Concurrent Disorders Treatment: Models for Treating Varied Populations

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Program Models Project 2003–04

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INTRODUCTION

Background

The term 'concurrent disorders' (CD) refers to the co-existence of both substance use and mental disorders. Over the last twenty years, such "dual difficulties" among people wanting treatment and support for these problems has become a prominent issue. Depending on the setting (e.g. community, mental health or addictions services, primary care), and the particular combination of co-morbidity being examined, prevalence rates for CD range from 20% to 80%[1]. We know conclusively that people experiencing mental illness have much higher rates of substance abuse than people in the general population. Similarly, individuals with a substance use disorder have much higher than expected rates of mental disorders. We also know that current approaches to treatment and support for either mental or substance use disorders is less effective for people who are experiencing both[2]. These findings speak to the need for improved models of service delivery for people seeking help for these problems.

In Canada, the addictions and mental health systems have traditionally functioned as two separate systems, each with their own range of services and particular approaches to treatment and support. Only recently have addiction treatment systems or mental health systems begun to focus on the provision of treatment and support to meet the needs of people living with concurrent disorders.

In 2001, Health Canada released its Best Practices document, *Concurrent Mental Health and Substance Use Disorders*[3], as part of Canada's Drug Strategy[4]. The document provided an updated synthesis of research information and expert opinion, and offered recommendations for the screening, assessment and treatment/support of people living with CD, as well as recommendations for broader systems change.

Since the release of the Canadian Best Practices document, people who plan and manage substance abuse and mental health programs in Ontario have been working to improve how they provide service to individuals with CD. Some new services have been developed, or are under development. There have been, for example, initiatives where a small number of agencies in a community have begun to collaborate and provide joint services. In addition, a number of service providers from both addictions and mental health have sought consultation, training and resources to help them develop treatment programming for those experiencing CD. Interest in developing a range of appropriate services and supports was clearly confirmed in a provincial forum in March 2003 that brought together 40 addiction and mental health providers and funders from across Ontario.

The *Concurrent Disorders Treatment Program Models Project* grew out of this desire and enthusiasm for improved service delivery for people with CD. Intended to build upon the Health Canada Best Practice report, CAMH's Concurrent Disorders Knowledge Exchange Area designed a project to identify and then describe program models that exist for treating individuals with CD. The present report is the culmination of the project and includes a review of 15 programs from Canada and the United States.

The information in this report will be of considerable interest to those currently planning programs, or to those wishing to compare their program to others. It will also be of interest to system planners, program funders, and others who are interested in discovering the range of options for integration of treatment for individuals with CD.

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[1] Source: Centre for Addiction and Mental Health, 'People with Concurrent Disorders,' in Virtual Resource for the Addiction Treatment System, Section 3: Special Populations. See: http://sano.camh.net/resource/pconc.htm.
[2] Source: ibid
[3] See: http://www.hc-sc.gc.ca/hecs-sesc/cds/pdf/concurrentbestpractice.pdf
[4] See: http://www.hc-sc.gc.ca/hecs-sesc/cds/ for information on Canada's Drug Strategy.

The objectives for the project were:

1. To review the current state of CD programs in Ontario and in other jurisdictions; and
2. To give others a menu of "program ingredients" from which to chose, for different settings and sub-populations, should they want to create or make changes to a CD program.

For the purposes of this project, we defined "program model" as: *a set of structured interventions and procedures to help individuals achieve some desired treatment or support goal.* We were particularly interested in identifying program models that treat specific sub-populations and that either emulate best practices or have been formally evaluated.

"CD Program" was defined as: *a collection of services and activities organized specifically for the treatment and support of those who are experiencing any combination of mental and substance use disorders.* These services and activities could either be housed within one agency, or formally coordinated between more than one agency.

Cautions and Limitations

The selected programs were chosen to illustrate a range of options for different sub-populations in different service-delivery settings. The programs are not necessarily the "best" programs, nor those that are achieving the best results. They are simply a collection of specialized programs that have integrated mental health and substance abuse treatments and supports. Although most of the agencies are following evidence-based practices, this report does not focus on this specifically, nor does it compare agencies on their use of practices supported by research.

The summaries of the CD programs are derived from interviews with program representatives, and from information contained in any documents provided by the interviewees, or found on agency websites. The descriptions of the programs are by no means all-inclusive, and not all information that was obtained has been included in this report. In addition, because of the limited interview time available (typically 60-90 minutes), and the semi-structured nature of the interview guide, not all questions were asked of all interviewees. As a result, some program summaries contain sections that are not covered by others, and some summaries contain only partial information in certain areas.

Another caution concerns our focus here on 'specialized' concurrent disorder programs. Based on the increasingly popular 'Quadrants Model'[5], the majority of programs we have selected would fall within Quadrant IV (i.e. those dealing with severe mental health problems and severe substance abuse). For this project, we have concentrated on 'specialized programs' rather than on programs that offer more generic mental health and/or addiction services, or those that may have enhanced their capability to identify and work with people with co-occurring disorders (e.g. improved screening and assessment). We concentrated on specialized programs because we are particularly interested in strategies for program and system integration. This does not imply, however, that all services for people with CD must be planned and delivered within specialized programs. All addiction and mental health service providers, including those who deal with less severe combinations of CD (Quadrants I, II, and III), and those using collaborative or consultative services, have a role to play in improving outcomes for those living with CD.

Program Search and Selection

The search for potential programs employed a multi-faceted approach. We engaged in extensive Internet research, sent out e-mails to CD-related listservs, and asked noted Canadian and American CD experts for program recommendations. A consultation was also held with system planning consultants from CAMH, Ontario.

5 See: National Association of State Mental Health Program directors and the National Association of State Alcohol and Drug Abuse, 1998.

Potential programs were considered only if they promoted themselves specifically as CD programs (i.e. they were designed for and/or treated only those with co-occurring mental and substance use disorders). Programs were targeted for inclusion if they offered a comprehensive array of services to those with CD. Programs that served particular sub-populations (e.g. homeless, women, criminal justice), and/or demonstrated that they are based on best practices, were given priority from the pool of potential candidate programs.

When selecting programs to be interviewed for this project, an attempt was made to find those that offered integrated treatment and support. According to Health Canada's CD Best Practices document, treatment integration can be on either a program or system level:

> *Program integration* means mental health treatment and substance abuse treatment are brought together by the same clinicians/support workers, or team of clinicians/ support workers, *in the same program*, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.[6]
>
> *System integration* means the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by *two or more clinicians/ support workers working for different treatment units or service providers*. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan.[7]

Programs were excluded if they required, *at the time of program entry*, clients to be abstinent from alcohol or other non-prescribed psychoactive drugs. If programs had a *treatment goal* of abstinence, but did not require clients to be abstinent prior to receiving treatment, they were not necessarily excluded. With our selection criteria, the pool of potential programs from across Canada and the U.S. was narrowed down, and 18 were selected for inclusion in the project. Of those, 15 participated.

There are noteworthy differences in the Canadian and American programs covered in this report. The U.S. has a plethora of programs that treat those with CD and it was difficult to narrow down which programs to select for this report. In the end, we decided to include those American programs that were very comprehensive and reflected a high level of integration. As a result, many of the American programs described in this report are much larger and/or more comprehensive than the majority of Canadian programs. Some have also benefited from comprehensive and well-resourced program evaluation and research grants. However, despite the fact that Canadian readers may not have the resources to develop and evaluate programs on the scale of some of the American programs described in this report, the US programs may have elements that are of particular interest to people and are feasible to implement. Thus, we feel their inclusion in the project remains highly relevant for the Canadian audience.

Data Collection

A semi-structured interview guide was developed and pilot tested with CAMH's own Concurrent Disorders Program. The interview guide[8] was subsequently modified to reduce the interview time from 3 hours to 1-1.5 hours. Program managers or directors from the selected programs were then contacted either by e-mail or by telephone and asked to participate in the interview. Respondents who showed interest were sent the interview guide and were asked to provide program-related documents, if available. All interviews (except for the pilot interview) were conducted over the telephone. Interviews were tape-recorded and transcribed. The transcripts, as

[6] Health Canada, 2002, p. vii
[7] Health Canada, 2002, p. vii
[8] See Appendix A for Interview Guide.

well as other relevant information culled from websites and other documents, were sent to the interviewees for content approval. Final summaries were also sent to the interviewees for accuracy check and final approval.

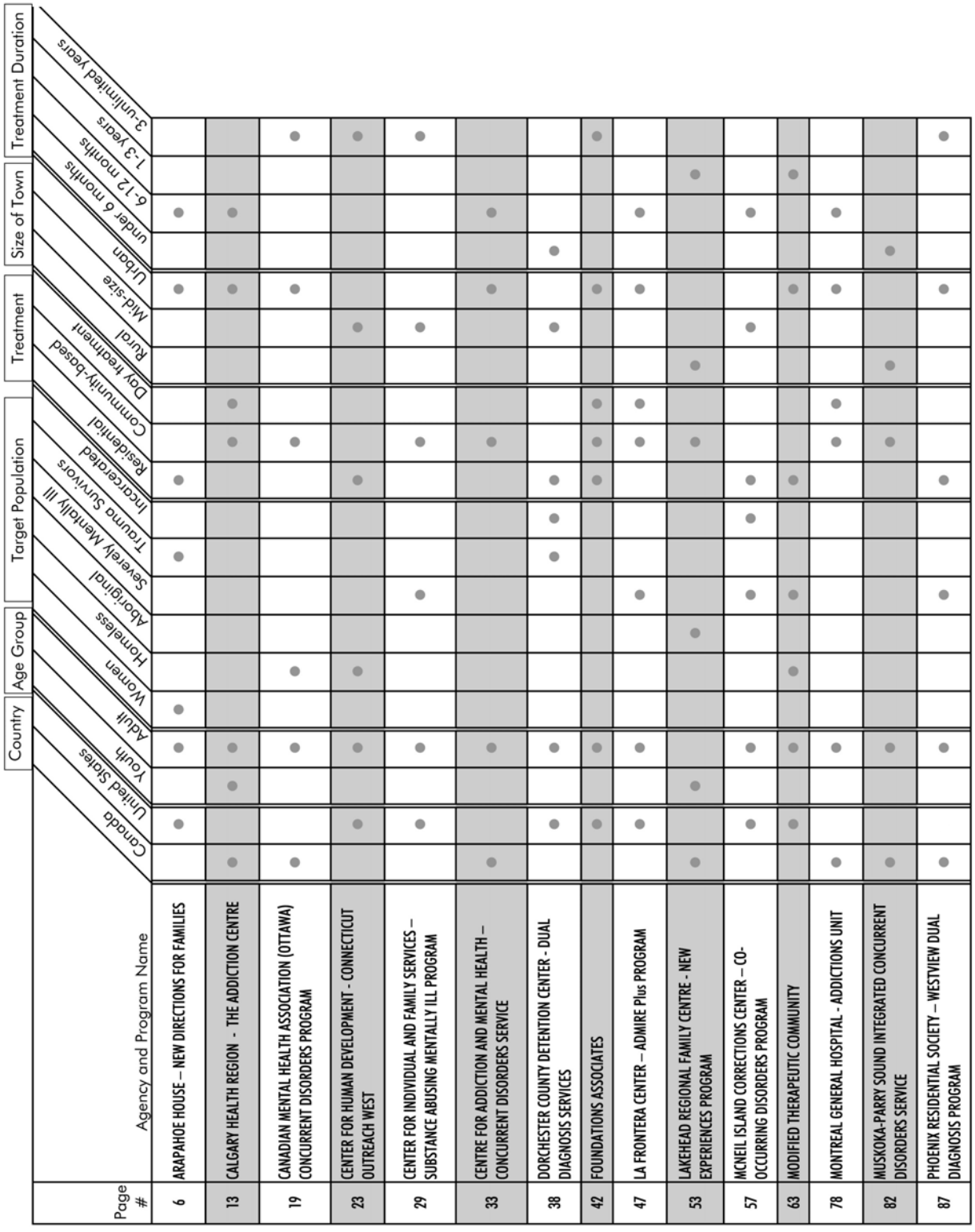
Organisation of Report

The program summaries have been placed in alphabetical order, based on the name of the agency that houses the program. A program chart precedes the summaries and includes a list of categorical descriptors of the programs (e.g. target population, age group, treatment setting and duration). This will help readers who are interested in particular program characteristics to locate relevant programs. A list of screening and assessment instruments used by the programs, including descriptions and availability information, can be found in Appendix B. At the conclusion of each program description, contact names and information have been provided. Readers are encouraged to contact the program directly if they have any questions or require more information about the program.

To avoid unnecessary repetition, a list of common characteristics among all the programs has been compiled. *Unless otherwise indicated*, all programs:

- Integrate mental health and substance abuse treatment;
- Do not require clients to be abstinent from substances at the time of program entry;
- Assess clients at intake for the following: family history, medical history, vocational history, history of physical/sexual/emotional abuse, history and treatment of psychiatric disorders, history and treatment of substance use disorders, status of substance withdrawal, current stage of all existing disorders, social support network, evaluation of psychosocial risk factors and needs, treatment motivation, and other services being utilized;
- Mix clients who have differing addictions and differing mental illness diagnoses within the same treatment and support groups.

PROGRAM CHART



Page #	Agency and Program Name	Country		Age Group			Target Population						Treatment			Size of Town			Treatment Duration		
		Canada	United States	Youth	Adult	Women	Homeless	Aboriginal	Severely Mentally Ill	Trauma Survivors	Incarcerated	Residential	Community-based	Day treatment	Rural	Mid-size	Urban	under 6 months	6-12 months	1-3 years	3-unlimited years
6	ARAPAHOE HOUSE – NEW DIRECTIONS FOR FAMILIES	•		•	•	•				•	•	•				•		•			
13	CALGARY HEALTH REGION - THE ADDICTION CENTRE	•		•	•							•					•	•			•
19	CANADIAN MENTAL HEALTH ASSOCIATION (OTTAWA) CONCURRENT DISORDERS PROGRAM	•		•	•	•						•				•				•	
23	CENTER FOR HUMAN DEVELOPMENT - CONNECTICUT OUTREACH WEST		•	•	•	•					•				•					•	
29	CENTER FOR INDIVIDUAL AND FAMILY SERVICES – SUBSTANCE ABUSING MENTALLY ILL PROGRAM		•	•				•				•			•						•
33	CENTRE FOR ADDICTION AND MENTAL HEALTH – CONCURRENT DISORDERS SERVICE	•		•								•				•		•			
38	DORCHESTER COUNTY DETENTION CENTER - DUAL DIAGNOSIS SERVICES		•	•						•	•	•			•		•				
42	FOUNDATIONS ASSOCIATES		•	•						•	•	•	•			•				•	
47	LA FRONTERA CENTER – ADMIRE Plus PROGRAM		•	•				•				•	•			•		•			
53	LAKEHEAD REGIONAL FAMILY CENTRE - NEW EXPERIENCES PROGRAM	•		•			•					•		•					•		
57	MCNEIL ISLAND CORRECTIONS CENTER – CO-OCCURRING DISORDERS PROGRAM		•	•				•		•	•	•			•			•			
63	MODIFIED THERAPEUTIC COMMUNITY		•	•		•		•			•						•		•		
78	MONTREAL GENERAL HOSPITAL - ADDICTIONS UNIT	•		•								•	•			•		•			
82	MUSKOKA-PARRY SOUND INTEGRATED CONCURRENT DISORDERS SERVICE	•		•								•		•			•				
87	PHOENIX RESIDENTIAL SOCIETY – WESTVIEW DUAL DIAGNOSIS PROGRAM	•		•				•				•				•					•

PROGRAM SUMMARIES

ARAPAHOE HOUSE – NEW DIRECTIONS FOR FAMILIES

The New Directions for Families program provides residential treatment for women (and their children) with substance abuse problems and mental illness who have been victims of violence. In addition to receiving treatment for a substance abuse problem and mental illness, women learn parenting skills, budgeting, and family health skills, and are assisted in locating jobs and developing a career plan aimed at long term self-sufficiency.

