mental and physical illness and/or substance abuse, or general suspiciousness about strangers.

- *Enter the client's frame of reference* and attempt to understand problems from his/her point of view.

- *Maintain openness and flexibility*. Recognize that conditions related to homelessness, illness, and addiction can create a complex behavioral picture that may change dramatically over short periods of time. Consequently, a person who is irritable and confused one day may be amenable to talking another day.

- *Be patient about the pace of engagement*. Individuals with co-occurring disorders will have varying capacities to develop relationships and become involved in services.

- *Maintain clear boundaries* and develop mutually determined goals. This helps distinguish the helping relationship from a friendship.

Positive and Tolerant

Practitioners who genuinely can focus on the person's potential for change, and can recognize small increments of improvement, are more likely to help the person achieve stability. Positive expectations, especially regarding abstinence, are important to overcoming discouragement and self-defeating behaviors. During the initial stages of the relationship, the person may especially benefit from a positive outlook by the practitioner. Experiencing small successes helps to develop readiness for more significant changes. It is also important to recognize the remarkable resilience and capacity for growth demonstrated by individuals living in extraordinarily stressful circumstances. By focusing on these strengths, practitioners can help redirect an individual’s energy toward mobilizing new resources, acquiring additional skills, and mastering new situations necessary for recovery.

Realistic

Practitioners who seek to engage severely disabled individuals face the challenge of accurately determining the person's strengths, interests, abilities, knowledge, and capacity for growth, as well as evaluating the influence of illnesses, addiction, and multiple psychosocial problems. Initially, there may be significant discrepancies between practitioner and client perceptions that should be recognized, especially if the individual is in denial about illnesses and/or addictions. Effective assessment and treatment planning usually require

numerous contacts over an extended period of time. However, it is important for the practitioner and client to work together to set a direction, define achievable goals, and determine a treatment plan.

Helpful

Effective helping relationships ultimately need to be helpful--that is, they should produce positive outcomes. Practitioners need to recognize that every encounter with a client is for better or for worse; the person is either helped or somehow diminished by each interaction (Carkhuff, 1969). Many complex factors impact whether a person achieves positive outcomes, but treatment interventions are of limited value unless a truly helpful relationship is developed. The helping relationship is indeed the foundation for outreach and engagement interventions, as well as all of the other service activities that are critical to facilitating recovery.

Skills to Develop and Maintain a Helping Relationship

Listen and Communicate Empathically

Empathy is defined as the capacity to feel *with* another, while sympathy is defined as the capacity to feel *for* another. Entering the frame of reference of the homeless person with co-occurring disorders is the key to developing an effective helping relationship. Empathic communication is a complex skill that requires practice, however, there are a core set of behaviors and skills that can be learned easily and applied in working with individuals who have co-occurring disorders (Birk, 1994).

- *Prepare to listen*. Eliminate distractions and focus attention exclusively on the client.

- *Attend to body language*. Body language should communicate interest in the client. Leaning forward and maintaining eye contact directs our focus on the person and prepares the practitioner to observe and listen more carefully.

- *Suspend judgment*. The practitioner's focus should be on the ideas, feelings, and beliefs expressed by the person, rather than on providing interpretation or advice.

- *Ask open-ended questions*. Practitioners should ask questions that provide the person with an opportunity to explore, rather than simply answer yes or no.

- *Explore content, feeling and beliefs*. Though giving advice can be useful, it should be avoided unless a trusting relationship has already been established. The process of empathic communication involves exploring the ideas, experiences, and beliefs of the person through responses that demonstrate understanding. Exploring discrepancies between individuals' perceptions of their current circumstances and their personal goals helps develop their readiness to engage in other treatment activities.

- *Respect the client's pace*. Practitioners should be sensitive to the person's capacity to develop a relationship. Moving too quickly or imposing an agenda can contribute to the individual's experience of suspicion and mistrust. This is especially true if the person has had negative experiences with service providers in the past.

Identify and Help with Problems

Homeless individuals with co-occurring disorders often have complex medical, psychiatric, social, and emotional needs. An essential part of the helping relationship involves the ability to meet individuals' urgent needs. Practitioners should have access to readily available sources of food, clothing, and shelter. Providing basic supports contributes significantly to establishing rapport.

Practitioners also should determine if the person's survival is "at risk" or "in crisis." "At risk" is a condition that warrants serious attention, requires monitoring, and could lead to a crisis if not attended to. Examples include exacerbations of psychiatric symptoms; medical problems such a dramatic loss of weight, persistent cough, or open sores; or changes in the environment, such as involvement in street gang activities.

"In crisis" is a condition that requires an immediate response to alleviate an urgent situation. Examples include violent behavior toward self or others, confusion or disorientation, obvious physical pain, bleeding or breathing difficulties, or an episode of acute victimization such as robbery or rape. People "in crisis" require an immediate emergency response from an ambulance or the police and immediate transport to a health facility or a place of safety. Survival status can change rapidly and requires continuous monitoring. In less urgent situations, collaborative problem-solving is an opportunity to help the client on a practical level, to build trust and rapport, and to educate the client in some basic skills.

Reinforce Coping Mechanisms

The extraordinary resilience demonstrated by people who have survived homelessness needs to be recognized as part of the helping relationship. By

focusing exclusively on solving problems, we can fail to engage and develop character strengths that are critical for improvement. Recognizing successful coping mechanisms is essential for facilitating growth. In addition, practitioners need to recognize and reward even small achievements. People with severe disabilities often make progress in small increments. Positive feedback for the smaller victories is an important part of achieving broader goals.

Set Limits

Practitioners are responsible for maintaining interpersonal boundaries and upholding the rules and policies of the program. The challenge for providers is to set limits consistently, while also maintaining a trusting relationship. Program rules about the use of alcohol and other drugs can present special challenges. The following steps will help practitioners establish interpersonal boundaries and limits as part of a healthy helping relationship.

- *Define the nature of the relationship*. It is incumbent upon the practitioner to review the role and expectations for both the practitioner and the client as part of every interaction.

- *Orient the client*. Practitioners should orient the client to both the formal and informal (unwritten) rules of the program as often as is necessary. This is especially critical for severely disabled clients and individuals with cognitive impairments.

- *Clarify positive expectations*. Expectations often are communicated by a list of rules that specify forbidden behaviors. Practitioners also should specify the behaviors that *are* expected. For example, in addition to a “no fighting” rule, the client might be instructed to consult with a particular staff member if he/she is angry and having difficulty resolving a difference.

- *Match expectations to the client's abilities*. Homeless individuals with co-occurring disorders are a heterogeneous population with a broad range of diverse needs. While programs need to be fair and consistent in setting expectations, there also should be some room for flexibility to accommodate the unique needs of individuals. Maintaining the appropriate balance of structure and flexibility is, in many ways, an art as well as a skill. Programs serving this population should have a variety of options available in order to match the pace and intensity of interactions to the clients’ abilities.

Ensure Safety

Safety should be of concern to anyone working with homeless individuals who have co-occurring disorders, especially those providers who work in unstructured settings such as the streets or shelters. Although these individuals are not necessarily more dangerous than people who have homes and are not disabled, they often live in crime-ridden areas. Some practical steps should be followed to avoid unnecessary risk (Bassuk, 1994; Winarski, 1994).

- *Go out with a partner*. If there is a need to meet with a person alone, the partner should observe from a short distance.
- *Avoid closed buildings or remote places* that seem particularly dangerous.
- *Trust your intuition*. Do not enter any situation that feels uncomfortable.
- *Develop a relationship with local law enforcement* officials, and become aware of safety issues that are specific to your community.

Assessment of Homeless Individuals with Co-Occurring Disorders

Assessing homeless individuals presents special challenges for practitioners. This segment describes characteristics of assessment that are specific to the unique needs of this population and summarizes some of the instruments and strategies that have been useful to practitioners in the field.

General Considerations from the CMHS/CSAT Collaborative Demonstration Program

Assessing people with co-occurring mental health and substance use disorders presented substantial challenges to each of the 16 demonstration programs. Providers routinely are confronted with complex and sometimes disturbing behaviors, a vast array of signs and symptoms, and settings for interventions that often lack the physical parameters required to structure clinical interventions. The challenge for each program was to collect and interpret information that would serve the immediate and long-term needs of each client.

The process for conducting assessments varied according to the type of intervention that was documented: outreach, case management, detoxification, day treatment, residential treatment, and system-wide coordination. The following discussion examines three characteristics of assessment that were common to, and necessary for, all of the demonstration programs, and that are specific to the unique needs of homeless people with co-occurring disorders (Winarski and Dubus, 1995).

Assessment is Ongoing

Each of the demonstration programs described a longitudinal approach to assessment, where a continuous process of collecting and interpreting information occurs as part of every client contact. Assessments generally are structured to acquire information about the signs and symptoms related to the person's biological, psychological, and social levels of functioning, rather than to make a diagnosis. It usually takes a period of many weeks and months to compile a comprehensive picture. Establishing a diagnosis that clearly distinguishes among the complex interaction of elements related to mental illness and substance use required the skilled interpretation of accumulated evidence and, ultimately, needed to include the analysis of a skilled clinician in a controlled setting, such as a hospital.

Programs utilized a combination of client self-report, observation, contact with family and significant others, a review of previous records, and some analysis of the congruence among these sources. Each program also developed a variety of intake, screening, and assessment forms. The most commonly used standardized instruments included the Mental Status Examination (MSE), the Michigan Alcohol Screening Test (MAST), the Addiction Severity Index (ASI), the CAGE questionnaire, and the Diagnostic Interview Schedule (DIS) based on the *DSM-III-R*.

The Structure of the Assessment Is Guided by the Hierarchy of Needs

Because homeless people with co-occurring disorders have such a diverse range of problems that can place basic survival in jeopardy, each of the programs structured assessments to follow a hierarchy of need. Homeless people live in conditions that expose them to the elements of weather, infectious diseases, violent crime, and the ready availability of chemical substances. They often do not receive treatment for medical and psychiatric conditions. Consequently, observations and inquiries about basic survival are a standard part of every contact and are especially important for programs targeting street dwellers and shelter residents.