1. Organizational and Service Delivery Setting

Arapahoe House is a community-based non-profit organization committed to the provision of accessible, affordable, and effective services for individuals and families with alcohol, drug, and other behavioural health problems living in Colorado. Established in 1975, Arapahoe House opened its original detoxification program in 1976 and has since grown to approximately 350 staff delivering services at over 25 sites with a budget now approaching $14 million. Each year Arapahoe House provides over 22,000 episodes of care to more than 17,000 individual clients. The agency delivers residential, outpatient and case management services to persons with co-occurring mental health and substance use disorders in Denver area sites and has administered programs for persons with co-occurring disorders since 1989.

The Arapahoe House *New Directions for Families (NDF)* program began in 1995 with funding from the Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration (SAMHSA). Initiated as a residential substance abuse treatment center for women and children, the facility combines comprehensive residential and outpatient treatment with parenting and self-sufficiency skills development.

The primary goals of the New Directions for Families program are as follows:

- To provide women with the motivation and skills they need to remain abstinent from alcohol and other drugs and to stabilize their mental health;
- To develop positive parent-child relationships, thus preventing the cycle of substance abuse and violence in families;
- To improve the health and well-being of the children; and
- To promote the self-sufficiency of families through linkage with education, employment, vocational training, and permanent drug-free housing.

Target Population: New Directions targets women who have co-occurring disorders, a history of physical or sexual abuse, are pregnant or have custody (or the likelihood of regaining custody) of a child aged birth to twelve years, and meet the state modified American Society of Addiction Medicine (ASAM) patient placement criteria for level 3.7 services[9]. Clients typically have depression, a bipolar disorder, or PTSD.

Staffing: Staff of NDF include three primary counselors who are required to be certified as addictions counselors. Counsellors have a caseload of between six and eight clients/families. Other staff include a full-time case manager and an onsite supervisor that is in charge of the facility, a family therapist and a number of milieu counsellors that

[9] For more information on ASAM Patient Placement Criteria, see Appendix C.

provide 24-hour supervision. In addition, there is a registered nurse, a vocational specialist, a team leader and child care staff. Staff members are cross-trained to have at least a minimal level of understanding and skills in the areas of substance abuse, mental health and trauma.

2. Referral, Screening and Assessment

At Arapahoe House there is a centralized assessment and referral department that conducts the screening for all of the programs within the organization. Potential clients call Arapahoe House and speak with someone at the screening centre. If they ask specifically for the New Directions Program, or if they are looking for any services for substance abuse and/or co-occurring mental illness and are parenting, they will be screened for eligibility for the New Directions for Families Program.

New Directions does not screen for mental illness specifically, nor do they administer any formal screening instruments. Clients of New Directions are screened over the telephone, and typically have to meet the diagnostic American Society of Addiction Medicine criteria for substance dependence (level 3.7). In addition, clients must be female, 18 years of age or older, and (in most cases) have had some other attempts at treatment. Although clients need to be substance dependent in order to enter New Directions, they do not need to have a co-occurring disorder. However, the majority of women (95%) have trauma issues and/or PTSD and mental health issues.

Because it is explicitly a parenting program, women must be in a parenting role (i.e. they have to either be pregnant or have a child between the ages of birth and 12 years with whom they either have custody, or are likely to regain custody). Children are also screened regarding whether they are appropriate for the program. If they require care that cannot be provided by the mother, or if they have complex or infectious medical problems, children will not be accepted.

Following screening, women can either be directly admitted to NDF, or they might first enter a withdrawal management program that Arapahoe House operates and later be referred to New Directions. Regardless of the entry point, the Information and Access Department does all of the screening for the program and maintains a waiting list.

At the time of admission to the program, each woman, and any dependent children living with her in the residential setting, participates in a comprehensive assessment of needs, skills, and resources. When children come in, they are assessed developmentally and for any kinds of psychological problems. Many of them also have a history of abuse, so may also require mental health treatment. The assessment forms the basis for treatment planning that involves the woman, clinical staff and other agencies involved in the care for the family.

Because the program is focused on treating those with a history of trauma, women are assessed for evidence of trauma, PTSD, and current symptomatology related to trauma. Trauma assessment is an ongoing component of the program. The women's assessment also covers substance abuse, mental illness, parenting, history of trauma, resiliency, knowledge of treatment related issues such as HIV and AIDS risk, drug and alcohol education materials, community resources, psychological symptoms, personal motivation and readiness for change, employment history, career interests and educational needs. If necessary a psychiatrist will see the client for evaluation regarding medications, as well as to confirm possible diagnosis. The local mental health center or the Arapahoe House psychiatric consultant provides psychiatric evaluation and oversees pharmacological treatment.

Clients are viewed as full partners in identifying their goals for treatment plans, and clinical staff assist them by suggesting interventions that are likely to result in goal attainment. Individual treatment goals and plans are developed jointly with the client and address all major treatment areas: substance abuse and relapse, mental illness, trauma related symptoms, parenting, employment, housing as well areas of concern for a particular individual. Treatment plans are reviewed weekly for the first few months, then twice monthly thereafter.

3. Treatment Approach

The New Directions program consists of four months of residential treatment followed by four months of outpatient treatment. Through individual and group therapy modalities, women use explorative and reflective techniques to uncover the developmental and historical roots of their mental health and trauma issues and use cognitive-behavioural techniques to manage symptoms in daily functioning. In addition to receiving treatment for substance abuse and mental illness issues, women learn parenting skills, budgeting, and family health skills. They are also assisted in locating jobs and in developing a career plan aimed at long-term self-sufficiency.

The New Directions for Families incorporates several complementary approaches in different parts of their curriculum, including The Stages of Change Model, Motivational Interviewing, Cognitive-Behavioural Approach, Solution-Focused Approach, and Integrated Services for Substance Dependence, Mental Illness, and Trauma. For trauma intervention, they employ a modified version of the Trauma Recovery Empowerment Model (TREM)[10] and use the Nurturing Families[11] program as a parenting intervention. Each of these approaches is delivered in the context of a family-oriented setting that emphasizes both the enhancement of the parent-child relationship and the woman's individual recovery.

Abstinence vs. Harm-Reduction: In terms of activities like cigarette smoking, or other kinds of behaviours, such as trying to reduce risk of HIV infection and reduce risk of subsequent pregnancies, New Directions is clearly harm-reduction focused. However, NDF does not use a harm-reduction approach regarding substance abuse treatment while in the residential phase of the program. They require abstinence while people are in the residential portion of the program in response to client surveys indicating that having individuals who are still using or in different phases of recovery living together does not work well.

Clients will not, however, be discharged because of substance use. The program recognizes that substance abuse has relapsing qualities to it, and if a client uses, they will try to ascertain whether or not the treatment is working, whether they need to modify the treatment plan in some way to provide more support, or whether another setting might be more appropriate for an individual. In some cases, clients might go for withdrawal management in the larger agency (Arapahoe House) and then come back. In other cases clients might stay at New Directions under an intensified treatment plan.

Treatment Phases

Treatment is divided into three phases: Women are in an intensive residential treatment phase for the first two of months of treatment, where they work on stabilizing mental health, substance use, trauma issues and parenting. This is followed by two months of residential treatment that is focused on reintegration into community, where women work or conduct job search during the day, and then have treatment activities in the evening. The last phase of treatment is outpatient and is focused on strengthening community ties and aiding women to remain employed and living independently.

Phase I: During the first few months of treatment, Phase I focuses on three main areas:

- Intensive treatment for substance abuse and mental health disorders,
- Treatment related to current or past trauma, and
- Parenting skills

[10] Harris, M. & The Community Connections Trauma Work Group, 1998
[11] Moore, J., Buchan, B., Finkelstein, N. & Thomas. K., 1997

The treatment staff work closely with the women, in both individual and group therapy, on developing the skills needed to remain abstinent, reduce symptoms of mental illness and the effects of trauma, and to improve parenting. In addition, education regarding family health and safety and basic life skills are emphasized during earlier stages of treatment.

Once clients are more firmly grounded in their recovery effort and parenting skills, they must apply to "transfer to Phase II". In order to move through the various stages of the program, the client follows specific criteria and meets particular goals. To move between Phase I and Phase II of the program, the woman must have completed or be working towards various treatment goals, have progressed in behavioural changes, and have identified and answered certain solution-focused questions regarding her recovery process.

Phase II: As women approach the latter half of residential treatment, they are expected to begin their job search and to develop a long-term self-sufficiency plan. Phase II emphasizes three primary areas: employment skills, job placement and relapse prevention. Women are required to work full time or to participate in unpaid employment in conjunction with job training. In addition to seeking employment, women prepare for the transition into the community by locating appropriate housing, enrolling their children in childcare or school, and developing a relapse prevention plan. During this time, women are encouraged to be active in peer support groups inside and outside the facility.

Phase III: Phase III begins when a woman leaves the residential setting and returns to the community, usually after four months of residential treatment. The primary goal of Phase III is to support the gains made in residential treatment.

Treatment Interventions

NDF uses an integrated intervention model based on the philosophy that issues of substance dependence, mental illness, and trauma should be addressed simultaneously and that attention to self-sufficiency is an integral part of the treatment and recovery process. Treatment activities supporting individual recovery include those services aimed specifically at substance abuse, mental illness, and trauma and those that integrate attention to all three disorders and how they impact parenting. Individual and group education and counselling sessions address each of these categories.

Substance Abuse Services: During the first phase of treatment, women receive substance abuse treatment six days a week for about two hours a day and thereafter, 2-3 times a week in two-hour sessions. Women attend on- and off-site peer-run support groups including Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Women in Recovery three times a week.

Services for Mental Health Disorders: Psychiatric evaluation and treatment, individual counselling, and education on mental illness and psychotropic medication address mental disorders. Treatment services are provided about two times a week for 6-8 hours during the first few months of treatment and approximately weekly thereafter

Trauma-specific Services for Survivors of Childhood Victimization: NDF adapted (for a residential treatment setting) the 24-session outpatient Trauma Recovery and Empowerment Model (TREM) designed to address issues of sexual, physical and emotional abuse. Part I of TREM addresses gender identity, sexuality, interpersonal boundaries, and self esteem. Part II of TREM covers sexual, physical, and emotional abuse, specifically the interaction of the abuse with mental health issues, substance abuse and relationships. The first 16 sessions of TREM occur in partially open groups meeting twice a week. The aim is to have women complete these sessions before they enter Phase II of Treatment. The Part II trauma group is held once a week in the evening and covers

sessions 17 -24. The self-help workbook, Healing the Trauma of Abuse (Copeland and Harris, 2000), orients women to the trauma material before they enter the group. The self-help workbook is also used for women who are not ready to address their trauma issues in the group but who would like to participate in individual trauma treatment.

Trauma-specific Services for Survivors of Domestic Violence: Services include safety planning, linkage with legal assistance, and individual and group counselling. Clients spend two to four hours a week in group therapy for the first two to three months at NDF with program staff trained in trauma recovery for the dually diagnosed. The group is modeled on the book Journey Beyond Abuse: A Step By Step Guide To Facilitating Women's Domestic Abuse Groups (Fischer & McGrane, 1997). The group covers the definition of domestic abuse, patterns and types of abuse and the cycle of violence, abusive relationships, anger shame and guilt, self-care, and healthy relationships. Women gain insight into why they have developed certain destructive behaviours and relationships and learn tools to create healthier lives for themselves and their children.

Parenting Services: NDF stresses activities that 1) build parenting skills with a trauma-informed perspective, and 2) reflect constructive and educational discipline. Positive reinforcement, limit-setting, and reasonable, reinforceable consequences are commonly used to promote healthy, loving family time. Corporal punishment is prohibited during the family's residential stay and is discouraged altogether as a disciplinary technique. Mothers learn a variety of behavioural modification techniques that respect and enhance self-esteem and teach children to make positive choices.

An interfamily parenting group, based on the *Nurturing Program for Families in Substance Abuse Treatment and Recovery*[12], modified for residential substance abuse settings, is provided to women and their children during the course of their stay at NDF. The eight-session curriculum covers topics such as: developing empathy, alternatives to corporal punishment, and child-parent role reversal.

Another multi-family group meets 1 to 1.5 hours weekly and teaches women how to be effective in providing healthy support systems for the recovery process. Clients are encouraged to have their significant others attend with them, as it provides an opportunity to gain a better understanding of the struggles that clients have endured and will likely face during recovery.

Children's Services: Using a family-oriented approach, NDF addresses the preventive and treatment needs of the children both directly and indirectly. The multi-family group and the interfamily group indirectly enhance the child's well-being and development by building extended families into support systems. Services have also been developed that directly address trauma-related experiences encountered by children and mental health issues that stem from their mother's substance use and mental illness.

Family Therapy: Each family has the opportunity to meet with the Family Therapist for a weekly one-on-one session, allowing the therapist to address each family's clinical needs individually. Family services begin with a Family Therapist's assessment of each family, including familial composition, strengths, cultural and spiritual relationships, disciplinary practices and issues, sources of support, and current issues, and development of individualized treatment goals. The Family Therapist attempts to engage the women's non-abusive partners and extended families in treatment to learn about addiction, family dynamics, and healthy communication.

[12] (Moore, Buchan, Finkelstein, Thomas, 1997)

Individual Counselling: Women see their individual counsellor twice a week, and may also receive crisis intervention coaching around parenting, as needed.

Pharmacological Treatment/Medication: The consulting psychiatrist and community mental health centers provide medication management for symptomatic concerns.

Education: Basic education about physical, sexual, and emotional abuse and witnessed violence addresses how current behaviours, including substance abuse, are linked to past abuses. In addition, basic life skills in wellness, health, nutrition, stress management and financial planning are integral components of the NDF program and are incorporated into all phases. Groups focus on the following topics weekly: HIV risk reduction, STD prevention, maternal substance abuse, violence, nutrition, child health, budgeting, and financial issues.

Skills Building: Skills development address a variety of issues including: self-regulation, boundary maintenance, assertiveness, communication, self-esteem, anger management, development of healthy relationships, female sexuality, correcting distorted thoughts and beliefs, personal empowerment, spirituality, cultural development, relationships, safety, self-care and symptom management.

Vocational or Employment: Women at NDF are required to work full time in paid employment or engage in a combination of unpaid work and training for at least 30 days prior to successful discharge from the residential setting. To facilitate this, the program employs an employment and vocational specialist to conduct an assessment of aptitude and skills and to assist the women in developing skills aimed at immediate employment and self-sufficiency. NDF provides clients with a full range of employment and vocational services, including GED tutoring and testing; computerized occupational job search, and job skills tutorials. Individual and group sessions aim to improve job acquisition and retention skills.

Linkages to Community Services: Services such as health and dental care, children's mental health treatment, cultural development and support, recreation, and recovery groups are provided through linkage to community agencies. The program employs a full-time peer case manager to assist in linkage to needed services both during residential treatment and as the family transitions to the community. Other linkages provided include:

> *Transportation:* During the residential stay, van service, bus tokens, and cab vouchers are available to transport women to some outside commitments. But upon leaving the program, women must find their own transportation and balance this difficulty with the other challenges faced during transition.
>
> *Childcare:* The program has an on-site licensed childcare centre with staff of three childcare workers. This allows mothers time to do their own mental health treatment, the recovery activities, or go to work when they are in the later phases of the treatment.
>
> Prior to leaving the program, women are referred to the Colorado Child Care Assistance Program for cash assistance with childcare, while the Child Learning Center staff assist women in selecting a childcare center.
>
> *Housing:* NDF aid women in finding safe and affordable housing. Upon admission to NDF, women learn about housing subsidies and options, and most women are placed on waiting lists for Section 8 vouchers.

Continuing Care Treatment Group: While the consumer is in the final month of Phase II, she begins attending the Continuing Care treatment group, which assists her in the transition from residential treatment into the community and self-sufficiency. The group combines women in Phases II and III and meets once a week for two hours per session. NDF provides or links consumers to transportation and childcare. The Continuing Care group

focuses on various topics such as cravings, triggers, relapse, stress, fun sober activities, high-risk situations, parenting, refusal skills, sexuality, interpersonal violence, development of healthy relationships, and development and maintenance of support systems. The group also provides women the opportunity to hear from her peers about the struggles of independent sober living and to better prepare for these struggles.

During the beginning two weeks of Phase III, the client and Continuing Care Counselor develop a continuing care plan. This includes several activities: working on a variety of goals; monitoring urinalyses and Antabuse as indicated; attending self-help support groups; meeting with the Continuing Care Counsellor individually at least every six weeks; complying with child welfare or probation requirements; and maintaining employment.

Alumni Program: Phase III includes POWER (Power of Women Recovery), the Alumni Program that provides social support for the families currently in residential treatment as well as those who are now residing in the community. POWER conducts a formal meeting once a month and occasional fundraising activities to support the expenses associated with their plans. Activities focus on developing ways to have fun without the use of drugs and alcohol.

4. Evaluation/Outcome Data[13]

An evaluation of the effectiveness of the New Directions program is in progress. Results of an older evaluation of New Directions for Families revealed the following about families enrolled in the program for the four years between 1995 and 1999:

- 47% of women successfully completed the program, defined as completing treatment goals and having housing and employment at discharge;
- Women involved in the program improved their parenting skills as measured by the Parenting Stress Inventory and self report;
- Women participating in the program demonstrated fewer symptoms of depression and other psychological symptoms at six-month follow-up interviews as compared with admission;
- The average weekly income of women increased from $187 to $237 between admission and six months following discharge;
- Of the women participating in the program, 60% were employed and 44% were participating in job-related training at six-month follow-up;
- 72% of women surveyed at six months after discharge had significantly reduced their use of alcohol or other drugs and 60% were not using at all;
- The number of women with children in their custody increased dramatically between intake (59%), discharge (92%), and six-month follow-up (81%).

For more information on this program, contact: Nancy VanDeMark (Manager), 303-781-1275 ext.108, nancy@ahinc.org

[13] Source: http://www.arapahoehouse.org/AHHTML/newdirections.html

Calgary Health Region – The Addiction Centre

The Calgary Health Region Addiction Centre, established in 1993, specializes in the assessment and treatment of adults and adolescents with substance or gambling addiction co-occurring with a psychiatric or physical condition (e.g. chronic pain). The Centre provides a range of individual, group and family therapy.

1. Organizational and Service Delivery Setting

The Addiction Centre is a treatment, education, and research facility operating out of a tertiary care general hospital (Foothills Medical Centre) in Calgary, Alberta. It operates under the Calgary Health Region as a Mental Health Program within the Acute Care Sector and is also affiliated with the University of Calgary. The Centre offers a combination of residential (two designated beds in the adolescent unit and four beds in the adult unit are available for psychiatric stabilization and withdrawal), day, and community-based treatment for adolescents and adults with concurrent disorders. At any one time the program has about 150-160 active clients.

Note: The Addiction Centre has two separate concurrent disorder programs – one for adolescents and one for adults. The following provides separate descriptions for each program. If not specified, the information provided refers to both programs. Please also note that, because the treatment setting is in a hospital, clients are often referred to as 'patients'.

Target Population:

- Adults over 18 years
- Adolescents aged 13-17 years (Parental/legal guardian involvement is required.)
- Adults and adolescents with a DSM-IV diagnosis of substance abuse and a major psychiatric disorder.
- Adults and adolescents with a significant psychiatric problem for whom substance abuse is complicating the course and treatment of that disorder.
- Adults and adolescents with a physical condition that is complicated by substance abuse.
- Adults experiencing substance abuse that results in significant physical complications.
- Adolescents with academic difficulties that are complicated by substance abuse.

Staffing: The Addiction Centre is staffed by a multidisciplinary team consisting of nine part-time (0.3 FTE min.) physicians, including five psychiatrists and four family physicians, a Manager Clinical Operations, seven Staff Nurses, two Family Counsellors, two Occupational Therapists, one Social Worker, four Psychologists, 2.4 Secretaries and a Psychology Assistant. All Addiction Centre clinical staff members have both addiction and mental health competence.

2. Referral, Screening and Assessment

A referral from a physician or community agency through a physician is required for treatment. The client's family physician is expected to be actively involved throughout treatment. Following receipt of a letter from a physician or community agency identifying current problems and brief history including the patient's demographic data, an intake nurse from the Addiction Centre contacts the patient, gathers all pertinent information and then schedules an appointment for assessment (there is typically up to a 3-month wait to get an assessment).

Youth Assessment

All clients are assigned a case manager. A multi-disciplinary team participates in the assessment using a structured interview (Adolescent Drug Abuse Diagnosis) plus urine drug screening. Youth receive a comprehensive 3-4 hour

bio-psychosocial assessment focusing on medical, social and family relationships, mental status, academic history as well as detailed substance abuse history. Developmental history is obtained through consultation with parents/care-givers. The youth's family is required to be present for the assessment. The assessment may also include consultation with any community agency/school system involved with youth and their family. A teacher consultant provided by the Calgary Catholic School District is available.

Adult Assessment

All clients are assigned a case manager who performs, in collaboration with a consulting physician, a two-hour, bio-psychosocial assessment using the Addiction Severity Index and a psychiatric review with corroboration from family members, employers and other health care professionals involved in the patient's care. Other assessments may include psychiatric, physical, occupational, psychological, and family evaluations. Not everyone sees a psychiatrist, since the majority of clients come with a psychiatric diagnosis already.

The case manager sends the referring physician a copy of the comprehensive bio-psychosocial assessment, and then coordinates with the consulting physician to develop a treatment plan. The case manager and consulting physician then sit down with the client and discuss the options in order to develop a treatment plan sensitive to the client's Stage of Change and treatment goals.

3. Treatment Approach

Treatment is multidisciplinary and may involve individual counselling, milieu therapy, group therapy, psychological assessment and testing, patient education about substance abuse and medications, pain assessment and management, social skills training, occupational assessment and counselling, recreation therapy, leisure counselling and family therapy. Some medication treatment and monitoring is provided.

ADULT TREATMENT

Treatment Levels

In April 2003, the Adult program at the Addiction Centre underwent a change in structure in order to accommodate a larger variety of client needs. The program now has four levels of care, with higher levels requiring a greater time commitment than lower levels. The lower levels suit people who are not ready for a goal of abstinence. The four levels are described below:

Level I: Previously, if a client was uncomfortable with groups and wanted to have individual counselling, they were not accepted into treatment. Now, they are admitted to Level I. In Level I, clients are given individual therapy for up to six sessions. The hope is that at the end of the six sessions the client would be more comfortable with the idea of group activities, and would then move to Level II.

Level II is the beginning of group encounters. The Addiction Centre focuses on harm-reduction and provides mostly education in a twice-a-week group. Groups are described below.

In **Level III**, clients attend both Level II and Level III groups. This level requires several hours' attendance per week. All patients are also expected to attend at least one community support group each week. The goal at this Level is harm-reduction. However, clients are encouraged to progress to Level IV.

In **Level IV**, the goal is abstinence and it is more interactive. Groups require a time commitment of a half-day, every day, five days per week.

Treatment Interventions

Open Group: This is a long-term supportive group for all Level I and II clients who have a chronic and persistent mental illness (e.g., schizophrenia) and addiction. Group leaders help patients to learn problem-solving skills and provide information and education about substance abuse and relapse prevention. They also facilitate discussions regarding illness, medication, stress reduction, abstinence, relapse prevention, and goals. All patients are expected to attend at least 10 consecutive group sessions.

Changes Group (motivational enhancement therapy): This group, held for 75 minutes twice per week, is intended for Level II and III clients who are undecided about changing their substance use or gambling. Group leaders assist attendees to take a critical look at how their lives have been affected by substance abuse or gambling. Topics include mental health, physical health, family and social issues, productivity, leisure and stages of change. Motivation for change is discussed, along with perceived barriers to change. Attendees can still be using (or gambling) but must be clean and sober the day that they attend the group.

Beyond Therapy Group: Group Leaders provide Level III clients with an overview of some community support groups including S.M.A.R.T. Recovery, Women for Sobriety, and 12-Step Recovery Programs. Issues that can encourage or interfere with individuals reaching out to community support groups are reviewed, as well as the importance of developing a support network.

Communication Skills Group: Level III clients are educated on topics such as communication styles, giving and receiving constructive criticism, listening skills, and mental health issues. Patients are encouraged to personalize each topic by discussing their own relevant circumstances and by engaging in role-plays. Completion of written homework exercises is encouraged.

Coping with Negative Moods Group: Patients are expected to attend a minimum of 3 sessions during their Level III. The cognitive-behavioral model of mood is used to structure educational material. Patients may be asked to self-monitor their mood and thoughts using a thought log. Group leaders work through examples of negative mood states drawn from patients' recent life experiences. Patients are shown how negative thinking can contribute to depressed mood states and put them at risk to relapse. Strategies for modifying negative thinking are introduced.

Skills Practice Group: Group Leaders facilitate discussions on incorporating a number of skills into clients' daily activities. Topics include: Drink Refusal Skills, Resolving Relationship Problems, Developing Social Supports, Managing Urges to Drink, Problem Solving, and Seemingly Irrelevant Decisions. Group Leaders invite group members to practice skills through role-plays and give constructive feedback on skills performed.

Interpersonal Group: In this group, therapists facilitate Level IV patients' awareness of their patterns of personal interaction and how certain patterns get them into trouble. Therapists orient the group to a "here-and-now" focus, in terms of their reactions and interactions, and comment on what is observed in individuals and the group process. Patients are also encouraged to give and receive feedback about what they notice about each other and how they impact each other.

Lifetraps Group—Part I: For Level IV clients, Part 1 (75-minutes, weekly for three weeks) of the Lifetraps group helps clients to identify chronic, self-defeating personality patterns. Group members are encouraged to discuss their individual maladaptive personality patterns during group and to reflect on how such patterns increase their

vulnerability for relapse and increase the potential for negative mood states. Suggestions for breaking the cycle of self-defeating behavior patterns are provided.

Lifetraps Group—Part II: For Level IV clients, Part Two (75-minutes, weekly for three weeks) provides information on identifying and labeling emotions. Group discussions focus on the functions and consequences of emotions. Members are provided with strategies for reducing vulnerability to negative emotions and increasing positive emotions. Clients also learn specific techniques/skills for managing emotional distress.

Relapse Prevention Group: This group provide Level IV clients with education and relapse prevention worksheets on topics such as mood, anxiety, grief and loss, sleep, lifestyle balance, return-to-work issues and relationships. Group leaders explore individual clients' risk factors, as they relate to the above topics and introduce them to skills to better manage risk factors and to reinforce protective factors.

Relaxation Group: For Level IV clients, this group first provides an introduction to the stress response, the relaxation response and abdominal and diaphragmatic breathing. Subsequent sessions introduce clients to a variety of relaxation techniques. Each session consists of a 10-minute technique introduction followed by a 20-minute relaxation exercise.

Self-expression Group: For Level IV clients, this group facilitates exercises aimed at helping patients identify their communication styles and patterns that cause them problems. Clients examine their beliefs about self and others, and learn tools to begin to shift their self-concept and communication style. Role-plays are frequently employed to practice assertive communication and receive practical feedback.

Specialized groups

Couples Participating in Recovery Group: This group is for couples where one partner is in recovery from alcohol, drugs or gambling addiction. The goals of the group are to maintain abstinence, to encourage individual recovery and to stabilize the relationship. Through group activities, couples develop communication skills through role-plays and home practice. The skills include: listening, direct expression of feelings, making positive specific requests, negotiating and compromising, and developing written agreements. Couples participate in homework assignments designed to restore goodwill and positive feeling in the relationship, including a weekly shared fun activity, daily compliments and other caring behaviors. All couples are expected to attend ten marital therapy sessions in-group format, as well as 3-5 pre-group sessions. They are also offered a year of monthly follow-up sessions.

Chronic Pain & Substance Abuse Management Group: This group is for patients with a chronic pain disorder complicated by pain medication abuse or other dependence issues.
Group members are expected to attend all ten sessions of this closed group. The group provides education on various techniques and concepts to enhance pain management skills and to prevent relapse. Clients learn: to explore the effect of chronic pain and substance abuse/dependence on psychological, social, physical and functional well-being; to be exposed to and practice a range of alternative pain management techniques; to make behavioral and lifestyle changes in order to improve pain management abilities; to decrease or stop use of addictive pain medications; and to develop relapse prevention techniques.

Gambling Group: This group is intended for clients with a diagnosis of pathological gambling and another major psychiatric diagnosis. Group members are expected to attend all ten sessions of this closed group. The relationship between gambling, substance abuse, mental health problems and personality traits is discussed.

Clients are introduced to a five-step problem-solving cognitive-behavioral approach to address gambling-related issues. Clients are taught to address irrational beliefs and cognitive distortions and realistically appraise consequences of gambling. In addition, clients learn to monitor their gambling behavior and understand how their gambling is connected to their cognitions and emotions.

Linkages: The Addiction Centre does not provide withdrawal-management. However, they work with community residential programs (e.g. the Alberta Alcohol Drug Abuse Commission) for those who need it.

ADOLESCENT TREATMENT

Adolescents do not have Levels, nor is it focused on harm reduction. Rather, treatment for adolescents is abstinence-based as much as possible. Everyone gets regular urine monitoring. Adolescents' treatment programs are individually tailored to include some of the following components:

a) Possibilities Group: For youth just starting treatment, this group consists of 10 sessions and is targeted to adolescents experiencing a substance abuse problem resulting in significant medical/psychiatric complications; adolescents with a significant psychiatric problem whose substance use affects the course and treatment of the psychiatric disorder and/or where the medical disorder is complicated by substance use; or adolescents with a medical disorder complicated by substance abuse.

Goals

- To provide adolescents with an overview of communication skills to promote positive communication between youth and their parents.
- To help youth develop an understanding of how drug use relates to difficulties with mood, relationships, school, behavior, etc.
- To invite adolescents to consider the impact of substance use on their health, relationships, and lifestyle.
- To employ motivational interviewing techniques to invite adolescents to identify discrepancies between their desired lifestyle and current lifestyle and the choices they are making that are contrary to their goals.

Activities

- Engagement of the adolescent, peers, and therapists as a means of creating a context for change.
- Weekly urine drug screens.
- Weekly exercises to examine youth perceptions around drug use and communication skills/styles.
- Homework exercises assigned to facilitate discussion and practice of new communication skills between youth and parents.

b) Invitations Group: Also consisting of 10 sessions, this group is for parents/step-parents/ other caregivers of an adolescent admitted to the Adolescent Program. Parents are concurrently engaged in-group activities similar to those that the youth participate in.

Goals

- To provide parents/caregivers with an overview of communication skills that can promote positive communication between youth and their parents.
- To develop an understanding of the relationship between their child's drug use and difficulties with mood, relationships, school, behavior etc.
- To facilitate parent/caregiver understanding of past coping/parenting skills that have not resulted in positive communication between them and their youth.
- Promotion of trust in the parent/child relationship.

Activities

- Engagement of the parent(s)/caregiver in the group process
- Weekly exercises to examine and practice positive communication skills
- Weekly homework exercises assigned to facilitate practice of new communication skills between youth and parents.

c) Family Therapy: Families are encouraged to attend individual family therapy sessions decreasing power struggles while re-establishing new avenues of communication focusing on rebuilding trust,

d) Individual Counselling and Pharmacotherapy: Treatment can include individual (supportive or cognitive-behavioural) psychotherapy, medication to support abstinence (e.g. Antabuse, naltrexone) as required, medication for co-occurring psychiatric conditions (e.g. depression, mania, anxiety)

e) Young Adult Program - Short Stay Inpatient Unit: Although the large majority of cases are treated through community-based groups, a small minority will have a 3-6 week residential stay (usually home on weekends) at the Young Adult Program. While in hospital the services available include individual counselling, psychological assessment and testing, patient education in substance abuse, sexuality education, social skills, medication, recreational therapy, milieu therapy, school, group psychotherapy, leisure counselling and awareness group. Residential patients are typically individuals with either a high suicide risk, a need for withdrawal management, or a need for further observation/assessment of their medical or psychiatric status.