Practitioners in the programs needed to be aware of the variety and severity of symptoms that may place a client in serious jeopardy. During the initial

contact and throughout the assessment process, practitioners repeatedly determined whether the person would do harm to him/herself or others, had the potential for being physically assaultive, could maintain a reasonable level of self-care, and exhibited deteriorating medical conditions.

After crisis situations have been stabilized and the most immediate basic support needs have been attended to, practitioners then can focus on issues related to social and psychological history. The focus of questions and inquiries often is established by the person's expressed need. For example, when a client expresses a need to find an apartment, the practitioner would begin the assessment by collecting information related to housing. As the person becomes engaged and agrees to work on a plan for treatment, more formal assessment procedures are implemented.

Programs also described the need to assess strengths as well as problem areas. They specifically assessed factors that contributed to survival, histories of positive relationships, and successful aspects of the person's social and vocational history. Programs included client strengths in the assessment process to promote a hopeful attitude and to support meaningful engagement in program activities.

The assessment process is integrally related to the client's progress. More accurate and detailed assessments become possible as clients establish stable living conditions and engage in meaningful treatment. Each of the programs noted that individuals became more involved in recovery when they perceived that their symptoms and addictions were obstacles to achieving positive goals. Assessment eventually became an activity that was done with, rather than to, the individual.

The Development of the Helping Relationship Is Integrated with the Process of Assessment

Each program described assessment as taking place concurrently with activities that facilitate the client's connection to the program. Information is gathered most effectively in the context of a trusting relationship and when pressures for basic survival are relieved. Practitioners cultivated trust through persistent and respectful attempts at engagement. Programs identified the need to gather assessment information during each contact, but never at the expense of alienating the person from the relationship (crisis situations are an exception).

Creating regular opportunities to meet in an environment free from distractions also is critical to conducting assessment with homeless people. As the helping relationship develops, clients are more honest about discussing sensitive emotional, medical, and psychiatric issues, substance use histories, and personal experiences that are critical to developing an accurate assessment.

Information Collection

Assessment is an ongoing process of collecting and organizing information, making immediate management decisions, and formulating appropriate treatment and referral plans. Assessing homeless individuals with co-occurring disorders can be a formidable task. Even in a controlled clinical setting, assessment is time- and labor-intensive, requiring a sophisticated set of clinical skills. Assessing clients on the street, in shelters, or other unstructured/non-clinical settings is even more challenging. Practitioners serving this population usually need to take decisive actions long before information collection is complete.

The following section represents a summary of the some of the instruments and strategies that have been useful for assessing this population. The focus is on identifying the data and screening processes that are most useful for early-phase assessments, where the emphasis is on stabilizing acute problems, identifying immediate treatment alternatives, and developing readiness for more intensive and long-term treatment activities.

Common Frameworks and Screening Instruments

The high prevalence rates of co-occurring disorders in both the general and homeless population require that individuals be screened for psychiatric and substance use disorders. Regardless of the treatment setting and the type of intervention, all contacts with individuals who may have co-occurring disorders should include a basic screening for psychiatric and alcohol and other drug disorders (AOD) that account for important biological, psychological, and social issues.

Practitioners often have a hard time deciding which disorder is primary and which is secondary. The focus at this point is on collecting information about the signs and symptoms of both disorders, rather than on establishing primacy or making a final diagnosis. However, the information collected should be considered an important part of an ongoing, longitudinal assessment and diagnostic process.

The following tables provide a common framework and some simple screening instruments for identifying the presence of co-occurring mental health and substance use disorders. Table 3 identifies the biological, psychological, and social issues that are important to consider when conducting an assessment, from both an AOD and psychiatric perspective. Table 4 describes the ABC Model, a simple screening technique for the presence of psychiatric

disorders. Table 5 describes the CAGE and CAGEAID questionnaires, a screening tool for detecting alcohol and other drug disorders.

Table 3
Biopsychosocial Assessment Issues from the AOD and Psychiatric Perspective

	AOD	*Psychiatric*
Biological	Alcohol on breath Positive drug tests Abnormal laboratory tests Injuries and trauma Toxicity and withdrawal Impaired cognition	Abnormal laboratory tests Neurological exams Psychiatric medications Other medications, conditions
Psychological	Intoxicated behavior Withdrawal symptoms Denial and manipulation Responses to AOD assessments AOD use history	Mental status exam Affect, mood, psychosis, etc. Stress, situational factors Self-image, defenses, etc.
Social	Collateral information Social interactions Involvement with other AOD groups Family history Housing and employment history	Support systems--family, friends, others Current psychiatric therapy Hospitalization

(CSAT, 1994)

Table 4
ABC Model for Psychiatric Screening

	Appearance, Alertness, Affect, and Anxiety
Appearance	General appearance, hygiene, dress.
Alertness	What is the level of consciousness?
Affect	Elation or depression, gestures, facial expression, and speech.
Anxiety	Is the individual nervous, phobic, or panicky?
	Behavior
Movements	Rate (hyperactive, hypoactive, abrupt, or constant?).
Organization	Coherent and goal-oriented?
Purpose	Bizarre, stereotypical, dangerous, or impulsive?
Speech	Rate, organization, coherence, and content.

	Cognition
Orientation	Person, place, time, and condition.
Calculation	Memory and simple tasks.
Reasoning	Insight, judgment, problem-solving.
Coherence	Incoherent ideas, delusions, and hallucinations?

(CSAT, 1994)

Table 5
The CAGE and CAGEAID Questionnaires for Screening AOD Use Disorders

The CAGE Questionnaire (Mayfield, et al., 1974)
Have you ever felt you should cut down on your drinking?
Have people annoyed you by criticizing your drinking?
Have you felt bad or guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?
The CAGE Questions Adapted to Include Drugs (CAGEAID) (Brown, 1992)
Have you felt you ought to cut down on your drinking or drug use?
Have people annoyed you by criticizing your drinking or drug use?
Have you felt bad or guilty about your drinking or drug use?
Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover, or get the day started?

Assessing Acute Problems

The initial step in assessing homeless individuals with co-occurring disorders involves determining whether the individual is “at risk” or “in crisis.” “At risk” is a condition that warrants serious attention, requires monitoring, and could lead to a crisis if not attended to. “In crisis” is a condition that requires an immediate response to alleviate an urgent situation. Three primary areas require assessment--medical (biological), psychological, and social. Practitioner assessments should include direct client interviews, collateral data, client observations, and a review of available documented history. The following is a list of questions/areas that are critical for exploration (CSAT, 1994).

Medical issues

Has the person been diagnosed or hospitalized for any major medical disorders?

Has there been a recent onset of any significant medical symptoms?
Have there been any episodes of head trauma or loss of consciousness?
Does the person take any prescribed or over-the-counter medications?
Have there been any recent changes in medication?
Has there been recent use of alcohol or other drugs?
What are the person's recent nutritional and sleep patterns?
What is the persons's cognitive level of functioning? Specifically assess orientation, memory, concentration, language, and comprehension.

Psychological issues

Does the person have a plan, means, and intent to commit violence to self or other?
Has the person experienced command hallucinations and delusions that have directed him/her to hurt him/herself or others?
Does the person demonstrate evidence of impaired judgment or cognition that may contribute to impulsive or destructive behaviors?
Does the person have a history of suicidal or homicidal behaviors?

Social issues

Does the person have access to sources for meeting basic needs such as food, shelter, money, medication, or clothing?
Has the person been the victim of violence or physical or sexual abuse?
Has the person exchanged sex for money, drugs, or shelter?

Signs, symptoms, and management risks

Practitioners commonly encounter individuals who are distressed, anxious, or agitated in response to the extreme stress of homelessness. Problems may be caused by any combination of medical, psychiatric, and substance use disorders. During initial contacts, the practitioner should make meaningful observations about the nature of these difficulties and quickly translate these impressions into actions. Table 6 summarizes signs and symptoms that are indicative of acute problems, and Table 7 identifies critical management options.

Table 6
Symptoms and Signs that Indicate Acute Problems

Symptoms	*Signs*	*Risks if Not Immediately Managed*
Intoxication (Alcohol)	Slurred speech; unsteady gait; loss of coordination; smell of alcohol.	Accident prone; rages; may erupt into violence; increased risk of suicide/homicide; risk of long-term neglect; risk of trauma: head injury, bone fractures.
(Heroin)	Constricted pupils; apathy; decreased activity.	Acute medical emergency and even death; risk of long-term neglect; difficulty functioning; antisocial behavior.
(Cocaine)	Restless; agitated; depressed.	Loss of energy; unable to function.
(Hallucinogens)	Severe panic; visual hallucinations; loss of identity.	Accident prone; irrational behavior.
Withdrawn, uncommunicative	Quiet; unresponsive; may have paranoid or psychotic features.	Long-term neglect; functionally impaired; increasing disability.
Suicidal behavior	Depression; thoughts about suicide; past suicide attempts.	Risk of suicide; may be increased by drugs or alcohol.
Agitation, threat of violence	Aggressive; poor impulse control; increasing belligerence poorly contained by relationship.	May erupt into violence; disruptive to milieu.
Serious and chronic self-neglect	Lack of motivation; extreme withdrawal; risk-taking behavior.	Functionally impaired; accident prone; serious illness.
Confusion, disorientation	Fluctuating level of consciousness (e.g., drowsy, stuporous); no sense of time or place; memory impaired; inattentive; lack of judgment and insight.	Serious medical problems that may worsen; may be caused by head injury, substance withdrawal, infection.

(Bassuk, 1994)

Table 7 **Responding to Acute Symptoms**	
Symptoms	*Crisis Management Options*
Intoxication Alcohol and poly-substance abuse Cocaine Hallucinogens	Support and reassurance. Limit setting.
Withdrawn, uncommunicative	Establish rapport. Determine nature of problem. Management options will depend on the nature of the crisis.
Suicidal behavior	Provide support and reassurance Closely observe. Refer to ER if actively suicidal. Refer to mental health counselor if not actively suicidal. Be sure to maintain some contact with the client until referral is made.
Agitation, threat of violence	Attempt to de-escalate crisis through supportive and directive interviewing. Determine if client is confused (see below). If he/she is, then transport to nearest hospital. Otherwise, set limits. If unresponsive, involuntarily commit if he/she meets criteria. Otherwise, ask him/her to leave.
Serious and chronic self-neglect	Establish rapport. Negotiate a referral. Refer to appropriate facility.
Confusion/disorientation Withdrawal from substances Head trauma and other medical problems	Transport to nearest hospital ER.