Follow-up: Following assessment or treatment at the Addiction Centre, follow-up care is often arranged with community agencies (e.g. AADAC, 12-step programs).

4. Evaluation/Outcome Data

Components of the Addiction Centre's concurrent disorder programs (e.g. the day program) have been formally evaluated. For results of the evaluations, please contact the program directly. Informally, a large database provides regular information upon which program modifications occur.

For more information on this program, contact: Dr. Nady el-Guebaly (Director) at (403) 944-2350; Or contact: Mrs. Diane Brown, RN, BHSc (Nsg), Manager, Clinical Operations at (403) 944-2025,
Diane.Brown@CalgaryHealthRegion.ca.

Canadian Mental Health Association (CMHA) – Ottawa Concurrent Disorders Program

CMHA's Concurrent Disorders Program is a community-based program that, in partnership with five local addiction agencies, operates groups for clients of CMHA who are seriously mentally ill, struggling with ongoing addictions, and who are homeless or at imminent risk of becoming homeless.

1. Organizational and Service Delivery Setting

The Canadian Mental Health Association, Ottawa Branch, is a non-profit organization dedicated to promoting good mental health, developing and implementing support systems and services, and encouraging public action to strengthen community mental health services and related policies and legislation.

CMHA-Ottawa has long recognized that many of their clients (upwards of 50%) had a co-occurring substance use disorder. Research indicated that these clients would best be helped by integrated treatment for both mental illness and addiction, which incorporates stages of change and takes a harm-reduction approach. No such program was offered by either the mental health service system or the addiction service system. Consequently, in 2001, the CMHA formed a partnership with 5 local addiction agencies and developed the Concurrent Disorders group-work program. Occurring at the addiction agency sites, an addiction worker from the addiction agency and a mental health worker from CMHA co-facilitate groups for these clients.

Target Population: CMHA's CD program serves those who are seriously mentally ill with ongoing addictions problems, and who are homeless or at imminent risk of becoming homeless. Typically, clients are poly-substance users who have an Axis I diagnosis of mood disorder or schizophrenia.

Staffing: CMHA-Ottawa has eight outreach workers and 20 case managers. Their new outreach program has added more outreach workers, a staff psychiatrist, two nurses, a recreational therapist, two mental health/addiction workers and an employment supports worker.

2. Referral, Screening and Assessment

The program's primary form of service delivery is assertive outreach and housing support. Outreach workers offer clients services primarily through the shelter system. Individuals who are interested in obtaining services become a client of the agency. Clients are then assigned either a case manager or an outreach worker, who is responsible for keeping track of everything about them.

When someone wants services, part of the work of the outreach worker is to assess the medical needs of that person and get them hooked up with housing support, basic needs support, clinical support, getting them on financial assistance, etc. Through that process the client will either have had a diagnosis or they will get a diagnosis through consultation with a psychiatrist.

All CMHA staff members have been educated about the high probability of clients with mental illness also having a substance use disorder. As a result, staff assume that new clients have an addiction problem and, during assessment, will specifically ask about it. Once a rapport is established, which happens through the outreach process over a period of months, all clients are screened, as a requirement of the Ministry of Health, with the PSR tool kit, as well as the Lehman's Quality of Life (LQOL) Interview, the Multonomah Community Ability Scale (MCAS), the Alcohol Use Disorders Identification Test (AUDIT), the Dartmouth Assessment of Lifestyle Instrument (DALI), the Global Assessment of Functioning (GAF), and the Drug Abuse Screening Test (DAST).

On a regular basis, the mental health worker who is assigned to the Concurrent Disorders project will talk to the case managers and the outreach workers to see if they think any clients could benefit from the CD groups. The

CD worker also talks to the clients themselves and discusses the CD group and why attending the program might be a good thing for them.

3. Treatment Approach

The CD groups are just one component of a comprehensive set of time-unlimited services offering housing, counselling, and clinical assistance to homeless individuals. Contrary to the 'popular theory' of treating homeless people – that housing should be the first priority before individuals can access mental health or addictions services - CMHA believes that there is no reason why people should have to wait for treatment because they are homeless. As a result, CMHA developed a service that homeless people can access from the street or from wherever they are: Prior to each group, the case manager will go out and find the clients in the community and transport them to the group, stay with them if they need that support, and then take them back. It is a very high-support treatment approach.

The CD Program runs ten groups at five locations, with one to ten people in each group. Facilitated by one mental health worker and one addictions worker, groups are open and non-structured. Each group makes their own rules. Groups are run once a week for an hour and a half to two hours, which includes provision of a meal. At the beginning some people just go for the lunch, but they eventually become interested in the groups and other services.

Abstinence vs. Harm-Reduction: In general, CMHA staff adopt a harm reduction philosophy and use the evidence-based practices of the Kim Meuser program that was developed out of New Hampshire. These include the use of motivational interviewing when appropriate. The harm reduction approach places a heavy emphasis on what the substance is doing to people. Staff are very careful to make sure that people feel no pressure to stop using, because the program does not want people to stop coming. Indeed, clients may attend group even if they are under the influence of substances, as long as they are not disruptive.

Treatment Interventions

Persuasion Groups: The goal of these groups is to help clients develop an understanding of how substance use has affected their lives, to become motivated to work on reducing their use of substances, and, if desired, to achieve abstinence. Thus, staff attempt to create an accepting group environment where clients are free to discuss their experiences with alcohol and drugs without fear of judgment, confrontation, or social censure.

Active Treatment Groups: These groups are for clients that have already developed an awareness of the negative effects of substance use on their lives. Through developing group support for shared goals and developing new skills for dealing with high risk using situations, clients work on reducing substance abuse or maintaining abstinence.

Specialized CD Groups: In addition to having mixed groups, CMHA's CD program provides groups specifically for young adults (ages 18-23), seniors, and male and female survivors of abuse – all with concurrent disorders. In addition, they run a completely francophone CD group. The groups differ to a certain extent, but there is no set agenda. The difference is on the focus, depending on what the group wants to talk about. For example, the seniors group would have a slightly different focus because they are seniors, and also because their substances are likely to be prescription pills and alcohol rather than crack cocaine. The women's group tends to focus on issues related to childhood trauma or sexual abuse. Similarly, the men-only group is for men who have experienced childhood trauma.

Non-judgmental Attitude: CMHA staff demonstrate total acceptance of clients and a non-judgmental attitude, so that people need not suffer shame over their disorders, but rather view it as a condition that many other people have, and that they are not going to get turned out of the group. Since homeless people are very rarely asked what they think, (their options for discussing important or personal issues are limited), CMHA provides a place of belonging where these clients can talk with each other and express opinions of their own.

Individual Counselling: Each client meets once a week with their case manager, who may provide them with individual counselling, if required. Clients always have access to individual support if something comes up for them in the group. In addition, clients will receive individual follow-up from their case manager if the worker doing the group indicates a concern for them.

Pharmacological Treatment/Medication: It is the client's choice whether or not they want to take medication. If clients do not have their own psychiatrists or doctors, the program facilitates access to one. Also, at the clients' request, the program can have a nurse talk to them about different medications. Often, the outreach nurse is able to help people to see the value of medication for the first time.

Social Activities: The program uses a variety of approaches to make people feel good about themselves and to provide a sense of belonging. For example, they have a big barbecue once a year for all the clients in the CD groups. The youth group is sometimes taken to movies or bowling. The program also has a budget for groups to order pizza or go out for breakfast or lunch in a restaurant once a month.

Linkages: The program uses several outside agencies for a variety of services including medical, social, day programs, and especially housing. In addition, CMHA-Ottawa has formal agreements with five addiction agencies, who provide an addictions facilitator and the space for the groups, and who are also able to provide the client with more intensive addictions services, as needed, such as withdrawal management.

4. Evaluation/Outcome Data[14]

An Outcome Evaluation of the Concurrent Disorders Group Program was conducted by the Centre for Research on Community Services at Ottawa University. The purpose of the outcome evaluation was to examine the progress of clients participating in CMHA's CD groups for the first 9 months.

The evaluation was designed to answer the following questions:

1. Are there changes in functioning (i.e., housing status, mental health, alcohol use, drug use) for clients over the course of participation in the group program? How do the changes in functioning over time for clients participating in the group program compare to similar clients not participating in the group program?
2. Are there changes in the quality of life of clients over the course of participation in the group program? How do the changes in quality of life over time for clients participating in the group program compare to similar clients not participating in the group program?
3. Does the frequency of participation in the group predict changes in functioning and quality of life of clients?

[14] Source: Aubry, T., Cousins, B., LaFerriere, D., & Wexler, A. (2003). *Evaluation of Concurrent Disorders Group Treatment Program: Outcome Evaluation Report*, Ottawa: Centre for Research on Community Services, University of Ottawa.

A quasi-experimental design was used for the outcome evaluation. In particular, the first group of 28 clients admitted to the CD groups who had participated in at least 7 sessions of the group (i.e. average of approximately one per month) formed the "treatment group" for the evaluation. These clients were already receiving services at CMHA, namely either intensive community support or outreach services. A matched "comparison group" comprised of clients with concurrent disorders receiving intensive case management or outreach services from CMHA but no group treatment was formed from the sample of participants in another study being conducted at CMHA (the Community Mental Health Evaluation Initiative - CMHEI).

Measures of functioning and substance abuse and demographic and clinical information were collected through the administration of a number of screening/assessment tools including: the Alcohol Use Scale (AUS), the Alcohol Use Disorder Identification Test (AUDIT), the Drug Use Scale (DUS), the Drug Abuse Screening Test (DAST), the Substance Abuse Treatment Scale (SATS), the Multonomah Community Ability Scale (MCAS), the Brief Symptom Index (BSI), the Lehman's Quality of Life Interview (brief version), and measures from the PSR toolkit.

Summary of Results

Positive outcomes for the participants in the concurrent disorders treatment groups suggests that the pilot program holds some promise as an adjunct to support services for clients presenting with mental health problems and substance abuse. Results show participation in the concurrent disorders group as being value-added:

1. CD group program clients report greater reductions in alcohol consumption.
2. CD group program clients report greater improvements in their level of satisfaction in the areas of daily activities and finances.
3. Clients participating in the group program and their matched counterparts also reported increased satisfaction in their health.

Limitations of Evaluation

1. Early stage of program development of the concurrent disorders group treatment program,
2. Use of a quasi-experimental design involving non-equivalent matched groups to examine outcomes,
3. Short period in which clients were followed, and
4. Small size of the client group under study.

The program staff believe that, even with the study limitations, the results are encouraging and support that the CD treatment is of significant value to clients.

For more information on this program, contact: Mary King (Coordinator), 613-737-7791, kingm@cmhaottawa.ca

Center for Human Development – Connecticut Outreach West

Connecticut Outreach-West is a program that offers long term, intensive residential support for those with the co-occurring disorders of mental illness and substance abuse. The service uses an Intensive Outreach model that strives to deliver assistance to clients wherever they may reside in the community.

1. Organizational and Service Delivery Setting

The Center for Human Development (CHD) is a large non-profit organization with headquarters in Springfield, Massachusetts. CHD has been working with chronically mentally ill adults since the late 1970's through a variety of different programs. The CHD outreach treatment model evolved over time: Initially, for a mentally ill client, getting an apartment on their own and being supported by an outreach program occurred only after sustained success in a group home. CHD considered such a rigid system as unnecessarily restrictive to those people who did not require a group home's level of support (24-hour supervision and highly structured programming), or could not tolerate the amount of human contact (staff and housemates) associated with group home living. Realising this, CHD programs began the unorthodox and controversial practice of placing some recently discharged psychiatric patients directly into their own apartments, bypassing group homes all together. The outreach model expanded to visiting clients in their own apartments. The frequency of visits would depend on the client's abilities. Those clients who had more skills received fewer visits while those who had fewer skills would receive more.

In 1995, the State of Connecticut asked CHD to develop a program based on well-researched interventions, including CHD's outreach model, as well as the work of Drake and Minkoff. As a result, the Connecticut Outreach -West (CTO-W) long-term residential support service was funded to work exclusively with people who have co-occurring chronic mental illness and substance abuse who are living in the Waterbury, Torrington and Danbury catchment areas (the northwest corner of Connecticut).

Program Objectives: Objectives for the program include: that at least 80% of individuals involved for at least six months will maintain or show an increase in time spent in the community when compared to the previous six months; that no more than 5% of individuals involved will have experienced homelessness during the course of any twelve-month period; and that individuals will show not only a decrease in frequency of use of substances, but a decrease in amount used as compared to any previous six month period. It is also anticipated that individuals will show a decrease in involvement with the criminal justice system and that eventually every one will experience some form of regular work.

Target Population: CTO-W services were designed to work with those individuals who have co-occurring disorders of mental illness and substance abuse. Specifically, the program serves individuals who have both a chronic, long-term Axis I psychiatric disability who have also been identified (diagnosed) with substance use/abuse. Typically, individuals served by this program have the severest of difficulties and are actively symptomatic, non-medicated, and previously called "treatment-resistant" or "treatment non-compliant". About 75% of CTO-W's clients are homeless.

Staffing: The Connecticut Outreach–West program staff includes: a Program Director (20%FTE) who is responsible for all aspects of the program; an Assistant Program Director (40%FTE) who is responsible for program supervision, supervision of managers, system interface, assists with budget and contracts, and does training; two full-time team managers who supervise outreach workers, run groups, oversee psychiatric meetings and represent the program at sub-system meetings; and several full-time outreach staff who provide day-to-day service provision to clients.

2. Referral, Screening and Assessment

The CTO-W program is in a "closed referral system" because it is funded by the Department of Mental Health and Addiction Services. This means that referrals can only come through the State of Connecticut Local Mental Health Authority (hereafter referred to as "the State"). Clients desiring services must first approach the State and request services. They then go through a State Intake process, where the State makes three initial determinations: the first is diagnostic - they want to determine whether or not a client has a mental illness or substance abuse problem. If a consumer has already been diagnosed, the State gets a copy of their records. If not, they arrange for the client to see a psychiatrist. The State also determines whether people are indigent. If they can afford services, they will be referred to a non-State provider. The third thing the State looks at is severity – is the consumer "sick enough" to be qualified for state services. Based on these three things, the State then makes a referral to an appropriate service provider.

All of the service providers in the closed referral system meet weekly to pick up the State referrals, which come with a referral packet for each client. The referral packets contain the initial screening that the State performed, including the client's basic demographic information, such as age, where they are living, who the closest relative is, and some diagnostic information. The packet will also have information about the person's assessment history, including either a copy of the last assessment, or names of places where copies of assessments can be obtained.

Following receipt of the referral package, CTO-W's first priority is to meet with a client to do their own screening and assessment. As a rule, the meeting will occur in whatever environment the person is in. Whether they are in a shelter or respite, or with a relative or a friend, the team manager and one of the staff will go out to the client as soon as possible - no longer than five days after receiving the referral packet. The initial meeting takes 90 minutes to two hours.

Initial screening of referrals focus on three things: 1) history of mental illness; 2) history of substance use; and 3) history of contact with the police. The main issues screened for are whether a person is a potential danger to the community and whether they have the severity of illness appropriate for the program's intensive level of services. CTO-W does not use any screening instruments. The CTO-W workers try to get as full a history as possible, including what clients feel about their mental illness, whether they agree with their diagnosis, histories of hospitalizations, etc. The client is also asked about their incarceration records, including not just prison, but also jail, and all other police contact. The workers also attempt to get a sense of what targets or goals that person wants to work on.

Within five days of the initial meeting, the client's case is reviewed by the team that will be working with that person, as well as the staff and the Program Director, and a decision is made about whether or not the person is appropriate for the program. CTO-W's admission criteria are: clients must be at least 18 years old and they need both an Axis I mental illness and an Axis I substance diagnosis. The program does not accept somebody with only an Axis II mental disorder. Also, the State requires them to be indigent, which means they lack the necessities of life due to poverty.

Once a client is accepted, staff immediately begin seeing that person and begin to assess the person's basic needs - housing, food, and clothing. If those needs are not met, the CTO-W team will work to meet those needs right away. To help determine the level of care needed by a person, CTO-W completes the LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services) – a simple tool that measures issues like suicidality, a person's ability to maintain housing, and ability to self-medicate. When a client's basic needs are met, they move to the next level – medication needs, doctor needs, and other physical needs a person has. If a person has not seen a psychiatrist for a long time, the team will get them in to see a doctor, usually within a week.

Client choice is central to the program. Services are provided to individual clients based solely on individual needs (determined through initial and ongoing assessments as well as direct experience) and are tailored and monitored, with client input, to each individual situation. Part of the intake process involves asking clients what

they want to work on, or where they want to be, and what they think are their immediate needs. Clients are involved in every major decision concerning their treatment. Treatment plans and connections with other providers always include client input. The program makes sure that clients understand their rights and responsibilities to the fullest extent possible.

3. Treatment Approach

A unique feature of the Connecticut Outreach-West's long-term residential service is that it incorporates a tailored treatment model of working with the dually diagnosed - the Pyramid Model. It is non-invasive in nature and fully integrates both mental health and substance abuse treatment methods. The model is based on modifications of work done by Drake, Minkoff, Prochaska and many others, and has been fine-tuned over five years so that it best matches the local mix of services, programs, systems and structure.

The CTO-W program uses natural consequences to help clients learn. Staff members do not punish people for making bad choices, nor for being sick. They point out the consequences of client's actions and do not save them from negative consequences. For example, if a client becomes homeless, they do not rush in to save that person if it was a consequence of their own actions. In such cases, staff will tell the client: "If you mess up your apartment to the point where you get thrown out, then you've got to go and live in a shelter for a couple of weeks." Staff continue to see the person wherever they are. If somebody gets arrested and goes to jail, they continue to see the person in jail.

Abstinence vs. Harm reduction: The program does not require clients to be abstinent, though it is a goal. Clients are not allowed in groups when they have been using, however, they are not told what to do in their own homes. Staff prefer that clients not hide the fact that they have been using, because they want to know what clients are doing. That allows clients to feel that they have more choice, and also lets the staff tell the doctor what clients' substance use is like so the doctor can best medicate them.

Treatment Phases

The Pyramid model emphasizes *a six-phase method of treatment:*

Stage 1 - Community Stabilization: The goal of Community Stabilization is to establish a safe and stable environment for growth, and to develop a contact routine between staff and client. Outreach staff assist the client with arranging entitlements, setting up a bank account, selecting furniture, etc. Attempts to establish links to psychiatric and substance abuse treatment services can also happen at this time if the client is willing. Positive natural support such as family members, relatives, and close friends might also be brought into the process. Helping the client find housing is the single most important aspect of this stage, perhaps the single most important aspect of the model.

Stage 2—Engagement: The goals of Engagement are to establish regular client and staff contacts and to have the client and the staff develop a working alliance and a trusting relationship. During this stage, CTO-W staff engage in: intensive relationship building, close monitoring of clients including drug screens, meeting clients 'where they are at', spending a lot of time with clients, and constantly assessing their needs and progress. Staff also promote medication compliance, and engage with clients' positive natural supports.

Stage 3—Education: The education process attempts to be as complete as possible and as wide-ranging as possible in order for recovery to be well rooted. The goals of the Education stage are to have to the client reduce denial, gain insight into mental illness and substance use, become aware of how these two illnesses impact people's lives, and develop a personal vision of a more healthier lifestyle. Clients are also encouraged to attend educational or

social groups on a regular basis. Social well-being, nutrition, physical and dental health issues are all raised for discussion. Interventions in the Education stage revolve around helping the client to perceive the adverse consequences resulting from their behaviours (natural consequences) and providing information on a range of associated issues. Staff make efforts to expose the client to positive peer role models and to clean and sober activities. Natural supports, if they exist, are also provided with education about substance abuse, mental illness and the interactions of the two.

Stage 4—Persuasion: The goals of the Persuasion stage are to have the client acknowledge that substance abuse is a problem for them, to gain an awareness that recovery is attainable, to admit their powerlessness to control the symptoms of mental illness and to limit substance use without help, and to begin to take personal responsibility for their participation in treatment. At this point, CTO-W staff provide: 1) an assessment of the value of external controls on substance use such as the drugs Norpramine or Antabuse, 2) empathic confrontation, 3) the offering and running of an active users group, 4) probing questions associated with clients mental illness and substance abuse, 5) awareness of cognitive dissonance and an ability to make this known to client, 6) psycho-education for positive natural supports, 7) motivational interviewing, 8) discussion of triggers and development of a trigger plan, and 9) a continued emphasis on discovering clean and sober activities.

Stage 5—Active Treatment: Although work done in previous stages was also 'treatment', what is different in this stage is that the client is more active in the process, making choices as to which services they want and where they want to receive them. The goals in the Active Treatment Stage include the client: building or maintaining motivation to sustain abstinence, moving towards more autonomy and independence, implementing positive changes including leaving old ways of living and behaviours, and engaging with appropriate self help groups and/or other recovery services.

Stage 6—Relapse Prevention: Relapse prevention begins once the client is fully involved in a treatment regimen, has sustained sobriety for over six months and has developed the knowledge and autonomy described above. The goals of the Relapse Prevention stage are that the client will: be actively involved in treatment, acknowledge that recovery is never complete but rather that recovery is a process, take charge of their recovery and integrate healthy coping strategies into their lifestyle.

Discharge: The prior stage, Relapse Prevention, is characterized by a reduction in services, or a shifting of those services from tradition caregivers to natural supports. Most notably, the services of an intensive outreach program such as CTO-W are no longer required. The termination process is individualized, including linking to appropriate alternative supports, and is paced such that the client (and staff) achieve appropriate closure. Before discharge, ideally, the client will have in place a behavioural plan that helps them cope effectively with their triggers.

Treatment Interventions

The Connecticut Outreach-West program is designed to provide assistance with the full range of potential client needs including: locating and securing housing and entitlements; making and maintaining linkages with appropriate day, vocational, clinical and medical treatment services as well as the utilization of any additional special services which would again be dependent upon individual client needs.

Team Approach: Clients do not have a case manager; rather, they have a team comprised of four caseworkers and a team manager. Every staff member works with every client to provide services such as crisis intervention, skill

building, abstinence support, as well as ongoing supports surrounding sober and clean social, recreational and leisure activities become the responsibility of all team members.

Client Visits: CTO-W is a very intensive service that has the flexibility to provide staff visits at any time between 8:00a.m. and 8:00p.m., seven days a week, 365 days a year. Clients are seen on a daily basis. The program has the capacity to see people three times a day if they need it.

During client visits, team members provide a wide range of services, ranging from medication delivery and medication monitoring to helping clients with specific tasks like grocery shopping or apartment cleaning. No one worker is ever designated as having primary client care responsibilities. Every client visit is logged and the logs are brought back into the office before each staff member leaves for the day. It is the responsibility of each team member to go through the logs and read every single one. The Team Manager, who also has some client contact, and who is responsible for overall scheduling and coordination, supervises each team. The CTO-W program has two teams, and each team sees about 15 clients.

Housing: Finding housing for clients is the first goal of the program, because the belief is that they cannot begin treatment until a person is housed. As a result, the program pays for a client's housing and gives clients loans for security deposits until such time as they have their State entitlements and can pay it back. CTO-W has a budget not only for housing, but to put furniture in the housing and food in the refrigerator. Most clients enter the program already on social security, so the program is not required to support more than four or five people at any given time.

Active Users Recovery Support Group: The program runs a group for people who are in the Contemplation stage, where they are acknowledging that they think they have a problem and they may want to do something about it, but they are still not actually seriously implementing anything.

Healthy Living Group: Is an education group that offers presentations on a variety of topics, such as substance use, diet, health, mental illness, but it covers those things in terms of a presentation. Material is presented in a very non-threatening manner, simply explaining, for example what heroin is, where it comes from, and what it does to a body. Ideally, clients start making connections between the information they hear and their own experiences

Substance-free Group Events: These groups have a few different focuses. First, they introduce people to the concept that they can have fun without "being high". The second is that they allow people to meet other people who are at different stages of recovery. Often, as clients move through the stages, they reach a point where they want to start helping other people along. The third focus of the groups is reducing stigma. Those with psychiatric symptoms have a place where people are not going to "look at them funny" or think of them as "being weird".

Individual Counselling: A variety of one-to-one counselling is provided by CTO-W staff, depending on the worker's training and background. Staff are capable of helping clients figure out mental illness and recovery issues, or helping them deal with their substance use. However, they are not equipped to provide counselling for "specialized issues" such as trauma.

Pharmacological Treatment/Medication: CTO-W has two doctors on staff and arranges for psychiatrist consults, as needed. Doctors will see clients every other week if needed. Prior to seeing clients, doctors will sit with program staff for the first 15-20 minutes of the day to get an update on all the clients they are going to see that day. The program does not force clients to see doctors or to take medication. It is the client's choice. However, staff tell almost everyone that they believe medication can help and that it should be strongly considered.

Linkages to Services: CTO-W staff are responsible for being case managers, so if the client needs something that the program does not provide, such as medical care or psychological testing, it is the staff's responsibility to put that together. The program has positive relationships with hospitals and with other facilities for withdrawal management. Staff help people with basic needs, like connecting them with soup kitchens and food banks. The program also helps to pay for a client's medication, if needed.

4. Evaluation/Outcome Data

The CTO-W program has not been formally evaluated.

For more information on this program, contact: Steve Sawicki (Assistant Program Director), 203-596-9323, ssawicki@chd.org

Center for Individual and Family Services – Substance Abuse and Mental Illness Program

The Substance Abuse and Mental Illness (SAMI) program, part of the Center for Individual and Family Services, has implemented the Dartmouth Integrated Dual Disorder Treatment model to deliver community-based services to men and women with concurrent disorders.

1. Organizational and Service Delivery Setting

The Center for Individual and Family Services (CIFS), located in Mansfield, Ohio, is a comprehensive community-based/outpatient mental health and drug/alcohol center which offers counselling, consultation, education, vocational services, residential treatment, crisis intervention, and medication services.

The SAMI program at CIFS was implemented in 1999 through joint funding of the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services, which funded nine agencies throughout the State of Ohio to demonstrate the New Hampshire-Dartmouth Dual Disorder Integrated Treatment model. In addition, the Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE) has supported CIFS and other agencies in the development, implementation, and ongoing operation of integrated SAMI Programs.

Target Population: The SAMI program targets male and female adults who have a severe and persistent mental illness, as well as a concurrent substance dependency. Typically, SAMI clients have schizophrenia, bipolar or psychotic disorders, as well as concurrent poly-substance dependencies.

Staffing: The Center for Individual and Family Services has approximately 150 employees, including psychiatrists, psychologists, nurses, social workers, vocational consultants, counsellors, and mental health technicians. The SAMI team is comprised of three full-time case managers, one full-time counsellor, one half-time psychiatrist, one half-time nurse, and a full-time team leader.

2. Referral, Screening and Assessment

Individuals may request services themselves by calling CIFS for an appointment, or other agencies/hospitals may refer them. All clients first meet with an intake clinician (either a licensed social worker or counsellor) who performs a standardized screening and assessment. Clients receive a complete bio-psychosocial assessment that meets Ohio state requirements.

Screening for the SAMI program consists of administration of the Dartmouth Assessment of Living Index (DALI). The intake clinician provides a diagnosis, and based on the results of the screening and assessment, referrals are made either to a program within CIFS or to other agencies in the community (e.g. to local hospitals for withdrawal-management).

For clients in crisis, CIFS has a Crisis Stabilization Unit. Clients may stay there for up to three months until they are stabilized and the crisis team has discovered what their needs are and what might be the best referral for them. If the client has a more chronic condition, screens appropriately on the DALI, and has a diagnosis of mental illness and substance abuse, they may be transitioned to the SAMI team.

Once referred to the SAMI team, clients meet with the case manager, who explains the SAMI philosophy and treatment model. Soon after, clients meet the SAMI team to discuss their needs, goals and preferences. The client is also 'staged' using the Substance Abuse Treatment Scale. The Integrated Dual Disorder Treatment model is a stage driven model - interventions are tailored to the stage of treatment that clients are in. Therefore, the SAMI team first finds out what stage a client is at, then develops an individualized treatment plan.

3. Treatment Approach

The SAMI program uses the stage-based New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model[15], which is an evidence-based practice that integrates substance abuse services with mental health services. The IDDT model combines pharmacological, psychological, educational, and social interventions to address the needs of clients and their caregivers (family and friends). Services are offered for as long as the client requires them.

Abstinence vs. Harm-Reduction: Abstinence is the overall goal of the SAMI program. Staff teach clients that the chance of them having negative effects and symptoms, both psychiatric or drug and alcohol, is significantly increased if they continue to use substances. However, staff understand that if clients are cutting down, or switching from IV drug use to something less dangerous, that is progress and it is rewarded and encouraged. Clients are never discharged from the program because of drug use.

Treatment Phases

The IDDT model is based four stages of treatment, summarized below. The SAMI program delivers a corresponding group for each stage:

Stage 1—Engagement: During the Engagement phase, SAMI team members engage in a lot of outreach and case management and do not give up on clients who are non-compliant or disinterested in treatment. SAMI staff focus on making contact with clients through outreach, building trust, and convincing clients that the program has something they want or need, such as practical information or direction for fulfilling their housing, financial, physical health, social, or vocational needs. Family members are encouraged to become part of the client's recovery process.

Stage 2—Persuasion: During the Persuasion phase, clients with co-occurring disorders are typically unmotivated to control their substance abuse. As a result, SAMI team members still engage primarily in case-management and focus on convincing clients to consider the possibility of long-term abstinence-oriented treatment. Through client peer groups, clients begin to explore the possibility that they might have mental health and drug and alcohol issues that are affecting their lives. It can take clients up to two years to progress through the first two stages of treatment and into the third stage, where positive outcomes begin to occur more consistently.

Stage 3—Active Treatment: Clients in the Active Treatment phase tend to respond more positively and remain committed to treatment when it is tailored to their specific needs. Ongoing clinical assessment is performed to determine the client's psychiatric severity and type and degree of chemical dependency. Case management deceases at this stage. The SAMI team uses a variety of medical, behavioural, educational, individual, family, and group interventions to help clients remain abstinent and sober. Clients are also encouraged to attend community-based support groups.

Stage 4—Relapse Prevention: Clients with concurrent disorders are prone to relapse, so the retention of clients in treatment over time is vital. Therefore, SAMI staff anticipate relapse and plan prevention efforts with clients and family members. Research has identified some common predictors of relapse, including: medication non-compliance, social withdrawal, losses (such as the transfer of case management, the ending of relationships, the death of loved ones), difficult anniversaries, holidays, wavering optimism, and controlled substance use, among

[15] For a complete description of IDDT, see Mueser & Noordsy, 2003.

others. Team members discuss the possibility of relapse with clients and family/caregivers and offer strategies for maintaining recovery. Case-management is significantly reduced at this stage. Clients are encouraged to participate in daily structured activities, such as work, school, or volunteering.

Treatment Interventions

Assertive Outreach: The SAMI program utilizes assertive outreach to keep clients engaged in relationships with staff, family members, and friends. A full-time outreach worker remains in contact with individuals who are not convinced that they can benefit from SAMI services. The outreach worker meets regularly with clients in community locations that are familiar to the client (such as in their homes or at their favourite coffee shops) and offers practical assistance with daily needs and living skills. This frequent and helpful interaction enables them to develop trust and a working alliance with clients that will hopefully lead to treatment.

Case Management: The SAMI program is very case-management driven. Case managers are active in the community - they spend most of their workday in community locations where clients spend their time. Case management helps clients with activities of daily living and provides linkages to services, housing and food, as needed. Case managers also transport clients to SAMI groups on a daily basis.

Substance Abuse Counselling: Clients who are in the Active Treatment stage or Relapse Prevention stage receive substance abuse counselling that includes the following: Techniques to identify and manage internal emotional signals (cues) that precede a return to substance use and psychiatric relapse; Techniques to identify and manage consequences of use; Skills to refuse alcohol and other drugs; Problem solving skills; Techniques to avoid high-risk situations; Examination of and challenges to their beliefs about substance use; and Coping skills and social skills training to deal with symptoms or negative mood states related to substance abuse (e.g., relaxation training, cognitive-behavioural therapy for depression or anxiety, coping strategies for hallucinations).