(Bassuk, 1994)

Identifying Longer-Term Needs

Once the practitioner determines that the person is not in crisis, the focus of assessments can shift to the behaviors, signs, and symptoms that impact longer-term functioning. The process of gathering and interpreting relevant information should be considered as an integral part of the overall treatment process, rather than as a discrete activity that occurs only prior to treatment (Kofoed, 1991). Effective assessments are conducted within the context of trusting relationship and are linked closely to the treatment process. The following are a list of

probing questions for acquiring more detailed information about delusions, hallucinations, and AOD use (CSAT, 1994).

Probing questions for delusions

"Do you sometimes feel as if people are talking about you?"
"Do you sometimes feel as if people are purposefully trying to injure or offend you?"
"Have you ever felt you were receiving special messages through the television, radio, or other sources?"
"Do you sometimes feel that you have special powers that other people do not have?"
"Have you ever felt that something or someone outside yourself was controlling you behavior, thoughts, or feelings against your will?"

Probing questions for auditory hallucinations:

"Do you sometimes hear things that other people cannot hear?"
"During these episodes, what exactly do you hear?"
"If you heard voices, what were the voices saying?"
"If you heard voices, did the voices tell you what to do, or criticize your thoughts or behaviors?"
"How often do you have these experiences?"

Probing questions for AOD disorders

"Do you often drink or use other drugs more than you plan to?"
"Have you made attempts to cut down or stop using alcohol and other drugs?"
"How much time during the week do you spend obtaining, using, or recovering from the effects of alcohol and other drugs?"
"Since you began using, have you stopped spending more time with family and friends and begun spending more time using alcohol and other drugs, or spending more time with people who do?"

In addition to collecting information about the signs and symptoms related to illness and addiction, practitioners need to learn about the person's overall functioning within the context of his/her living environments. The following questions explore the person's overall status, as well as the availability of resources and potential barriers to treatment (Bassuk, 1994).

Person's overall status

What is the person's view of his/her situation?
What are his/her strengths?
How much distress is he/she in?

How impaired is his/her overall functioning?
What is his/her level of motivation?

Availability of resources/Potential barriers to treatment

How well known is the person at area programs?
Is the person involved in treatment currently or has he/she been involved in the past?
What is the history of treatment? Will the person give you permission to call his/her current caregiver, if necessary?
How does the person view the provider?
What were the obstacles to treatment in the past, if any? Is the person resistant to treatment? If yes, describe.
Are there any family or other supports?
What is the person's daily life like?
Is transportation available?

Specific Instruments for Assessing Co-Occurring Disorders

Brief instruments such as the CAGE questionnaire, the Michigan Alcohol Screening Test (MAST), and case manager rating scales will detect most AOD disorders (CSAT, 1994). However, practitioners serving clients with mental health disorders have been limited by a lack of validated instruments for assessing substance use disorders in people with severe mental illnesses.

This situation has recently improved with the publication of the *Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness* (©1995 Robert E. Drake). The toolkit provides the information needed to assess the presence of substance use disorders in persons with a psychiatric disorder, to determine the severity of the alcohol and drug abuse, and to gauge where an individual falls on the continuum of recovery from substance abuse (Mueser, et al., 1995). The text specifically includes a discussion of the following information:

- A review of the scope and prevalence of substance use among individuals with severe psychiatric disorders.
- A discussion of measurement problems and a consideration of the differences between assessment and treatment planning.
- A review of the recovery process for persons with co-occurring disorders, along with rating scales for monitoring the recovery process.

- A discussion of methodological and training aspects of assessing substance use disorders in people with severe mental illnesses.
- An examination of the public policy implications of conducting substance use assessments with this population.

The three clinician rating scales will be of special interest to practitioners serving this population. The alcohol and drug use scales were developed to enable clinicians to assess and monitor substance use in people with severe mental illness. The scales describe the categories of abstinent, use without impairment, abuse, dependence, and dependence with institutionalization.

The Substance Abuse Treatment Scale is designed to assess the person's stage of substance abuse treatment and is not used for establishing a diagnosis. The scale describes eight stages of treatment: pre-engagement, engagement, early persuasion, late persuasion, early active treatment, late active treatment, relapse prevention, and in remission or recovery.

A Vignettes for Substance Abuse Treatment Scale provides case examples for each of the treatment stages. In addition, the toolkit includes a Drug/Alcohol Follow Back Calendar that provides a framework for gathering information about alcohol and drug use. The scales are designed to be user-friendly and easy to administer.

The *Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness* also provides the rating scales on a 3.5" disk. The Toolkit is available for $15 from Human Services Research Institute (HSRI) in Cambridge, MA, (617) 876-0426.

Building Motivation for Change

Engaging homeless individuals with co-occurring disorders into treatment is one of the most formidable challenges for practitioners serving this population. These individuals often have experienced significant and sometimes traumatic disruptions of interpersonal relationships. Many have also had negative experiences with service providers. Maintaining hope in the face of deprivation and an often indifferent culture is a significant challenge for both clients and practitioners.

Case studies describe individuals who often are not interested in, or ready for, participation in active treatment programs (Winarski and Dubus, 1995). In examining the factors that impact the person's motivational state (Miller and Rollnick, 1991), we can observe that many of these individuals do not perceive a need to change, do not believe that positive change is possible, have more often

been the recipient than the initiator of changes, and have not had opportunities to meaningfully discuss their intentions to make changes. Enhancing motivation and developing readiness to take positive actions are critical precursors to involvement in any treatment program.

The Stages of Change

The basic assumption from which all motivational development strategies are derived is that motivation is a state of readiness to change rather than a fixed personality trait. It is not an inherent and unchanging dimension of character. Motivation can change over time and is subject to influences that may come from inside or outside of the person. Practitioners can conduct activities that will increase an individual's readiness to make positive changes.

Prochaska and DiClemente (1982) have developed a model describing the stages through which people pass in the course of changing a problem. It provides a useful framework for understanding how change occurs. The authors describe six specific stages, each reflecting an internal state that can be influenced by external factors.

Precontemplation Stage

During this initial stage the person is not yet considering the possibility of change and is not likely to be interested in treatment activities. The person has probably not contemplated having a problem and does not yet perceive a need to change. For example, a homeless person with co-occurring disorders may be comfortable using a variety of chemical substances that are common to his/her peer group. He/she may not perceive substance abuse as a prime contributor to health problems or to difficulties with keeping a job and an apartment. At this point, only someone outside of the person is aware of a problem.

The challenge to practitioners during the precontemplation stage is help the person develop a felt need to change based on an awareness of a problem and the possibility for change. Providing feedback about the consequences of behaviors can facilitate deeper awareness. The person will not be receptive to advice and invitations for services that are not perceived as needed. However, the practitioner should explore how substance abuse created barriers to achieving valued goals.

Contemplation Stage

The contemplation stage represents the initial stages of awareness of a problem and is usually characterized by a feeling of ambivalence. It is common for the

person to question the advantages and disadvantages of making changes, and to experience difficulty reaching a clear decision.

The prime task for the practitioner is to help the person decide in the direction of change. This is best accomplished by exploring the reasons to make a change and the risks of not doing so, rather than by making recommendations about solutions or treatment. It is also helpful to reinforce any decisions and steps for positive change the person has made in the past.

Determination Stage

In the determination stage, the person has "tipped the balance" toward making a change. This may be reflected in statements that reflect the beginnings of motivation. For example, the person may say, "I'm tired of blackouts and waking up in the gutter. I've got to do something or I may be dead soon!"

This stage represents a temporary state from which the person may begin to take action or return to further contemplation of the pros and cons. The primary task for the practitioner is to help the person find a course of action that is "acceptable, accessible, appropriate, and effective." The determination stage often represents a narrow window of opportunity that can close at any time. It is critical for practitioners to be aware of its opening and to respond appropriately.

Action

During the action stage, the person takes steps that are intended to bring about change. For practitioners, this often involves engaging the person in specific treatment activities to produce changes in particular problem areas. For example, the person may agree to enter a residential treatment program that requires abstinence from alcohol and drugs.

Maintenance Stage

During the maintenance stage, the person sustains the change accomplished by previous actions. The challenge of maintaining long-term change is different from the steps necessary for initial change. For example, the person who entered residential treatment may begin to question if it is worth the effort and may have had expectations about the recovery experience that were not realized. A return or relapse to previous problem behaviors is not uncommon. The primary task for the practitioner is to provide the person with the knowledge and skills to help prevent relapses.

Relapse Stage

If the person relapses into previous problem behaviors, his or her primary task is to return to the process of change as soon as possible. Most people do not achieve long-standing change without some setbacks. The key task for the practitioner is to help the person overcome discouragement and recognize relapse as a normal part of achieving goals that will endure. The focus should be on continuing to contemplate change and to renew determination, action, and maintenance efforts.

It is important to recognize that most people cycle through these stages several times before achieving enduring, long-term change. Prochaska and DiClemente (1982) observed that smokers typically cycled through these stages between three and seven times before quitting for good. The stages also provide valuable insights into the nature of recovery as it relates to the broad range of human experience. Homeless individuals with co-occurring disorders experience the process of change in the same way as any person. Illness and addiction present special challenges, but the fundamental tasks required to produce lasting change are universal.

The implications for practitioners are significant. Motivation is a state that is subject to change from a broad range of internal and external influences. Practitioners can work with individuals to enhance the state of motivation as part of an overall strategy of helping people take the steps that will lead to lasting change. Further, particular change strategies are most effective for influencing specific stages of change. Table 8 presents a summary of practitioner tasks that are critical for each stage of change.

Table 8
Practitioner Tasks for Stages of Change

Client Stage	*Practitioner's Motivational Task*
Precontemplation	Raise doubt--increase the client's perception of risks and problem with current behavior.
Contemplation	Tip the balance--evoke reasons to change, risks of not changing, strengthen the client's self-efficacy for change of current behavior.
Determination	Help the client to determine the best course of action to take in seeking change.
Action	Help the client to take steps toward change.
Maintenance	Help the client to identify and use strategies to prevent relapse.

Relapse	Help the client to renew the process of contemplation, determination, and action, without becoming stuck or demoralized because of relapse.