Skills Development Groups: All SAMI clients are encouraged to attend Living Skills groups. There are four levels of living skills groups, from basic to advanced, addressing a variety of topics, from how to start a conversation to drug refusal skills. Groups are run by case-managers and the topics change, depending on client need. Clients at any stage of recovery may attend these groups. It is not uncommon for clients to go through each group more than once, at various stages, and get something different out of the groups each time.

The skills groups rely heavily on manuals and workbooks to help clients learn new skills. Popular titles used are: Solutions step by step: A substance abuse treatment manual. (Berg & Reuss, 1998); Social skills training for schizophrenia: A step-by-step guide. (Bellack, Mueser, Gingerich, Agresta, 1997); Coping with dual disorders: Chemical dependency and mental illness. (Daley & Campbell, 1994); and Overcoming addictions: skills training for people with schizophrenia. (Roberts, Shaner, and Eckman, 1999)

Transportation Outreach: In order to increase attendance at SAMI groups, it is the practice of the program to go out into the community and pick up clients in order to transport them to the groups. This is known as 'transportation outreach' because it is done by case-managers, who also take the opportunity to perform outreach and persuasion work with clients.

Pharmacological Treatment: The SAMI program has physicians and nurses who are trained in concurrent disorder treatment and who work closely with clients and their treatment teams to help clients increase their adherence to their prescriptions. They are also trained to decrease the use of potentially addictive medications and to offer medications that may help reduce addictive behaviour. Physicians and nurses working with SAMI clients prescribe psychiatric medications despite active substance use.

Group Home: This 9-bed 'damp house' residential facility is open to men and women who do not have the option of staying with family or friends, or for those who want or need more structure in their lives than independent living can offer. Clients living in the group home have access to the SAMI team and SAMI groups, as well as a few groups that are specific to the house. The group home, staffed 24 hours/day, enables clients to relearn life-management skills (cooking, cleaning, bathing) before returning to independent living or to the home of family and friends. Residential services are not time-limited. The average stay is six months.

Drop-In Center/Clubhouse: The drop-in center is staffed and operated by clients. It provides a safe space and support network for clients by offering meals, recreational activities, social activities, and basic living-skills training.

Family Psycho-educational Support Group: Monthly psycho-educational groups are held for family and friends of persons with concurrent disorders. Caregivers learn about the symptoms and effects of mental illness, the effects of substance use and abuse, about the medicines used in treatment, and the challenges that clients face. The multiple family aspect of the group encourages caregivers to develop informal networks of support and to teach each other skills that will help them manage their stress while they help their family members or friends manage their mental illnesses and substance abuse addictions.

Self-Help Groups: Clinicians connect clients who are in the Active Treatment and Relapse Prevention stages with self-help programs in the community, including: Dual Recovery Anonymous, Double Trouble, Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Rational Recovery.

Aftercare: When clients no longer need the intensity of a SAMI team, they are transferred internally to a less intense service, where they can still obtain needed psychiatric medication and see a doctor every three months for monitoring.

4. Evaluation/Outcome Data[16]

A formal evaluation of the SAMI program has not yet been completed. However, documented tracking of client service utilization and anecdotal evidence have revealed the following SAMI program outcomes:

- Reduction in state and local hospital admissions
- Reductions in crisis-bed occupancies at the Center
- Reductions in "Pre-Screens" (SAMI team members conduct a pre-screen when someone is having a psychiatric emergency and it seems as if the client will be admitted to a state emergency facility.)
- Increase in group attendance
- Less involvement with the criminal justice system
- Increase in independent living
- Increase of "quality time" with family and friends
- Some increases in employment rates overall
- SAMI Team sees improved medication compliance, which is a contributing factor to client recovery

For more information on this program, contact: Donald Chell (Team Leader), 419-756-1717, don@cifs.cifscenter.org

[16] Source: http://www.ohiosamiccoe.cwru.edu/ohio/ohioprograms.html

Center for Addiction and Mental Health – Concurrent Disorders Service

The Concurrent Disorders Service, part of Toronto's Centre for Addiction and Mental Health (CAMH), offers specialized community-based (outpatient) treatment to people facing both addiction and mental health problems. Specialized concurrent disorder services include consultation, treatment planning and preparation, group therapy, limited individual therapy, case management, pharmacotherapy, treatment research, and education and training.

1. Organization and Service Delivery Setting

CAMH is the largest mental health and addiction facility in Canada. It was formed in early 1998 through the merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre, and is affiliated with the University of Toronto. Since the merger, the Centre has focused on developing a seamless integration of addiction and mental health services in a functional and flexible environment.

Since 1992, the Addiction Research Foundation offered mental health services to addictions clients. After the merger and formation of CAMH, the Concurrent Disorders Service was developed. The Concurrent Disorders Service (CDS), a part of CAMH's Addictions Program, offers a number of different concurrent disorder groups. In addition, CDS offers more intensive outpatient treatment for specific subgroups of patients in the following four Concurrent Disorders Specialty Clinics:

1. Dialectic Behaviour Therapy (DBT) Clinic for those with Borderline Personality Disorder,
2. Eating Disorders and Addiction Clinic,
3. Anger and Addiction Clinic, and
4. Integrative Group Therapies Clinic – offering a variety of different group psychotherapy approaches.

Treatment Objective: CAMH's Concurrent Disorders Service has the objective to help people reduce the harm associated with their substance use and make improvements in the area of mental health and overall quality of life.

Target Population: Clients must have a concurrent psychiatric diagnosis with a substance use diagnosis in order to be accepted to the CDS. The majority of clients have medium to serious mental illness and moderate to severe substance use diagnoses.

Staffing: The Concurrent Disorders Service Staff Team reports to a two-pronged leadership team: a full-time Clinical Director and an Administrative Director. CDS staff resources consist of a full-time Deputy Clinical Director, Service Manager, Secretary, and four Clinic Heads. In addition, there are 8 Psychiatrists (full and part-time), one part-time Psychologist, and 11 Therapists (full and part-time). Other staff members include two Advanced Practice Clinicians, a Clinical Project Leader, Research Analysts, Psychiatry Fellows and Residents, Doctoral-level Psychology Interns, Social Work Graduate Students and Volunteers. Except for trainees, all staff who do clinical work have minimum of a Master's degree with a mental health background (e.g. Psychology or Social Work).

2. Referral, Screening and Assessment

Clients may call CAMH directly, or a referring clinician can call on the client's behalf. All clients must initially be seen at CAMH's "Intake Assessment Service" for a 2-hour preliminary assessment. The Intake process includes

administration of a variety of instruments, including the standard Ontario Ministry-mandated assessment tools[17], the RAI, the GAF, as well as a computerized CD Screening tool. Clients screening positively for co-occurring mental illness and addiction are strategically matched to the appropriate therapist that runs the CDS group the client might be interested in (e.g. if the client has an eating disorder and an addiction, they will be referred to a therapist in that Clinic). The Intake worker contacts the appropriate group therapist directly to discuss the referral and then makes an appointment for the client.

The CDS therapist then meets with the client and performs a psychosocial assessment in the form of a standardized, semi-structured interview which focuses more on the psycho-social aspects of their situation than on repeating the intake questions about diagnostic and medication information. The assessment is performed to determine treatment suitability for groups and individual therapy and to see whether referral to a psychiatrist is necessary (some clients have well-established diagnoses from outside psychiatrists and do not need to be diagnosed again). In some cases, the Intake Worker can opt to refer a client directly to a CDS Psychiatrist for one of three reasons: (1) a diagnosis is needed, (2) medication needs to be considered, or (3) a psychiatric consultation is required.

Using a collaborative approach, the therapist and the client will then develop a flexible individualized treatment plan taking into account the unique needs of the client. Throughout the assessment and discussion about treatment options, CDS staff like to give clients choices and are collaborative in their approach. Staff attempt to engage clients and work with them 'where they are at', rather than imposing treatment goals on the client. They are client-centered and collaborative, but do not simply ask what the client would like. Rather, it is 'a meeting of the minds' in terms of sharing feedback with the client and giving them recommendations and a menu of options, and then together deciding what would be a good option.

3. Treatment Approach

The CDS treatment recognizes the fact that substance use and mental health influence one another interactively. An important part of the treatment philosophy is that both the substance use and mental health problems are regarded as 'primary', regardless of which disorder developed first. CDS offers "integrated" treatment, in that the same team of clinicians provides addiction and mental health treatment in the same setting. The CDS multi-disciplinary team also follows the recommendations in Health Canada's Best Practices for Concurrent Disorders document, such as: a staged approach to engagement and treatment, harm reduction philosophy of care, use of motivational interviewing, and cognitive behavioral therapy where applicable, appropriate integration or sequencing of interventions depending on the particular disorders in question, and a comprehensive psychosocial rehabilitation treatment plan for people with severe mental illness, to name a few. The team ensures that clients receive care that is effective and coordinated.

Abstinence vs. Harm-Reduction: All staff subscribe to the harm-reduction philosophy of care. Abstinence is not required. Staff work collaboratively with clients at whatever stage or level of readiness they feel they are prepared to work at, and try to move them along the stages of change, regardless of what their substance use goal is. However, when a client has a concurrent mental health problem, staff carefully explain that it is not in their best interest to continue to use substances. Staff engage in psycho-education about the harmful consequences of ongoing substance use and the impact on their mental illness, but it is done using motivational interviewing techniques rather than a lecture format.

[17] See Appendix B for list of Ontario Ministry-mandated tools.

Treatment Interventions

The Concurrent Disorders Service consists primarily of group therapy programs that are organized into the following four Specialty Concurrent Disorders Clinics, as well as some additional CD groups:

1 - Integrative Group Therapies (IPT) Clinic

Concurrent Disorders Psycho-Educational Group: This group is designed to provide clients with knowledge and strategies for coping with concurrent mental health and addiction issues. It consists of 12 weekly topic-based sessions, with each session running 90 minutes. Key topics include understanding personal patterns & links between substance use and mental health symptoms, coping with urges to use substances, managing thoughts and emotions in healthy ways, self-care, nutrition, and developing supportive relationships. The emphasis is on "uncovering clients' capacity to assume responsibility for their own recovery with increased hope and commitment to change, self-awareness, compassion and perseverance".

Interpersonal Group (1): This group is designed for clients who have alcohol dependence as the substance use disorder, along with a mental health problem. This group is for clients who are new to the CD program and who are in the early stages of recovery. Clients attend a group once weekly, for a 90-minute session. Focusing on the here-and-now, clients work on the primary goal of getting their alcohol use under control, and managing related mental health issues. The duration of this group is six months, with possible extension.

Interpersonal Group (2): This group is open to clients with either any substance use disorder, in addition to a mental health issue. In the context of this group, clients are helped to explore and identify their interpersonal communication style and its impact on others. Part of the group focus is on making efforts to understand interpersonal issues in their historical contexts and particular familial backgrounds. In this group, clients explore how problematic and self-defeating relational patterns contribute or manifest in mental health symptoms as well as addictions. Part of the group process involves work in the here-and-now, which includes observing and discussing interactions between group members and providing each other with feedback. The duration of this group is six months, with possible extension.

2 - Dialectical Behaviour Therapy (DBT) Clinic (for Clients With Borderline Personality Disorder)

This is a treatment program specifically designed for people who meet criteria for Borderline Personality Disorder. The program is tailored to individuals who may also have multiple concurrent mental health problems or addiction problems. Treatment is comprehensive and entails a team approach involving a combination of: weekly individual therapy, a weekly (2-hour) skills group, and after-hours telephone consultation. A psycho-educational group for family and friends of people with Borderline Personality Disorder is also available. Treatment focuses on helping people manage emotions, deal with problems, improve their relationships and lead a more balanced lifestyle. Treatment requires a 1-year commitment.

3 - Eating Disorders and Addiction Clinic

Treatment involves a combination of individual and group psychotherapy for both female and male clients with concurrent substance use and eating disorders. The treatment approach involves a combination of: weekly 2-hour group sessions that are gender-specific (involving both experiential therapy and coping skills training); weekly one-hour individual psychotherapy sessions; and meetings with a physician, nurse, and dietician, as needed. This therapy focuses on helping individuals to decrease problematic eating and substance use behaviours, and increase healthy relationships, sense of self, ability to manage emotions, and the ability to cope with stress. Treatment requires a 1-year commitment.

4 - Anger and Addiction Clinic

Therapy involves a combination of individual and group psychotherapy for male and female clients with concurrent substance use and anger-related problems. Treatment focuses on reducing anger and aggressive behaviour, eliminating substance use, enhancing mindfulness and regulation of emotions, and improving distress tolerance and interpersonal effectiveness. Therapy is conducted by a treatment team, and involves weekly two-hour skills-training groups, as well as individual therapy, as appropriate.

Additional Concurrent Disorders Groups: Some additional groups (not associated with the particular Clinics noted above) include the following:

Psychiatric Support Group: This group is for clients with active substance use problems as well as a severe mental illness, such as Schizophrenia. This group meets weekly for an hour, and is ongoing. Various approaches are used in this group and include relapse prevention, motivational interviewing, interactional therapy, and support.

Trauma Group: This group is for both male and female clients with a substance use disorder, who have suffered from serious childhood trauma (i.e., sexual, physical, emotional abuse, neglect, or other trauma) that is causing interference in their lives. This group meets once weekly for 2-hour group sessions. The group commitment is one year.

Anxiety and Addiction Groups: This is a 4-month (16-session) group targeting substance use as well as anxiety symptom management. Group sessions are 2 hours. Treatment also addresses more global areas of functioning including: self-care, affect regulation, self-esteem, and personal responsibility. The group approach is an integrative one involving cognitive explorations, behavioural approaches as well as the use of a psychodynamic framework.

Most of the groups require a six-month commitment, while some require 1-year. However, recognizing the complexity of concurrent disorders problems and the often longitudinal process of recovery, all groups hold the possibility of contracting for an extension if it is determined that a person has residual goals to work on. (Some people can and do stay for years).

Specialized Populations: CAMH has many specialized services for particular sub-groups with addictions. For example, within the Addiction Program, CAMH has a separate Women's Service, Aboriginal Service, and the Rainbow Services (for gay/lesbian/bisexual/trans clients). When clients of these Services have mental health issues, but would rather stay within the specialized area, these Services consult with the Concurrent Disorder Service. CDS collaborates on developing customized individualized treatment plan for those clients and sometimes clients in the specialized Services see one of the CDS psychiatrists or therapists concurrently.

Individual Counselling: In addition to attending group once weekly, many clients also receive supplemental individual therapy. The length of sessions is usually an hour. The frequency is flexible, depending on the needs of the client. Usually the group therapist is also the individual therapist. This therapist also often acts as case manager, liaison, and coordinator with other caregivers that may be involved.

Family Services: Significant others and family members of CD clients are offered support. Family groups running in the CD Service include a CD psycho-education family support group, and two family and friends support groups related to the DBT Clinic.

Pharmacological Treatment/Medication: Many CD program clients are on medication and although medication is not a required component, it is considered when requested. Each client in the CD program has a psychiatrist to monitor medication - often one right from within the Concurrent Disorders Service. If the client's psychiatrist is from outside, the primary therapist coordinates with them.

Linkages to Resources: The Community Support and Research Unit has two housing workers who help clients in the Addiction Program, including CD clients. Clients have access to a resource room with toiletries and food (canned and boxed). In addition, clients can also be referred to the Vocational Adjustment Program within CAMH. For more intensive addictions treatment, CAMH has partnerships and relationships with agencies offering any other type of intensity of intervention (e.g. withdrawal management, residential, day treatment) to match client needs.

4. Evaluation/Outcome Data

CAMH's Concurrent Disorders Services have not been formally evaluated for several years. However, three of the four CDS Clinics (the DBT, Anger and Addiction, and Eating Disorders and Addiction Clinics) are currently conducting an evaluation of their therapeutic approaches through various research studies. The fourth Clinic (the IGT Clinic) has similar plans for the future.