Five Principles of Motivational Interviewing

The following section describes some of the basic principles and strategies for building motivation that are presented in *Motivational Interviewing: Preparing People to Change Addictive Behavior* (Miller and Rollnick, 1991). Readers who wish more detailed information about the steps for conducting motivational interviewing are referred to the text, available from the publisher (Guilford Press, New York), and to the manual, *Motivational Enhancement Therapy*, available free of charge from the National Clearinghouse for Alcohol and Drug Information, (800) 729-6686.

Miller and Rollnick (1991) describe five broad principles that provide an important context for applying the strategies of motivational interviewing. This approach presumes that all individuals have an inherent potential for change, and that it is the responsibility of practitioners to unlock that potential. More than a set of techniques, this approach focuses on treating individuals with respect, and as an ally rather than an adversary. The goal of motivational interviewing is to "get the person unstuck and to start the change process happening." The following principles describe the foundation for building a relationship that can help individuals overcome barriers to producing enduring change.

Express Empathy

Motivational strategies are best employed within the context of relationship that refrains from judgment and focuses on understanding the perspective of the client. An attitude of acceptance and respect contributes to the development of an effective helping relationship and enhance the individual's self-esteem. The focus is on respectful listening and exploration. Ambivalence and uncertainty are viewed as a normal part of the change process. Empathic responses demonstrate that the practitioner understands the person's point of view and provide an important basis for engaging the person in a process of change. In summary, the authors emphasize three important points about expressing empathy and developing readiness for change:

- Acceptance facilitates change.
- Skillful, reflective listening is fundamental.
- Ambivalence is normal.

Develop Discrepancy

The principle of developing discrepancy is based on the understanding that motivation for change is created when the person perceives a discrepancy between his/her present behavior and important personal goals (Miller, 1985b). Many homeless individuals with co-occurring disorders experience some ambivalence about the nature of their problems and whether it is advantageous to take actions for change. The goal of motivational interviewing is to explore and develop this discrepancy.

By exploring the pros and cons of change, the practitioner facilitates a confrontation that occurs within the person, rather than one that is imposed from outside. The focus is on exploring the impact of current behaviors on the achievement of personal goals. The practitioner seeks to increase the person's perception of discrepancy without exerting pressure or coercion. When successful, the person's perception of discrepancy leads to a perceived need to take actions for change. In summary, the authors emphasize three important points about developing discrepancy and creating readiness for change:

- Awareness of consequences is important.
- A discrepancy between present behavior and important goals will motivate change.
- The client should present the arguments for change.

Avoid Argumentation

Because motivational states can be influenced by external factors, and resistance to change is strongly affected by the practitioner's response, arguments should be avoided. Direct confrontations in which the practitioner accuses the person of denial usually result in defensive responses and increased resistance to change. Resistance is an indication that the practitioner should change strategies rather than argue. The authors also warn against requiring that the person accept a diagnostic label, such as "alcoholic" or "bi-polar." The emphasis is on helping the person with self-recognition of problem areas rather than coerced admission. In summary, the authors emphasize four important points about avoiding argumentation and developing readiness for change:

- Arguments are counterproductive.
- Defending breeds defensiveness.
- Resistance is a signal to change strategies.

- Labeling is unnecessary.

Roll with Resistance

Practitioners should not view resistance as a force that must be overcome or defeated. Rather, the practitioner should provide information and alternatives and skillfully explore possible solutions. Resistance is a response generated by the person's perception of the problem. The task of the practitioner is to help the person develop perceptions that are conducive to achieving goals and taking positive actions. This approach assumes that the person has the capacity to contribute to problem-solving. Indeed, the person must contribute for there to be a chance for lasting success. In summary, the authors emphasize four important points about rolling with resistance and developing readiness for change:

- Momentum can be used for good advantage.
- Perception can be shifted.
- New perspectives are invited but not imposed.
- The client is a valuable resource in finding solutions to problems.

Support Self-Efficacy

Even if a person recognizes that he/she has a serious problem that needs improvement, no effort is likely unless the person has hope for change. Self-efficacy refers to the person's belief in his/her ability to take the steps that will lead to some positive outcome. It relates to the person's confidence to take on and complete a task. For homeless individuals with co-occurring disorders, this level of confidence is often low. In spite of demonstrating a remarkable capacity to survive, individuals often have suffered many disappointments. The challenge for practitioners is to convince the person that it is still within his/her power to make a change.

A person is more like to take steps toward change when available options are perceived as desirable and achievable. For example, an individual is not likely to commit to acquire housing if he/she believes that no desirable alternatives exist. Ultimately, the person needs to be able to say, “I can do it,” before he/she can say, “I will do it.” In summary, the authors emphasize three important points about supporting self-efficacy and developing readiness to make changes:

- Belief in the possibility of change is an important motivator.
- The client is responsible for choosing and carrying out personal change.
- There is hope in the range of alternative approaches available.

Contrasting Motivational Interviewing with Three Common Approaches

The authors describe how motivational interviewing differs from three other approaches that focus on more confrontational strategies for producing change: confrontation-of-denial approach, skill-training approach, and nondirective approach. The comparisons in Tables 9, 10, and 11 provide an overview that clarifies the distinguishing characteristics of the motivational interviewing approach (Miller and Rollnick, 1991).

Table 9
Contrasts between Confrontation-of-Denial and Motivational Interviewing Approaches

Confrontation-of-Denial Approach	*Motivational Interviewing Approach*
Heavy emphasis on acceptance of self as having a problem; acceptance of diagnosis seen as essential for change.	De-emphasis on labels; acceptance of "alcoholism" or other labels seen as unnecessary for change to occur.
Emphasis on personal pathology, which reduces personal choice, judgment, and control.	Emphasis on personal choice and responsibility for deciding future behavior.
Therapist presents perceived evidence of problems in an attempt to convince the client to accept the diagnosis.	Therapist conducts objective evaluation, but focuses on eliciting the client's own concerns.
Resistance is seen as "denial," a trait or characteristic requiring confrontation.	Resistance is seen as an interpersonal behavior pattern influenced by the therapist's behavior.
Resistance is met with argumentation and correction.	Resistance is met with reflection.
Goals of treatment and strategies for change are prescribed for the client by the therapist; the client is seen as "in denial" and incapable of making sound decisions.	Treatment goals and change strategies are negotiated between client and therapist, based on data and accessibility; the client's involvement in, and acceptance of, goals are seen as vital.

Table 10 **Contrasts Between Skill-Training and Motivational Interviewing Approaches**	
Skill-Training Approach	*Motivational Interviewing Approach*
Assumes that the client is motivated; no direct strategies are used for building motivation.	Employs specific principles and strategies for building client motivation for change.
Seeks to identify and modify maladaptive cognitions.	Explores and reflects client perceptions without labeling or "correcting" them.
Prescribes specific coping strategies.	Elicits possible change strategies from the client and significant others.
Teaches coping behaviors through instruction, modeling, directed practice, and feedback.	Responsibility for change methods is left with the client; no training, modeling, or practice.
Specific problem-solving strategies are taught.	Natural problem-solving processes are elicited from the client and significant others.

Table 11 **Contrasts between Nondirective and Motivational Interviewing Approaches**	
Nondirective Approach	*Motivational Interviewing Approach*
Allows the client to determine the content and direction of counseling.	Systematically directs the client toward motivation for change.
Avoids injecting the counselor's own advice and feedback.	Offers the counselor's own advice and feedback where appropriate.
Empathetic reflection is used unconditionally.	Empathetic reflection is used selectively, to reinforce certain processes.
Explores the client's conflicts and emotions as they exist currently.	Seeks to create and amplify the client's discrepancy in order to enhance motivation for change.

Practitioner responses during the early stages of an individual's recovery are critical for developing an effective helping relationship and supporting a process of change. Ultimately, providers need to help "unmotivated" individuals develop readiness to take actions that will lead to enduring, positive changes.

Critical Program Components

The range of needs experienced by homeless individuals with co-occurring disorders is broad and typically requires that practitioners provide multiple services and supports. Many individuals may need to access the entire range of medical, mental health, and social support services in a community at various points in time. The following list of specialized service components are critical for addressing the specific needs of homeless individuals with co-occurring disorders. The components include housing with services, group treatment, detoxification, toxicological screening, family involvement, and self-help groups.

Housing

Housing is one of the most urgent needs for homeless individuals with co-occurring disorders. Helping people acquire and maintain adequate and stable housing is a critical part of any plan supporting recovery from mental health and substance use disorders. In addition, providing treatment for co-occurring disorders is important to help reduce the risk of homelessness and to enable individuals to escape homelessness (Osher and Dixon, 1995).

The factors that contribute to homelessness among this population are complex and involve both social and economic factors, as well as issues related to illness/addiction and disability. The Federal Plan to Break the Cycle of Homelessness (1994) identified declining wages, lost jobs, poor schooling, persistent illiteracy, racial discrimination, declining public entitlements, chronically disabling health and mental health problems, the scarcity of affordable housing, the increasingly concentrated nature of poverty, and changes in family and household structures as significant factors contributing to homelessness. Though it is difficult to discern the relative causal impact for each of these factors, studies have demonstrated that, as a group, individuals with co-occurring psychiatric and substance use disorders are disproportionately at risk for housing instability and homelessness (Belcher, 1989; Drake, Osher and Wallach, 1991; Canton, et al., 1993).

Strategies for helping homeless individuals with co-occurring disorders acquire and maintain housing need to account for the preferences and the treatment and support needs of the individual, as well as the available housing options. Osher and Dixon (1995) have identified four elements that are specific to developing and implementing housing for people with co-occurring disorders.

Residential Tolerance

Practitioners need to determine the degree to which residential environments will tolerate the behaviors of individuals who are recovering from illness and addiction. Individuals at different stages of recovery exhibit varying levels of readiness for participating in programming and adapting to residential expectations. Most housing programs that include treatment and supports for co-occurring disorders prohibit the use of alcohol and other drugs. Independent apartments and rooming houses offer no such formal requirements, but private landlords are reluctant to rent to individuals with mental illnesses and/or substance use problems, and eviction is likely if the person demonstrates behavioral problems. Practitioners play a critical role in coordinating the efforts of housing and service providers and should provide the following functions to meet the special needs of this population (Interagency Council on the Homeless, 1992):

- Assess the person's readiness to meet the behavioral requirements of residential environments.
- Provide services and supports that reflect the treatment stage of the individual (Osher and Kofoed, 1989).
- Develop a plan for responding to emergencies and special needs.
- Identify and advocate for the housing needs of individuals with co-occurring disorders.

Safety

Homeless people often live in environments that are dangerous, and they are frequently victims of crime. Many have suffered multiple losses, extreme deprivation, and abuse. Any plan for housing homeless individuals needs to ensure that the residence is safe. A safe residence helps the person develop the internal experience of security that is critical for recovery.

Respect for Client Preference

A prime task for practitioners is to balance availability, client preference, and client need when planning and implementing housing interventions. The range of housing options for this population is often limited. Individuals may not have the functional capacity to be successful in the residences they prefer and/or the service system may not provide adequate supports.

Cooperative Agreements between Providers and Housers

The ultimate success of any strategy to house homeless individuals with co-occurring disorders depends upon the collective efforts of mental health/substance abuse providers and housing providers. The complex needs of clients, and the administrative and economic separation of housing and treatment services, present many formidable challenges to working together effectively. Cooperative agreements can be a useful mechanism for integrating essential services and resources. They identify responsibility and accountability for critical tasks and ensure that clients receive the appropriate combination of housing, services, and supports.

Case Management Models

Case management has emerged as an important intervention for homeless individuals with co-occurring disorders. Many of these individuals have complex needs that require attention from multiple providers in the community. In addition, these individuals often have difficulties with both accessing and staying connected to needed services. Case management services are designed to address directly the issues of client access and service integration. Recent program demonstrations have shown that case management could be used to integrate treatments and was helpful in engaging individuals into community services (Mercer-McFadden, and Drake, 1994).

Case management interventions have been used to engage hard-to-reach persons with severe psychiatric disabilities for many years (Test and Stein, 1976). A variety of models have evolved, but most case management programs share the following elements: assertive outreach, linking/referral to direct services, monitoring functions, education about disorders (symptoms and addictions), and the coordination of treatment planning across programs (Osher and Kofoed, 1989). Many models that include combinations of the above functions have been employed in both mental health and substance abuse treatment settings (Willenbring, et al., 1991). The following summary describes three case management models that have been used prominently for individuals with co-occurring disorders: the Brokerage Model, the Dyad Model, and the Assertive Community Treatment Model.

Brokerage Model

The Brokerage Model focuses on coordinating treatment plans and is especially needed in systems where mental health and substance abuse services have been separate, and treatment for people with co-occurring disorders has been implemented on parallel tracks. The goals are to develop an ongoing relationship, link the client to services, and resolve crises. The Brokerage

Models has also been implemented to achieve system-oriented goals, such as reducing inpatient hospitalizations.

Case managers using the Brokerage Model identify clients who are at risk for not receiving appropriate services and develop a close working relationship with both the mental health and substance abuse programs. They serve as the critical linkage point between the client and the network of service providers. (Winarski and Dubus, 1995). The case manager can make a critical difference in ensuring that clients are not lost to the service delivery system, but they can not serve as a substitute for a coordinated system of care.

Dyad Model

The Dyad Model of case management utilizes teams of two case managers who are cross-trained in providing mental health and substance abuse services. Programs employing this model focus on providing both direct services and coordination services, including the following activities: outreach, assessment, service planning, linking and monitoring of services, skills development, and advocacy (Winarski and Dubus, 1995).

The Dyad Model is similar to the Assertive Community Treatment Model in addressing the unique needs of individuals with co-occurring disorders, but is designed to be less cumbersome than larger teams in providing comprehensive, in-vivo services. The dyad is also structured to facilitate a close helping relationship between the client and both of the team members. In addition, by combining staff and training resources from the mental health and substance abuse fields, this models contributes to the overall integration of the treatment system.

Assertive Community Treatment Model

The Assertive Community Treatment (ACT) Model provides outreach, intensive interventions, and service integration functions similar to case management models that were developed to respond to the needs of individuals with severe psychiatric disabilities (Test and Stein, 1976), but provides adaptations to meet the needs of people with co-occurring substance use disorders (Teague, Drake, and Akerson, 1995).

This model employs a multidisciplinary team approach that includes clinicians with a background in psychiatry, nursing, case management, substance abuse, and rehabilitation. The teams provide substance abuse interventions that are specific to the phase model of treatment (Osher and Kofoed, 1989). The ACT Model deals with service fragmentation by drawing on the mutual expertise of the team rather than by referring the client to other agencies, and its base of operations is within the mental health system (Drake, et al., 1991).

The case management functions of assessing, planning, linking, monitoring, and advocating are conducted by various members of the team, each of whom has a relationship with the client, and whose role is determined by the client's individual treatment needs. The implementation of motivational approaches to prepare clients for substance abuse treatments is an important program component (Drake and Noordsy, 1994).

Each of these approaches shares on emphasis on aggressive outreach; ongoing, long-term helping relationships; the need for cultural relevance; and a focus on facilitating access to essential treatment and support services. The size of caseloads vary, with the case managers in the Brokerage Model carrying the most clients. The flexibility of case management interventions allows practitioners to adapt to the complex needs of this population. By integrating interventions that are specific to the stages of substance abuse treatment (Osher and Kofoed, 1989), they also can be instrumental in engaging individuals in a process of recovery from addictions (Drake and Noordsy, 1994).

Group Treatment

Group approaches to treatment are increasingly recognized as an essential component of services for individuals with co-occurring disorders (Kofoed and Keys, 1988; Hellerstein and Meehan, 1987; Osher and Kofoed, 1989). Groups can be designed to facilitate movement through treatment stages (Osher and Kofoed, 1989) and to provide psychoeducational information and peer support (Hellerstein and Meehan, 1987).

Noordsy and Fox (1991) described group intervention techniques that include strategies specific to treatment stages, focus on psychoeducation and skill development, and offer integration with self-help programs. The two primary groups are described below.

Persuasion Groups

Persuasion groups provide a nonconfrontational approach to help participants become aware of the negative consequences of drug use in their lives. The pace and intensity of interactions are adapted according to the needs of the individual participants. Acknowledging problems with alcohol or other drugs is not a prerequisite for participation, and group leaders need to be able to manage behaviors related to the symptoms of illness/addiction, while also focusing on the specific tasks of the group.

Active Treatment Groups

Active treatment groups provide a more focused, behavioral approach for clients who are beginning to develop an interest in abstinence. The group provides exercises for acquiring the knowledge and skills that support sobriety, including information about symptoms and strategies for medication compliance. Peer interaction is encouraged, and successful peers serve as models for other group members. The group also focuses on the feelings and struggles that are common to individuals attempting to maintain sobriety. Participants in the group should be screened and matched according to their verbal, social, and cognitive levels of functioning.

Detoxication

For many individuals, detoxification is an early step in dealing with a substance use addiction and psychiatric symptomatology. People often enter detoxication units during a period of crisis, sometimes involuntarily, and present unique challenges to practitioners. The process of evaluation, detoxification, stabilization, behavior management, treatment planning and referral are all complicated by symptoms of mental illness. A detoxification program in the CMHS/CSAT Collaborative Demonstration Program developed an intervention specifically for clients with co-occurring disorders that included the adaptations described below (Winarski and Dubus, 1995).

- Because individuals with psychiatric disorders are more vulnerable to experiencing intense symptoms during withdrawal that may contribute to disruptive behaviors the program implemented four management precautions: (1) doors had alarms to alert staff of a client leaving the unit prematurely; (2) an unlocked and observable “quiet room” was created for clients requiring less stimulation; (3) an emergency/crisis unit was made available for severely ill clients; and (4) the standard five-day chlordiazepoxide detoxification protocol for acute treatment of agitation was extended for use during the client’s entire stay.

- More staff were designated for behavior monitoring and medical consultation. The direct-care staff of addiction counselors and aids provided regular, intensive support.

- When the person achieved medical and psychiatric stability, he/she made the transition to a highly structured milieu that provided group treatment focused on psycho-education, self help, and services and supports needed after discharge.

- The program attempted to form strong helping relationships with individuals who were high recidivists. Rather than treat each admission as a singular acute episode requiring stabilization, the unit

also tried to build a foundation for recovery and increase the client's readiness to use community supports.

- Practitioners focused on engaging clients in longer-term interventions. Detoxification has no lasting benefit unless it is followed by long-term rehabilitation and support.

Toxicological Screening

Toxicological screening can be a useful tool for supporting abstinence in programs that are providing active treatment to individuals with co-occurring disorders. Because substance abuse is a chronic and relapsing disorder, and denial is a common feature, it is essential to have a mechanism to provide accurate feedback about alcohol and other drug use. Osher and Kofoed (1989) described the benefits of using random Breathalyzer™ and urine drug tests to detect unacknowledged relapse. These techniques

- support abstinence in the treatment milieu;
- provide clients with an external support for remaining abstinent during a period when an internal commitment is not fully developed; and
- provide clients who are successfully abstinent an opportunity to develop confidence.

Family Involvement

Family members can offer valuable support in assessing and treating homeless individuals with co-occurring disorders, and they can be instrumental in providing the human connection that is needed for integration into mainstream culture and long-term recovery. Though homeless people sometimes have lost connection to family relationships, practitioners should explore these and other meaningful associations with the client. However, practitioners should always get the person's permission prior to contacting family and should respect confidentiality. Involving the family in treatment has many potential benefits, as noted below.

- Families can provide information that is valuable for making an accurate assessment.
- By educating family members about illnesses/disorders, they can help identify the early onset of symptoms and/or drug use.

- Family participation in monitoring substance use can increase motivation and reduce the incidence of relapse.

- Healthy family support can provide the experience of safety and security that is essential for long-term recovery.

Family members also benefit from receiving emotional support and information about treatment that can help them cope with their relatives' symptoms of illness and addiction. Family support groups provide important assistance, as do groups that may include the individual with co-occurring disorders.

Self-Help Groups

Self-help groups such as AA and NA that are based on a 12-step recovery program provide interpersonal supports, education, and structure for many recovering individuals. They have been an invaluable asset for people who are comfortable with the 12-step program orientation. These groups also can be helpful to individuals with co-occurring mental health disorders, though the membership in some groups may not be accepting of psychiatric treatment, especially the use of psychotropic medications. Though negative attitudes about psychiatry are changing and not representative of all meetings, practitioners should be aware of the group's orientation to mental health issues before referring the client. Practitioners also should orient the person to 12-step principles and the 12-step group process.