For more information on this program, contact the manager of the Concurrent Disorders Service, CDS Reception: (416) 595-6096.

Dorchester County Detention Center – Dual Diagnosis Services

The Dorchester County Detention Center's Trauma, Addiction, Mental Health, and Recovery (TAMAR) Program provides trauma-oriented services for jailed men and women with mental illness and co-occurring substance abuse disorders. In addition to providing integrated treatment within the jail, the Detention Center connects offenders with treatment, recovery, housing and employment services in the community upon their release.

1. Organizational and Service Delivery Service

Dorchester County Detention Center, located in Cambridge, Maryland, houses approximately 275 minimum, medium and maximum-security inmates, both male and female. The Detention Center is one of 23 jurisdictions that participate in the State of Maryland's Community Criminal Justice Treatment Program to meet the needs of persons with serious mental illness and/or co-occurring disorders who are incarcerated in local jails[18].

In 1996, the Division of Special Populations[19] received funding over two years from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a women and violence initiative. Dorchester County Detention Center was one of three pilot sites that focused on women in the criminal justice system. The pilot project (TAMAR) provided a full array of clinical services to women who had co-occurring substance use and psychiatric disorders that had also been traumatized by physical or sexual abuse. The pilot project was so successful that it received funding from Maryland's Mental Hygiene Administration to continue at the Detention Center. The program was also expanded to meet the needs of male inmates with trauma histories.

The primary goals of the program are as follows[20]:

1. To provide comprehensive treatment and support services for persons incarcerated in the detention facility;
2. To appropriately transition offenders into a community-based system of care after incarceration, and;
3. To reduce recidivism to state psychiatric hospitals, detention centers, and homelessness.

Target population: The TAMAR program targets male and female inmates who have serious mental illness (from depression to trauma disorders to psychotic disorders), a co-occurring substance use disorder, and histories of violence.

Staffing: Trauma-informed mental health and addiction treatment services at Dorchester Detention Center are provided by:

A Community Service Coordinator, who coordinates all mental health and substance abuse services provided through the Jail Mental Health Program and provides direct services;

- A Masters level Clinical Social Worker (LCSW) who provides in-center services to persons with serious mental illness and collaborates with addictions staff to meet the needs of persons with co-occurring mental health and substance use disorders;
- A Substance Abuse Specialist (M.A.), responsible for developing coordinated treatment of inmates with concurrent disorders;

[18] Jail vs. Prison: A jail houses individuals who are in custody while awaiting trial, or who have a sentence of less than 18 months. Prisons house those who have already been sentenced and whose sentence is over 18 months.

[19] The Division of Special Populations fosters the development of programs for consumers of mental health services with special needs. This includes individuals with psychiatric disabilities who are homeless, are in jail, have co-occurring substance abuse disorders, histories of trauma, or are deaf.

20 The following document was used as a source throughout this summary: Exemplary Methods National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors (2002). *Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders.* Final Report of the NASMHPD-NASADAD Task Force on Co-Occurring Disorders. Authors: Alexandria, VA and Washington, D.C.

- A Trauma Specialist (LCSW-C) who delivers TAMAR services both in the county jail and in the community; and
- Other community agency staff specialists who deliver services to inmates in the jail setting on an ongoing basis.

Psychiatric services are provided by a contractual psychiatrist. In addition, every correctional officer has been trained in understanding trauma and how it affects people, and how to conduct themselves so that they do not re-traumatize others.

2. Referral, Screening and Assessment

Upon incarceration, each inmate receives a comprehensive screening and assessment for mental illness and substance abuse problems, with immediate crisis intervention and stabilization services provided as necessary. If referral to a psychiatrist indicated, it is arranged with the consulting psychiatrist. The psychiatrist or LCSW-C can make diagnoses, if needed. A medical exam is also performed, with any prescribed medication being managed on an ongoing basis.

Inmates are given a short screening form regarding trauma issues, which is placed in a sealed envelope and sent to the trauma specialist. The trauma specialist then meets individually with those who might benefit from the TAMAR program. Inmates are eligible for the TAMAR program if they will be serving at least three months, have both addiction and mental health issues, have a trauma history, and desire treatment within the facility. The inmate must also be deemed appropriate and clinically stable so that group dynamics will not be influenced. If an individual is eligible, but not stable, the trauma specialist will see them individually.

The trauma specialist works with the inmate and the mental health professionals, the psychiatrist and a correctional officer, to develop an individualized treatment plan which takes the inmate's goals into account. Any desired individual and group mental health or addiction treatment, including the TAMAR program, is begun as soon as possible.

3. Treatment Approach

TAMAR provides integrated services for men and women who have interrelated trauma, victimization, substance abuse, and mental illness issues. In addition to providing trauma-informed services within the jail, the program works to connect inmates to services within the community upon their release.

Abstinence vs. Harm-Reduction: All inmates at the Detention Center are required to be abstinent from non-prescribed drugs and alcohol while they are incarcerated.

Treatment Interventions

In addition to the TAMAR groups, inmates with concurrent disorders have access to intensive substance abuse treatment, individual counseling, case management, work and educational programs, and other groups and services within the Detention Center.

TAMAR Groups: The TAMAR curriculum is facilitated by the trauma specialist and consists of group and individual counselling sessions. The trauma specialist conducts four 90-minute groups per week - two for men and two for women. Meeting in closed groups of no more than 10 inmates, participants focus on abuse (physical, emotional and sexual), trauma, addiction, containment, tolerating distress, self soothing, boundaries and safety, trust and intimacy, HIV/AIDS education, condom skills, communication and negotiation skills, and parenting. Group methods include discussions, counselling, role-plays, and individual and group exercises to enhance

program learning. Group members are encouraged to share their stories with one another and to engage in therapeutic activities such as art therapy and journal writing. Men's treatment includes an 8-session Anger Management module.

The TAMAR groups bring together mental health and substance abuse treatment, looking at trauma as the underlying cause of both. The groups are psycho-educational in nature, focusing on helping participants develop an understanding of the critical role that their early physical and sexual trauma experiences played in the development of illegal and otherwise dysfunctional behaviors that led them to jail. Much of the trauma treatment education revolves around understanding symptoms, understanding what is a reaction to trauma, and learning how substances may have been used as a defence mechanism against the traumas or mental health issues in their lives. A TAMAR "cycle" takes about four months to complete, at which time participants may chose to attend a new cycle if they are still incarcerated.

Drug-Alcohol Recovery Training (DART): For those requiring more intensive treatment for substance addiction, the DART program is available. DART is a 28-day, in-house addictions program providing individualized addictions treatment and referral services, including: addictions assessment, court planning, treatment planning, drug/alcohol education, individual and group counseling, and post-release continuing care. DART groups are offered during the morning, afternoon and evening of each weekday. Separate DART groups are available for male and female inmates. The trauma, addiction, and mental health workers plan and coordinate treatment together so that inmates may attend both DART and TAMAR groups.

Other Internal Resources: Other programs and services that are available to inmates on site during their incarceration include: AIDS/STD education and treatment services; a Smoking Cessation program, supported through the local Red Cross (Smoking by inmates is not permitted); a Parenting Program, offered by the Health Department one day a week; Pre-Natal Care Management, offered by the Health Department, is a program to teach mothers how to care for themselves and their new born child; Narcotics Anonymous and Alcoholics Anonymous is offered separately for males and females several evenings a week; and General Equivalency Degree classes are offered several days a week separately for male and female inmates through the Board of education.

Discharge

A critical aspect of preparing for the discharge of inmates from the Detention Center is the coordination of aftercare services designed to ensure a successful transition back into the community. The underlying assumption is that in-jail services are only the beginning of the service continuum. Housing, general welfare assistance, vocational training, supportive employment, psychosocial day rehabilitation, mental health/medication management, substance abuse treatment, and a link to the community TAMAR group are all offered to individuals preparing for discharge from the Detention Center. Accessing these services significantly increases the likelihood that individuals will maintain themselves in a stable living environment and not return to jail.

Aftercare: The smooth transition of inmates from incarceration to community life requires that great care be taken to adequately prepare individuals for the pressures that they will face upon discharge. The Dorchester case manager prepares inmates for discharge by developing an aftercare services plan that focuses on treatment, recovery, housing and employment. In fact, the foundation for aftercare services is being built while the inmate is going through the treatment program in the jail -- relationships are established between the inmate, corrections officers and treatment staff that can be depended upon after discharge. After the offender is released, the case manager coordinates all services in the community.

Housing Support: Access to a secure living environment upon discharge is key to a successful transition from the Detention Center to the community. The Shelter Plus Care Program was developed in 1995 by the Mental Hygiene Administration in response to a lack of housing for persons with mental illness who were homeless or at risk of homelessness upon discharge from detention centers. The program provides tenant and sponsor-based rental assistance to discharged Dorchester inmates.

Linkages: Upon release, inmates are able to meet in community TAMAR support groups run by the jail's trauma specialist. Additional mental health services are offered by Warwick Behavioral Health Services (the local mental health center). The ALEX ("Automated Labor Exchange") assists inmates in finding jobs upon their release. Vocational and employment services are provided by Channel Markers, Crossroads, or STEP Inc.

The Detention Center depends upon the strength of its relationships with state and community agencies that contribute to a comprehensive system of aftercare. The assumption is that the degree to which community agencies participate in and take responsibility for providing solutions to communitywide problems is directly related to the community's quality of life and the level of public safety enjoyed by all its citizens.

4. Evaluation/Outcome Data

The Dorchester County Detention Center's TAMAR program has not been formally evaluated.

For more information on this program, contact: Joan Gillece (Director for Special Populations for the Department of Health and Mental Hygiene), 410-724-3238, gillecej@dhmh.state.md.us*. Or contact: Steven Williams (Warden, Dorchester County Detention Center), 410-228-8101,* swilliams@docogonet.com

Foundation Associates

Foundations Associates specializes in the treatment of adults with concurrent disorders. Two campuses, located in Nashville and Memphis, Tennessee, offer a wide spectrum of services, including residential, transitional, and community-based (outpatient) treatment - exclusively to individuals with co-occurring mental health and addiction disorders, and to their families.

1. Organizational and Service Delivery Setting

Foundations Associates is a not-for-profit company incorporated in the State of Tennessee. It is licensed by both the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services.

The founder of Foundations Associates, Michael Cartwright, has a co-occurring condition. In his early 20's he had a psychotic break and was an addict, and for years he had no success in treatment. In 1995, he and Bob Nash co-founded Foundations with the goal of developing a program that would meet the needs of those with concurrent disorders.

Since 1995, Foundations has consistently grown and now has facilities in two cities. The Memphis facility has an outpatient facility, a 50 bed intensive residential unit, two eight-bed and one five-bed transitional living units, and a Drop-In Center. The Nashville facility has an outpatient program, as well as 16 intensive residential beds (10 beds specifically for Dual Diagnosis Court), 1 four-client facility for women and children involved in the criminal justice system, 16 respite beds, and 12 step-down beds. In addition, Nashville has a 16-bed crisis stabilization unit (not CD-specific).

Program Goals: The mission of Foundations Associates is "to provide a sober transition into the community by offering comprehensive, client-centered treatment, supportive housing and educational services that will assist dual-diagnosed clients and family members[21]."

Target Population: Foundations Associates targets men and women over the age of 18 who have co-occurring substance use and mental disorders. The vast majority of people served have very severe mental health and substance abuse symptoms.

Staffing: Foundations has approximately 250 staff, including Psychiatrists, doctoral-level Psychologists, Vocational Specialists, Clinical Social Workers, Family Therapists, Psychiatric Nurse Practitioners, Psychiatric Nurses, and Licensed Alcohol and Drug Counsellors.

2. Referral, Screening and Assessment

Clients can self-refer, but most clients are referred from other agencies, including from intensive case-management agencies that are designed to treat the people with severe psychiatric conditions. Following referral, a 'low-threshold' (the agency does not want to erect artificial barriers to access) screening is conducted by telephone. Clients are asked in a phone interview about their history and presenting symptoms. If it seems that the individual has any indicators that suggest he or she may have a co-occurring condition, an intake assessment is scheduled, either on-site or at the client's location.

[21] http://www.dualdiagnosis.org/foundations.html

The Intake Assessment consists of several stages. First, the client completes the Stages Of Change Readiness and Treatment Eagerness Scale (SOCRATES). This is followed by a Comprehensive Psychosocial Interview, which includes: determination of mental health and substance dependency treatment history, prior traumas, behavioural trends, psychiatric symptomatology, mental status examination, and assessment of contributing factors, including: social/family/peer concerns, legal, cultural, spiritual, vocational, housing, abuse, and other client-specific issues. Other information obtained includes: information from collateral informants; Release of Information; consent to participate in research; and eligibility for public assistance.

A standardized assessment battery is administered to identify co-occurring disorders, and then additional tools are administered to determine what level of care the individual needs. Typical assessment tools include: the Addiction Severity Index (ASI), the Brief Symptom Inventory (BSI), the Personality Assessment Inventory (PAI) (Schizophrenia Subscale), the Quality of Life Inventory (Customized Lehman's QOLI), the Treatment Services Review (TSR), the Government Performance and Results Act (GPRA) Report Form, the University of Rhode Island Change Assessment (URICA), Triage Assessment for Addictive Disorders (TAAD), and the Short Form Health Survey (SF12).

The assessment interview and tools are administered by a single clinician, who then generates a summary report, makes initial treatment-planning recommendations, and makes appropriate referrals for other needed clinical assessments (e.g., psychiatrist, psychologist, or other specialists). If needed, the client receives a psychiatric assessment, which includes a psychiatric interview and review of previous assessment materials, a multi-axial DSM-IV diagnostic assessment, assessment of need for pharmacotherapy, and assessment of acute intoxication/ withdrawal risk.

Once all the assessments are completed, that information is reviewed by a multidisciplinary team. The American Society of Addiction Medicine (ASAM) Patient Placement Criteria-IIR is used to determine what level of service is most appropriate for that individual[22]. Assessment outcomes are discussed with the client and, through motivational interviewing, treatment goals are developed based on what the client is looking for, what stage of change the client is at, and what the client perceives to be his or her reason for being there. Following this, a plan is developed which includes the services collectively determined to be appropriate.

3. Treatment Approach

The objective of Foundations Associates is to be fully integrated. As a result, Foundations offers the whole continuum of treatment services to those with concurrent disorders, including crisis stabilization, case management, 'dual diagnosis assertive community treatment' (DACT), intensive outpatient, intensive residential, halfway house, and independent living residential treatment. Their treatment model incorporates well-researched interventions, including those of Robert Drake and Kenneth Minkoff for integrated treatment, as well as Miller and Rollnick's Motivational Interviewing, and Prochaska and DiClemente's Stages of Change model.

Abstinence vs. Harm-Reduction: While Foundations endorses and supports abstinence, they do not require it. Certain programs are based on harm reduction (reduction in frequency, intensity, severity of substance use), while others are abstinence based (e.g. intensive residential - although a single relapse does not mean that the individual will be discharged from that service). Foundations uses stage-specific motivational measures to move clients toward whatever goals they may have. If an individual is not in a stage of readiness where abstinence is appropriate, then that person will not be placed in a level of treatment that is abstinence-based. However, a client in a harm reduction based program cannot attend while under the influence.

[22] For more information on ASAM Patient Placement Criteria, see Appendix C.

Treatment Interventions[23]

Crisis Stabilization Services (not concurrent disorder specific): Clients admitted to the 16-bed unit typically stay 72 hours to stabilize their psychiatric and/or substance abuse symptoms and receive medication adjustments. Services include 24-hour supervision, monitoring by a psychiatric nurse, psychiatric evaluation, and 24-hour on-call response by medical and clinical staff. Clients are placed in one of the Foundations programs or are linked to community services upon leaving the crisis unit.

Case Management: Case management services are available 24 hours/day to offer help needed during a crisis, to offer support, or to enhance access to community resources. Services include a 24-hour crisis hotline and a specialized Dual Diagnosis Assertive Community Treatment (DACT) team for people with co-occurring conditions who have intensive service-use histories.