Self-help groups that use 12-step principles and are adapted for people with mental health problems are becoming more common in many communities. These groups are more sensitive to the needs of people with mental health problems, more tolerant of behavior problems, and supportive of mental health treatments, including the use of psychotropic medications. They can be an invaluable component of treatment for individuals with co-occurring disorders.

System Planning/Coordination and Client Advocacy

Individuals with co-occurring disorders typically require various services and supports over an extended period of time that ideally should be provided within an integrated system of care. The Federal Task Force on Homelessness and Severe Mental Illness (Interagency Council on the Homeless, 1992) has recommended that an integrated system include health care, mental health services, substance abuse treatment, social services, income support, legal services, housing, and rehabilitation and employment services.

Many communities lack the administrative structures and systems of accountability to coordinate this vast array of services. Concerns about limited resources and separate funding streams also inhibit coordination. Consequently, individual programs struggle to meet the complex needs of clients within a fragmented and unresponsive service delivery system. Service fragmentation has been identified as a principle factor related to negative outcomes among this population (Osher and Kofoed, 1989; Ridgely, et al., 1987).

Though there have recently been significant advances in understanding the special needs of these individuals and integrating services for them, a truly integrated behavioral health care system is still in the future (Osher, 1996). Programs providing services to homeless individuals with co-occurring disorders have in many ways acted as pioneers in the health and human service delivery system. They represent the front-line response to a myriad of social problems and target people who have been most difficult for traditional systems to serve. These programs have had to respond to the rapidly changing and ever-increasing demands of these clients, while also taking a leadership role in coordinating services.

The following section on system planning/coordination and client advocacy summarizes principles and objectives that guided the practice of programs in the CMHS/CSAT Collaborative Demonstration Program, and discusses critical implementation issues.

Findings from the CMHS/CSAT Collaborative Demonstration Program

The 16 demonstration programs described treatment planning and coordination as two of the most critical elements in providing care to homeless individuals with co-occurring mental health and substance use disorders. Each of the programs developed a strategy to organize interventions with the goal of creating an efficient and responsive network. The strategies accounted for the heterogeneity of the population, the diverse and complex treatment needs of individuals, and the need for participation from multiple providers within each community.

The programs recognized that individuals needing care could enter the service system at many points, including the hospital emergency room, an outpatient mental health clinic, or a shelter program. Each program made an explicit commitment to not let people “fall through the cracks,” and cultivated relationships with a broad range of community providers.

Though strategies for treatment planning and coordination varied according to program and community need, all of the programs shared three common objectives: (1) to ensure continuity in the continuum of care, (2) to ensure access

to needed services, and (3) to ensure that multiple services/treatment plans are working toward a common goal.

Ensure Continuity in the Continuum of Care

Each of the programs often performed the role of central coordinator, ensuring a consistent focus in the treatment plan, and serving as an educator to mainstream programs about the needs of homeless individuals with co-occurring disorders. However, the staff responsible for service coordination usually did not have decision-making authority outside of his/her own agency. The level of cooperation among agencies more often depended upon the efforts of individual practitioners and programs than on a formal policy for organizing community care. The following are some of the distinguishing elements of planning and coordination described by the demonstration programs for ensuring continuity in the system of care.

- The focus of coordination is on all of the possible services and supports that a client may need.
- The number and frequency of client contacts are designed to be as high as the client will accept or tolerate.
- Client involvement in treatment planning is encouraged.
- Case managers/clinical coordinators usually provide other direct care services and seek to develop an ongoing relationship that can be responsive to changes in the individual's needs over time.
- Case managers often advocate for the development of needed services both within their home agency and the broader system.
- Case managers' caseloads are generally below 15 clients.
- The informal networks of communication among practitioners from different agencies often are a more significant source for coordination than formal policy.
- Programs attempt to streamline community linkages by sharing information about policies and procedures that impact referrals and the exchange of clinical information.

Ensure Access to Needed Services

A continuum of care essentially provides a network for providers from which they can coordinate services that best meet the needs of homeless people within the

community. However, the 16 programs demonstrate that simply providing a range of services does not ensure that they are responding effectively to the needs of individuals within each community. Even a well-coordinated and comprehensive network of care can not be effective unless people make use of the services, and unless each program truly responds to the strengths and problems of its clients. The level of coordination and planning among the 16 community systems often was less than ideal, and the number of services, supports, and resources sometimes fell short of the need. Consequently, ensuring access to the programs that do exist is extremely critical.

Each of the 16 demonstration programs described numerous factors that impede client access to needed services. They include rigid eligibility criteria, inflexible scheduling, long waiting lists, negative attitudes toward homeless clients, and self-defeating client attitudes that impact their readiness to use services effectively. Some community programs simply are not respectful of homeless people or responsive to individual needs. Other programs believe that homeless individuals with co-occurring disorders are destined to fail. Consequently, homeless people are some of the least wanted clients among service providers.

The demonstration programs addressed these community barriers through education and advocacy initiatives, and by preparing their clients for the types of barriers they were likely to encounter. In addition, each program emphasized the need to develop flexible program structures that are responsive to changes in client need. Management and front-line staff regularly examined program principles, policies, and practices, and they identified the following tasks as critical for improving clients' access to needed services.

- Maintaining a safe environment without using security procedures that inhibit the development of an open and welcoming community.

- Maintaining flexibility with the intensity and duration of interventions with individual clients, while still maintaining clear expectations for participation and performance.

- Developing a capacity within the agency to attend to basic support needs.

- Establishing requirements for abstinence that set clear boundaries and limits for behavior, and yet are sensitive to the difficulties common to the process of recovery.

- Determining how much flexibility could be exercised in enforcing eligibility and expulsion criteria, without compromising the clinical integrity of the intervention.

- Including clients in the development, implementation, and enforcement of program regulations.

- Including clients in setting goals for achievement that realistically account for the person's strengths and weaknesses, and yet demonstrate client progress to program funding sources.

The process for implementing flexible and responsive programs without losing a clear procedural focus required that each program identify its principles and be vigilant about ensuring that these principles guided the interventions. These programs teach us that it is possible to create services that are both accessible and effective, even for populations that have been difficult to reach.

Ensure that Multiple Services/Treatment Plans Are Working Toward a Common Goal

The complexity of client problems within these programs often requires the participation of several agencies, and often the use of several programs within each agency. When the person is engaged in the required services, programs must ensure that these interventions serve a single purpose that is in the best interests of the client. The demonstration programs described many challenges to ensuring that goals are consistent and that treatment activities are congruent with these goals.

None of the communities had a centralized planning mechanism or system of accountability. Consequently, programs relied upon the initiative of case managers and front-line practitioners to create a consistent focus. These efforts typically included referring clients to agencies with congruent philosophies and maintaining regular communication with each of the providers and the client. In addition, programs also provided cross-training and shared educational resources as a means to bridge the differences between the mental health and substance abuse fields. The experience of the 16 programs demonstrates that efforts to communicate among service providers are an important factor in ensuring focus on a common goal. However, they also highlight the need for organized planning on the system level to promote a unified perspective.

Critical Implementation Issues

The primary objective of treatment planning/coordination and client advocacy activities is to ensure that clients have access to all needed services and are being treated appropriately. Individuals should be able to receive all of the services they need for as long as they need them. The McKinney Demonstration Programs support the critical importance of planning/coordination and advocacy

interventions. Findings indicate that clients will use accessible, relevant community mental health treatment services; appropriate services can decrease homelessness; advocacy does help increase access to entitlement income; and housing stability, appropriate mental health treatment, and increased income can lead to an improved quality of life (CMHS, 1994).

The following issues were identified as critical to developing and implementing treatment planning/coordination and advocacy interventions (Winarski and Dubus,1995).

Intensity of Contact

The need to develop strong helping relationships requires that practitioners be persistent in maintaining regular contact with clients. Staff/client ratios should be adjusted to make this possible. However, practitioners need to adjust the frequency and intensity of contacts to meet the needs of individuals. Some people are unable to tolerate intensive contact but will still benefit from a regular connection.

Client Participation in Planning

By including the client in all phases of treatment planning and goal setting, practitioners enhance the probability of follow-through. Client involvement also enhances an individual's motivation to take action steps and ensures that both the client and practitioner are working together.

Location of Services

The need for outreach does not apply only to initial engagement interventions. Programs serving homeless individuals sometimes need to take planning, coordination, and advocacy activities out of the program site and to the places that clients live. It is not uncommon for practitioners to conduct outreach, assessment, treatment, and planning/coordination activities as part of one visit.

Agency "Turf" Issues

A lack of clarity and definition about responsibilities for providing care can be a significant obstacle to planning and coordination efforts. Programmatic responsibilities can be divided according to location, diagnosis, and ability to pay. Homeless individuals do not easily fit into any of these categories: they are often transient and not necessarily a "resident" in a catchment area; they present a complex diagnostic picture and may not have been thoroughly evaluated or diagnosed; and they often are uninsured. The differences among mental health and substance abuse providers only compound these problems. Practitioners need to be aware of the issues that are specific to their local systems to plan and coordinate services effectively.

Summary

Helping homeless individuals recover from co-occurring mental health and substance use disorders requires specific interventions that focus on developing trust; assessing multiple health, personal, and social factors; and building motivation to change. Practitioners must coordinate needed housing, services, and supports, and advocate for their clients in the larger social service system.

5
Conclusion

Perhaps the greatest challenge of implementing interventions for homeless individuals with co-occurring mental health and substance use disorders is developing strategies that are comprehensive, while also attending to the great diversity of needs among individuals. In addition, the complexity of problems and the disaffiliation from mainstream culture that is common to this population can obscure our perception of the fundamental humanity that we share, and that we ultimately must acknowledge, if recovery is to occur. Unfortunately, many of these individuals share histories of being rejected by family, friends, and service providers, and have lost roles that are fundamental to life in our culture. Perhaps the most profound and pervasive theme that we see in personal histories, even more than illness, addiction, and poverty, is the experience of loss. Taken collectively, the coercive effects of loss and chronic deprivation destroys hope and diminishes human dignity. Homeless people can feel trapped by their circumstances and powerless to do anything to improve them. This seeming inertia has become the source for making judgements about the moral character and intrinsic worth of people who are seen as a breed apart. Homeless people with disabilities and addictions are truly the "outcasts on main street" of our society (Interagency Council on the Homeless, 1992).

Yet it is the intrinsic power in all persons to recover and grow, and the extraordinary resilience exhibited by homeless individuals with co-occurring disorders that stand as a testimony to what is possible in the future. The theories and strategies described in this technical assistance package all share a recognition of the fundamental dignity of the person and the need to engage each individual as a valued member of our communities. They also reflect the need to include the full range of community resources as part of an integrated response to mental health and substance use problems. The recent development of effective models for treating individuals with co-occurring disorders and the efforts to coordinate community programs and systems provides hope that we can better meet the challenges of providing effective care to this population.

References

Anthony, W.A. (1991). Recovery from mental illness: The new vision of services researchers. *Innovations and Research*. (Vol. 1) 1:13-14.

Bassuk, E.L. (1994). *Community Care for Homeless Clients with Mental Illness, substance abuse, or dual diagnosis*. Newton, MA: The Better Homes Fund.

Belcher, J.R. (1989). On becoming homeless. A study of chronically mentally ill persons. *Journal of Community Psychology*. 17:173-185.

Birk, A.W. (1994). Developing and maintaining a helping relationship. In Bassuk, E.L. (Ed.). (pp. 6-1, 6-9). Community care for homeless clients with mental illness, substance abuse, or dual diagnosis. Newton, MA: The Better Homes Fund.

Birk, A.W., Bassuk, E.L., and Kisthardt, W. (1994). The foundation for helping: the human relationship. In Bassuk, E.L. (Ed.). Community care for homeless clients with mental illness, substance abuse, or dual diagnosis. Newton, MA:
The Better Homes Fund.

Brown, R.L. (1992). Identification & office management of alcohol & drug disorders. In: Fleming, M.F. & Barry, K.L., (Eds.). *Addictive Disorders*. St. Louis: Mosby Yearbook.

Carkhuff, R.R. (1969). *Helping and human relations*. (Vols. 1 & 2). New York: Holt, Rinehart, & Winston.

Caton, C.L. & Wyatt, R., et al. (1993). Follow-up of chronically homeless mentally ill men. *American Journal of Psychiatry*. (Vol. 150) 11:1639-1642.

Center for Mental Health Services (1994). *Making a difference: Interim status report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Center for Substance Abuse Treatment (1994). *Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse*.

Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Deegan, P. (1988). The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. 11:11-19.

Drake, R.E., Antosca, L.M., & Noordsy, D.L. (1991). New Hampshire's specialized services for the dually diagnosed. In Minkoff, K. & Drake, R.E. (Eds.). (pp. 57-68). *Dual diagnosis of major mental illness and substance disorders*. San Francisco: Jossey-Bass, Inc.

Drake, R.E., Mueser, K.T., Clark, R.E., & Wallach, M.A. (1996). The course, treatment, & outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry*. (Vol. 66) 1:42-51.

Drake, R.E. & Noordsy, D.L. (1994). Case management for people with coexisting severe mental disorder & substance use disorder. *Psychiatric Annals*. (Vol. 24) 8:427-431.

Drake, R.E., Osher, F.C., & Wallach, M. (1991). Homelessness & dual diagnosis. *American Psychologist*. 46:1149-1158.

Drake, R.E. and Wallach, M. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry*. 40 : 1041-1046.

Drake, R.E., et al. (1993). Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease. 181:606-611.

Fischer, P.J. (1990). *Alcohol and drug abuse and mental health problems among homeless persons: A review of the literature, 1980-1990.* Rockville, MD: National Institute of Alcohol Abuse and Alcoholism and National Institute of Mental Health.

Fisher, P. & Breakey, W. (1991). The epidemiology of alcohol, drug, & mental disorders among the homeless. *American Psychologist*. 46:1115-1128.

Hellerstein, D.J. & Meehan, B. (1987). Outpatient group therapy for schizophrenic substance abusers. *American Journal of Psychiatry*. 144:1337-1339.

Institute of Medicine. (1988). *Homelessness, health, and human needs*. Washington, D.C.: National Academy Press.

Interagency Council on the Homeless. (1992). *Outcasts on main street: Report of the federal task force on homelessness and severe mental illness*. Washington, D.C.

Kessler, R.C., Nelson, C.B., McGonagle, K.A., Edlund, M.J., Frank, R.G., & Leaf, P.J. (1996). The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization. *American Journal of Orthopsychiatry*. (Vol. 66) 1:17-31.

Kisthardt, W.E. (1992). A strengths model of case management: Principles and functions of a helping partnership. In Saleebey, D. (Ed.). *The strengths perspective in social work practice*. New York: Longman.

Kline, J., et al. (1991). Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults. In Minkoff, K. & Drake, R.E. (Eds.). (pp. 95-106). *Dual diagnosis of major mental illness and substance disorder*. San Francisco: Jossey-Bass, Inc.

Kofoed, L. (1991). Assessment of comorbid psychiatric illness and substance disorders. In Minkoff, K. & Drake, R.E. (Eds.). (pp. 43-56). *Dual diagnosis of major mental illness and substance disorder*. San Francisco: Jossey-Bass, Inc.

Kofoed, L.L. & Keys, A. (1988). Using group therapy to persuade dual diagnosis patients to seek treatment. *Hospital and Community Psychiatry*. 32:1209-1211.

Lehman, A.F. (1996). Heterogeneity of person and place: Assessing co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry*. (Vol. 66) 1:32-41.

Lehman, A.F. and Cordray, D.S. (1993). Prevalence of alcohol, drug, and mental disorders among the homeless: one more time. In *Contemporary Drug Problems*. 20 (3): 355-383.

Mayfield, D., McLeod, G., & Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry*. (Vol. 131) 10:1121-1123.

Mercer-McFadden, C. & Drake, R.E. (1994). *A Review of Demonstration Programs For Young Adults with Co-occurring Substance Use Disorder and Severe Mental Illness*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Meyer, R.E. (1986). How to understand the relationship between psychopathology and addictive disorders: another example of the chicken and the egg. In: Meyer, R.E. ed. *Psychopathology and Addictive Disorders*. New York: Guildford Press.

Miller, W.R. (1985b). Motivation for treatment: A review with special emphasis on alcoholism. Psychological Bulletin. 98:84-107.

Miller, W.R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York/London: The Guilford Press.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In Minkoff, K. & Drake, R.E. (Eds.). (pp. 13-27). *Dual diagnosis of major mental illness and substance disorders*. San Francisco: Jossey-Bass, Inc.

Mueser, K.T., Drake, R.E., Clark, R.E., et al. (1995). *Tool kit for evaluating substance abuse in persons with severe mental illness*. Evaluation Center at Health Services Research Institute. ©1995 Robert E. Drake.

Noordsy, D.L. & Fox, L. (1991). Group intervention techniques for people with dual disorders. *Psychosocial Rehabilitation Journal*. (Vol. 15) 2:67-78.

Osher, F.C. (1996). A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry*. (Vol. 66) 1:71-76.

Osher, F.C. & Dixon, L.B. (1995). Housing for persons with co-occurring mental and addictive disorders. In Drake, R.E. and Mueser, K.T. (Eds.). *Dual Diagnosis*. San Francisco: Jossey-Bass, Inc.

Osher, F.C. & Drake, R.E. (1996). Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry*. (Vol. 66) 1:4-11.

Osher, F.C. & Kofoed, L.L. (1989). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry*. 40:1025-1030.

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

Regier, D., Farmer, M., Rea, D., Lock, B. et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic

Catchment Area Study. *Journal of the American Medical Association*. 264 : 2511-2518.

Ridgely, M.S. (1991). Creating integrated programs for severely mentally ill persons with substance disorders. In Minkoff, K. & Drake, R.E. (Eds.). *Dual Diagnosis of major mental illness and substance disorders*. (pp. 29-41). San Francisco: Jossey-Bass, Inc.

Ridgely, M.S., Osher, F.C., & Talbott, J. (1987). *Chronic mentally ill young adults with substance abuse problems: Treatment and training issues*. Baltimore: University of Maryland at Baltimore, School of Medicine, Mental Health Policy Studies.

Teague, G.B., Drake, R.E., & Ackerson, T.H. (1995). Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services*. (Vol. 46) 7:689-695.

Test, M.A. & Stein, L.I. (1976). Practical guidelines for the community treatment of markedly impaired patients. *Community Mental Health Journal*. 12:72-82.

Winarski, J.T. (1994). Providing outreach outside the shelter. In Bassuk, E.L. (Ed.). (pp. 10-1, 10-18). *Community care for homeless clients with mental illness, substance abuse, or dual diagnosis*. Newton, MA: The Better Homes Fund.

Winarski, J.T. and Dubus, P. (1995). *An analysis of 16 federally-funded programs for homeless individuals with co-occurring mental health and substance abuse disorders*. Rockville, MD: Center for Mental Health Services/Center for Substance Abuse Treatment. (MONOGRAPH: 137 pages).

Wright, J.D. & Weber, E. (1987). *Homelessness and health*. New York: McGraw Hill.

Appendix A

Contact Information for CMHS/CSAT Dual Diagnosis Treatment Demonstration Projects

Alaska

Anchorage Community Mental Health Center

Name Crossover House

Contact John Bajowski
Clinical Team Leader

Address Anchorage Community Mental Health Services, Inc.
Southcentral Counseling Center
1000 East 4th Avenue
Anchorage, Alaska 99501

Phone (907) 258-4512

Type Drop-in Center

Abstract Crossover House conceptualizes all of its services as being part of an outreach process. Their manual provides a practical and detailed description of three major phases of intervention: identification and assessment, engagement and planning for services, and integrated and linked service provision. The intervention emphasizes the special needs of ethnic minority groups and specifically those of Native Alaskan/American Indian decent.

California

Bonita House, Inc.

Name Bonita House

Contact Richard Crispino
Executive Director

Address Bonita House, Inc.
P.O. Box 3780
Berkeley, California 94703-0780

Phone (510) 704-9239

Type Residential Treatment

Abstract Bonita House provides a continuum of residential programs including: intensive residential treatment, supported transitional living, and subsidized permanent housing. Specific interventions include outreach and engagement, specialized detoxification and relapse prevention services, individual and group counseling, family education, and referral. The program manual describes engagement activities in detail.

California

San Francisco Department of Public Health

Name Transitions Within the Continuum of Care

Contact James Curtis
Director of Homeless Programs

Address Department of Public Health
Division of Mental Health and Substance Abuse Services
City and County of San Francisco
1380 Howard Street, 4th Floor
San Francisco, California 94102

Phone (415) 255-3507

Type Program Coordination Within the Service Delivery System

Abstract The San Francisco Department of Public Health, Division of Mental Health and Substance Abuse provide services to people with co-occurring psychiatric and substance abuse disorders through a broad network of individual treatment agencies. The services range from outreach and engagement to long term housing. Programs serve a culturally diverse population. The program manual provides a description of how services are linked to maximize client access and coordinate clinical operations.

California

Desert Counseling Clinic, Inc.

Name Kern Linkage Program

Contact William Drakos
Director of Clinical Services

Address Desert Counseling Clinic, Inc.
814 Norma Street
Ridgecrest, California 93555

Phone (805) 326-1122

Type Case Management

Abstract The Kern Linkage Program provides continuum of services using a case management model that includes outreach, engagement, assessment, and referral. They provide services in a rural environment covering a broad geographic area. The program manual describes a 16 week dual diagnosis program that includes counseling, education, and skills training.

California

Vietnam Veterans of San Diego

Name Vietnam Veterans of San Diego

Contact Cheryl Deblois

Address Vietnam Veterans of San Diego
4141 Pacific Highway
San Diego, California 92110

Phone (619) 479-0142

Type Residential Treatment

Abstract The Vietnam Veterans of San Diego operates an 80-bed transitional residence program with services designed to be an integral part of a continuous and comprehensive program of recovery. The scope of service includes eight major programmatic areas: outreach, case management, substance abuse treatment, mental health treatment, recreation, life skills development, and housing. Services are designed for Vietnam veterans with co-occurring substance abuse and post traumatic stress disorders. The program manual describes the development of the peer community as the unifying paradigm for all program activities.

Colorado

Arapahoe House, Inc.

Name Connections

Contact Nancy Van DeMark
Director of Program Services

Address Arapahoe House, Inc.
8801 Lipan Street
Thorton, Colorado 80221

Phone (303) 657-3700

Type Case Management/Dyad Approach

Abstract The Connections Program provides intensive case management services that utilize a dyad/team approach for each client. One case manager partner in the dyad comes from a mental health background while the other comes from a substance abuse background. The two primary goals are to develop a strong relationship that will be maintained over time, and to facilitate connection to needed services. The program manual describes the outreach, engagement, assessment, and referral services that the case managers provide.

Connecticut

Connecticut Department of Mental Health

Name Assertive Community Treatment

Contact Nina Kontos

Address Connecticut Department of Mental Health
Research Division
P.O. Box 351
Woodward Hall
Middletown, Connecticut 06457

Phone (203) 344-2081

Type Intensive Case Management

Abstract The Connecticut Department of Mental Health has established an assertive community treatment (ACT) team to provide integrated treatment for homeless persons with co-occurring psychiatric and substance abuse disorders in the city of Bridgeport. They collaborated with the Dartmouth Medical School and the Greater Bridgeport Community Mental Health Center to develop a program manual that describes treatment processes for the stages of engagement persuasion, active treatment, and relapse prevention. They provide service from within a social network and cognitive behavioral approach.

Florida

Miami Mental Health Center, Inc.

Name Intensive Outpatient Program

Contact Lizette Zuniga, MSW
Director of Substance Abuse Outpatient Division

Address Miami Mental Health Center
2141 SW First Street
Miami, Florida 33135

Phone (305) 643-7771

Type Day Treatment

Abstract The Miami Mental Health Center developed the intensive outpatient program to meet the special needs of clients with co-occurring disorders. It is an adaptation of traditional day treatment programs, operating on a levels system that adjusts the intensity of program structure according to client need. The program manual describes the program structure and activities, including: 12 step groups, individual and family therapy, psychiatric consultations, and family therapy. The manual also describes a culturally sensitive approach to serving a primarily hispanic client population.

Massachusetts

Bay Cove Human Services

Name Andrew House Dual Diagnosis Detoxification and Treatment Center

Contact Paul Saley
Program Director

Address Bay Cove Human Services
50 Redfield Street
Dorchester, Massachusetts 02122

Phone (617) 479-9320

Type Detoxification Center

Abstract Andrew House is a 28-bed voluntary acute care inpatient unit that developed highly specialized medical detoxification and alcohol and drug treatment for clients with co-occurring psychiatric disorders throughout the metropolitan Boston area. Program goals include a safe medical detoxification, psychiatric stabilization, and the development of a comprehensive treatment program. The program manual describes the following primary treatment activities: medical detoxification, group treatment, short term case management, and medical and psychiatric consultations. It highlights the essential role of detoxification as an early intervention in an ideal service continuum.

Missouri

St. Louis Mental Health Center

Name Community Support Systems

Contact Joseph Yancey
Clinical Coordinator

Address St. Louis Mental Health Center
Community Support Systems
1508 South Grand Avenue
St. Louis, Missouri 63104

Phone (314) 241-9810

Type Continuous Treatment Team

Abstract The Community Support System operates as part of the St. Louis Mental Health Center and provides services from a fixed site where homeless individuals congregate. People with co-occurring psychiatric and substance abuse disorders are served by a continuous treatment team that provides both mental health and substance abuse services. Each treatment team provides on-site service and linkages to other recovery services in the community. The manual describes the program structure and treatment components of the program: outreach and engagement, screening and assessment, intensive case management, substance abuse services, health care and family services.

Nebraska

Lincoln Lancaster Drug Projects, Inc.

Name Lincoln Lancaster Drug Projects, Inc.

Contact Charles Thiessen
Clinical Director

Address Lincoln Lancaster Drug Projects, Inc.
610 “J” Street
Lincoln, Nebraska 68508

Phone (402) 475-5161

Type Modified Therapeutic Community

Abstract The Lincoln Lancaster Drug Projects provides comprehensive outpatient, residential, and emergency services to young people and adults with substance abuse problems and dual disorders. The program is based on a biopsychosocial approach that integrates the following primary treatment components: recreation therapy, case management, medication management, health care, and therapeutic counseling. The program manual provides a detailed description of recreation therapy interventions with adolescent residents in the modified therapeutic community.

New York

Center for Therapeutic Community Research

Name Institute for Community Living

Contact Stanley Sacks, Ph.D.

Address Center for Therapeutic Community Research
Two World Trade Center, 16th Floor
New York, New York 10048

Phone (212) 845-4400

Type Modified Therapeutic Community

Abstract The Institute for Community Living is a residential program provider for the Brooklyn, New York area that provides a comprehensive system of services and uses recovery based therapeutic community methods. The program manual describes a stage/phase recovery process and a modified procedure for treating clients with co-occurring disorders that includes: induction, primary treatment, re-entry, and continuance. Interventions are designed to facilitate client progress through a continuum of recovery.

New York

BRC Human Services Corporation

Name Emergency Reception Center

Contact Douglas J. Warn
Director of Planning

Address BRH Human Services Corporation
191 Chrystie Street
New York, New York 10002

Phone (212) 533-5700

Type Emergency Housing

Abstract BRC Human Services Corporation is a multi-service mental health, housing, and addiction services agency that has been helping homeless adults with co-occurring substance abuse and psychiatric disorders since the late 1970's. BRC has developed a comprehensive continuum of care (including housing and treatment) based on an integrated biopsychosocial-recovery-competence model. The program manual describes the activities of the Emergency Reception Center, a 24-bed emergency housing facility that targets people living on the streets and subways of lower Manhattan, including the following major components: outreach, engagement, stabilization, early rehabilitation, and referral.

Oregon

Mental Health Services West

Name Mental Health Services West

Contact Sharon Stahly
Dual Diagnosis Program Coordinator

Address Mental Health Services West
710 2nd Avenue, SW
Portland, Oregon 97204

Phone (503) 228-7134

Type Integrated Treatment

Abstract Mental Health Services West is the primary mental health provider for the homeless in the city of Portland, providing a comprehensive network of treatment and rehabilitation services. The program manual describes an integrated treatment approach that addresses mental illness and substance abuse issues simultaneously within one environment. Four features characterize the program: a large array of services, flexible use of program components, use of relapse prevention as an educational tool, and an intensive monitoring by dual diagnosis staff and case managers. Clients are helped to choose from among nearly 20 treatment groups and a wide variety of services.

Pennsylvania

Western Psychiatric Institute and Clinic

Name STEPS OUT

Contact Victoria Butterworth, Ph.D.
Project Coordinator

Address Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, Pennsylvania 15213

Phone (412) 647-8239

Type Integrated Outreach/Treatment

Abstract The STEPS OUT program is a four step peer-integrated comprehensive outreach and treatment program that has been developed by a collaboration of agencies within the city of Pittsburgh. The program manual describes a process of outreach, case management, vocational and volunteer services, and dual-diagnosis treatment groups. Assessment, referral, and case management services are provided by a team of professionals and formerly homeless staff members. The intent of the program is to create a structure that is sufficiently flexible to respond to immediate needs but firm enough to support movement toward stabilization, sobriety, housing, and employment.

Virginia

Alexandria Community Service Board

Name Alexandria Community Service Board

Contact Omayra Hunt, MPH
Project Coordinator

Address Alexandria Community Service Board
720 North Asaph Street
Alexandria, Virginia 22314

Phone (703) 838-6400

Type Intensive Case Management

Abstract The Alexandria Community Service Board provides a wide range of mental health and substance abuse services to residents in the metro Alexandria area, and also has linkages to a broad scope of social service agencies in this region. Services for people who are homeless and dually-diagnosed are provided through a process of intensive case management. The distinguishing features of this intervention include a low staff/client ratio, a team approach, and a commitment to maintaining a relationship over time. The program manual describes the following major components: outreach and engagement, an ecologically based comprehensive assessment, comprehensive treatment plans that emphasize multi-agency coordination, long-term relationships, advocacy, and resource development.