Residential Treatment: Foundations provides multi-level integrated residential treatment services corresponding to ASAM PPC-IIR Level III, including Intensive Residential Treatment, Halfway House, and Independent Living. The level of intensity of residential treatment is matched to the needs of the individual. Clients progress through the levels of the residential program as they accomplish certain tasks and exhibit improved self-management and independent living skills.

Intensive Residential Treatment: Intensive Residential Treatment is the most intensive of Foundations' residential treatment programs. Clients are part of a therapeutic community (men separate from women), with programming which includes structured activities and community related events such as community planning, meal planning, facilities management, goals planning, level changes, etc. The therapy program is conducted five days per week, three hours per day, and involves a combination of skills training, psycho-education, addictions treatment, relapse prevention, coping strategies, and family therapy and education. In addition to formal therapy, each client is assigned a peer mentor, and contributes to the life of the community through chores and assignments.

Staffing in the Intensive Residential unit consists of 24-hour awake supervision by resident counsellors, the majority of whom are program graduates. In addition, a master's level therapist is on-site during business hours and a family therapist/educator works each Sunday. The family therapist works closely with the client and his/her family through individual sessions and family therapy.

Length of stay in Intensive Residential Treatment ranges from six weeks to three months, depending upon the client's level of symptomatology, usage history, and progress in treatment. Following completion of this phase, the client may move to another Foundations residential program or into community-based treatment.

Halfway House: Foundations has a number of Halfway Houses (ASAM PPC-IIR Level III.3) where clients can live while accessing community-based services including individual, group, and family therapy. As opposed to the 24-hour staffing plan in the intensive program, clinical staff are available in person eight hours per day, with 24-hour crisis call availability.

An Independent Living Housing Coordinator works closely with each client at the Halfway House level of care to develop goals and begin reintegration planning. All residents participate in development of an individualized therapeutic contract that defines their community, individual, and financial/rental goals and arrangements. The primary focus is on life skills, personal responsibility, independence, and structure. A vocational specialist also works with all clients to address employment and educational needs, from developing resumes and establishing a job search plan to directly teaching skills through supportive

[23] Much of this section is borrowed from http://www.dualdiagnosis.org/foundations.html

employment. There is no charge for treatment, but clients are required to be competitively employed and pay market rate rent that includes food costs. Halfway House services average 2-4 months.

Independent Living: Supervised independent living is the final phase of Foundations residential continuum. As with the halfway house, clients are required to be competitively employed and pay rent that includes food costs. Therapy sessions are reduced to monthly or bimonthly contacts, and the client becomes responsible for coordinating psychiatric visits, medications, community services, and other needs. Aftercare participation remains a standard requirement. Length of stay in Independent Living housing ranges from 2-4 months.

Community-based/Outpatient Services: Foundations offers a variety of community-based services, as defined under ASAM PPC-2 Levels I, II, and III. Community-based services are flexible in their level of intensity to accommodate changing client needs.

Intensive Outpatient: The Intensive Outpatient program provides intensive, integrated dual treatment with three daily closed groups, one hour in length, designed to provide psycho-education, addictions treatment, relapse prevention, therapy, and coping strategies. The treatment emphasizes development of core skills based on interventions that address both disorders and their interaction. Groups include: Diagnostic Education (covering all diagnoses and the impact of co-occurrence), Dual Relapse Planning & Prevention, Medication, Job Skills, Developing Support Systems, Obtaining a Sponsor, Dual Recovery, Spirituality, Self Growth, Trauma and Grief, Healthy Living, and Life Skills.

A multidisciplinary team of professionals with concurrent disorder treatment expertise delivers services and provides treatment according to the client's readiness to change. Cognitive therapy, motivational interviewing, and non-confrontational methods of directing change are integrated with a twelve-step dual recovery intervention. Psychiatric evaluation, medication management, individual psychotherapy, and case management also are provided for all clients.

Specialty Groups: Less intensive than Intensive Outpatient Treatment, specialty groups are designed to build support and to assist clients in developing essential skills. These one-hour sessions are tailored to the special needs of specific sub-populations, such as people who have been victims of sexual abuse, battered women, people who are re-entering the community from jails or prisons, and others. Groups focus on developing healthy living skills to enhance community adjustment (*e.g.,* medication education, anger management, community resources, etc.).

Pharmacological Treatment/Medication: Foundations offers the most current and effective medications to treat both mental health and addiction disorders. At intake, every client is evaluated by a psychiatrist, and if appropriate and desired, pharmacologic treatment is initiated to improve quality of life by managing mental health symptoms and mitigating cravings. Medication education, medication monitoring, and ongoing evaluation and treatment are also provided by the psychiatrist.

Self-help Groups: Foundations houses Dual Recovery Anonymous (DRA), a 12-step program that teaches the steps and traditions of recovery with emphasis on both mental health and addiction. DRA groups are completely client-run, client-led, and open to anybody.

Vocational Services: The Foundations vocational rehabilitation program offers clients hope and a concrete solution to reintegrate back into the work community. After an assessment of job and social skills, clients enter a job preparation program. Initially, clients explore career interests and desires, identify skills and discuss personal values. Education is provided on work ethics and work habits, money management, personal hygiene and health care needs, how to keep a job, as well as logistical issues such as transportation. Following this, clients focus on identifying vocational goals, job search plan, resume writing, filling out job applications and mock job interviews.

Discharge: Discharge planning is based on ASAM criteria as well as other factors, such as the likelihood that the client would benefit from less restrictive services, inability to benefit from less restrictive services, and client progress regarding presence of admission symptoms/needs. The discharge plan includes a crisis plan, plans for psychiatric follow-up, relapse prevention strategies, as well as linkages to community services.

Aftercare: Aftercare is offered for individuals who have successfully completed preliminary treatment components. Aftercare services monitor the client's recovery effort, promote healthy community reintegration, and provide an ongoing support system. Clients have ongoing access to self-help groups. A telephone follow-up occurs immediately following discharge to ensure connection with services. Clients are also followed-up on 6 and 12 months following services.

4.Evalutation/Outcome Data[24]

Foundations Associates continually measures the effectiveness of their programs, as well as the satisfaction of their clients and the long-range benefits of their services. All clients entering Foundations are offered an opportunity to participate in the evaluation, which consists of administration of the regular intake tools at the time of admission, and again six and twelve months following completion of the treatment program.

Findings from a recent evaluation of Foundations' residential program indicated:

- A substantial decrease in substance use in all major drug categories following treatment.
- An increase in abstinence rates at 6 month and 12 month follow-ups.
- Abstinence in 70–80% of Foundations' clients up to 1 year following treatment.
- Severity of psychiatric symptoms was reduced by 60%, with corresponding improvements in quality of life.
- Psychological assessment indicated a 30% reduction in psychiatric symptomatology.
- Results from analyses of the Addiction Severity Index and the Brief Symptom Inventory indicated that clients reported substantial reductions in psychiatric symptomatology following treatment in Foundations' residential program in all key symptom domains and remain stable even 12-months later.
- When looked at in terms of how many days a client experiences mental health problems in the month prior to each interview, treatment appeared to reduce symptomatic days by approximately 35%.
- High-cost service utilization outcomes showed substantial reductions in inpatient visits (47% reduction in inpatient care for physical problems, 80% reduction in inpatient psychiatric treatment, and 81% reduction in inpatient substance abuse treatment).
- There was also a substantial reduction in utilization of emergency room services (63% reduction in ER care for physical problems, 92% reduction in ER psychiatric visits, and 92% reduction in ER visits related to substance abuse.
- Service profiles showed an increase in appropriate, cost-effective utilization of community supports and services.
- Measures of functional status showed that client income typically doubles within one year.

For more information on this program, contact: Pam Raby (Associate Director), 615-714-8485. praby@dualdiagnosis.org *or Michael Cartwright (Executive Director), 615-642-6429. For more information about admission to the agency, contact Foundations Associates' Intake department at 615-256-9002.*

[24] Sources: http://www.dualdiagnosis.org/foundations5.html and Foundations Associates, 2003.

La Frontera Center – Admire Plus Program

ADMIRE Plus, part of La Frontera Centre, Inc., is a community-based (outpatient)/day-treatment program which provides an opportunity for persons with both a serious mental illness and substance abuse disorder to learn how to effectively cope with and manage psychiatric symptoms, while also reducing the frequency and severity of substance use, with a goal of abstinence.

1. Organizational and Service Delivery Setting

La Frontera Center is a non-profit, community-based behavioural health agency that has been helping southern Arizona's children, adults, and families since 1968. With over 400 staff and an over 30 million dollar budget, La Frontera serves about 10 000 clients annually across 20 sites in Pima County. La Frontera offers a comprehensive, flexible array of substance abuse treatment services, including outpatient counselling, DUI (Driving Under the Influence) education and treatment, opioid treatment, pregnant client services, outpatient withdrawal management, and residential treatment. In addition, adults diagnosed with a serious mental illness can access a wide array of psychiatric rehabilitative services, including case management, supervised residential (group homes and apartments), homeless outreach and concurrent disorders treatment.

Although the entire agency is competent in concurrent disorders, the ADMIRE Plus program is specifically designed to treat individuals with concurrent disorders. In fact, the design of the ADMIRE Plus program was based on the results and lessons learned from a five-year concurrent disorder treatment research project funded by the National Institute on Drug Abuse, and on a one-year pilot project grant from the State of Arizona Division of Behavioral Health with funding from the Center for Substance Abuse Treatment[25].

The primary treatment objectives of the program are as follows:

- Facilitate client empowerment
- Set and achieve personal treatment and life goals
- Develop personal relapse prevention plan to maintain sobriety
- Build skills to maintain mental health
- Increase knowledge of substance use and mental health disorders
- Learn to manage medications optimally
- Decrease crises and hospitalizations
- Develop a variety of coping and stress management skills
- Build social skills
- Learn to manage anger
- Develop new problem solving techniques
- Improve communication skills
- Harm reduction

Target Population: ADMIRE Plus clients must have co-occurring mental illness and substance abuse diagnoses. They accept all diagnoses (Axis I and Axis II) into the program. Typical clients of ADMIRE Plus have multiple psychiatric and multiple substance diagnoses.

[25] http://www.cpsa-rbha.org/News/Outcomes/Spring2000.pdf

2. Referral, Screening and Assessment

The majority of people that enter the ADMIRE Plus program come from the community mental health system, and mostly from La Frontera itself. Clients typically enter La Frontera through city crisis services, and then they are randomly assigned to one of three local providers, one of which is La Frontera. Clients may request a specific provider, so if they prefer La Frontera, they can ask to go there.

At La Frontera, clients are interviewed by a clinical staff member and are also screened for psychiatric and substance abuse symptoms using instruments that are mandated and created by the State. The Intake workers, most of whom are Master's level clinicians, apply the screening tools to identify if a client has co-occurring disorders. If the screening indicates a need for a psychiatric evaluation, this is done by one of the psychiatrists at La Frontera, who would provide a diagnosis and medication, if needed. The client would then be assigned, based on their assessment and needs, to a primary therapist or case manager in one of three funding streams: either the general mental health, serious mental illness, or substance abuse funding stream. New clients first establish relationships with La Frontera case managers, who then would refer them to the ADMIRE Plus program.

Referrals all go to the ADMIRE Plus program coordinator/supervisor, who then contacts the referring person to schedule a comprehensive psycho-social interview, which always takes place at the ADMIRE Plus site. The interview consists of a series of questions and an assessment tool that is a combination of a variety of published assessments for substance abuse, mental health and readiness for change. Conducted with the referring person present as well as the client, the interview is used to determine how well-suited the client is for the program. Staff focus more on whether the program will fit the client's needs and desires, rather than on whether a client is 'acceptable' for their program.

Once the interview is done, the person's case is discussed at the weekly ADMIRE Plus team meeting. Staff consider where they think the client's needs would best be met, and whether the program or another service within the La Frontera system would be better. They then get back to the referring person to let them know the results of their discussion. If they all agree, the client enters the program, yet retains their referring treatment team (case manager, agency psychiatrist, etc).

3. Treatment Approach

ADMIRE Plus delivers client-centered, empirically supported treatment interventions that incorporate the Arizona Integrated Treatment Consensus Panel Principles[26] and the La Frontera Clinical Practice Guidelines for Adults with Dual Diagnoses.

The ADMIRE program is non-confrontational, accepting, non-punitive, strength-based, and non-judgemental. Program staff are always making sure that the client feels safe. The client's sense of safety is fundamental to every group and, because the program is often dealing with people who are feeling fragile, mentally and emotionally, they have to be willing and comfortable in the program.

Abstinence vs. Harm-Reduction: ADMIRE Plus uses a harm-reduction model with the goal of abstinence. Abstinence is not required for admittance or continuance, as long as the effort is being made. Clients are progressively assisted in reducing their substance abuse and other unhealthy behaviours in their efforts to reach the ultimate goal of sobriety.

[26] For more information, see: http://www.hs.state.az.us/bhs/aitcpnews5.pdf

Treatment Milestones

The ADMIRE Plus treatment program is generally up to one year in duration. Clients progress through three treatment 'milestones'. The first two milestones typically last for 3-6 months, and the final milestone lasts about 6 months. Successful graduation from each milestone is based upon accomplishing individual treatment goals within the context of the program.

The daily program structure is set for all clients. The program runs from Monday through Friday. Milestone I (M1) is most intensive, with progressive milestones being less intensive in terms of attendance days. Milestone I requires attendance four days a week, plus one optional day (Wednesday is "outing day"). Milestone II (M2) is two days a week – on Monday they attend the same groups as M1 clients, and they also come to groups on Wednesday (while the M1 group is on their outing). Milestone III (M3) clients come only on Wednesdays and share groups with M2 clients.

The majority of programming is through groups (described in more detail below). Milestone I and II clients start the week with 'Goal Review and Check-In', followed by 'Goal Setting', then lunch, which the program provides. After lunch is 'Mental Health Awareness', followed by the '12-Step Education' group. On Tuesdays, M1 clients attend 'Anger Management', 'Men's/Women's Process Groups', 'Problem-Solving', lunch, 'SMART Recovery ®', 'Acu-detox', and an optional 'Spirituality Group'. On Thursdays and Fridays, in addition to previously mentioned groups, M1 clients attend 'Understanding Addiction', then 'Social Skills Building', and 'Relapse Prevention'. On Wednesdays, M2 and M3 clients attend the 'Process Group', followed by the 'Life Works' group. Many of the M1 groups are also optional for M2 and M3 clients.

Although the attendance at the program diminishes with each milestone, clients' involvement with self-help community-based recovery groups increases. One of the goals of the program is to stabilize the client, help them obtain some recovery, and then begin to help them re-integrate back into the outside world. In Milestone I, clients are required to attend at least one outside self-help meeting (not necessarily 12-step) a week. In Milestone II, they would then increase their attendance at outside meetings to at least two. So they are still engaging in recovery activities conceivably four days a week – their two ADMIRE Plus days in M2 as well as two other days that they attend outside meetings. In Milestone III, where they attend the program only one day, they are encouraged to attend three outside meetings each week.

Treatment Interventions:

12-Step Education group: This group is not a 12-step meeting. Rather, it is an education group to help people learn how to use 12 step programs. Often consumers feel that 12-step meetings may not work for them. ADMIRE Plus focuses on helping them to develop a better relationship to the 12-step programs. A client may never choose 12 steps as their primary recovery tool, but having knowledge of how the principles work can help them navigate through 12-step programs.

SMART Recovery ® (Self-Management and Recovery Training[27]) Group: These self-help meetings, offered twice a week, are an alternative to 12-step meetings. Based on cognitive therapy, this approach teaches clients to examine and understand how their beliefs affect their actions and feelings. By changing beliefs that are unhelpful, untrue, or unrealistic, one can better control actions and feelings. SMART is well suited to people with co-occurring disorders because it can address both substance abuse and psychiatric symptoms, as well as other problems in living. These groups are open to the community.

[27] www.smartrecovery.org

Acu-detox (Acupuncture): Acu-detox has been practiced and studied since 1972 in the United States. In Acu-detox, a certified specialist inserts acupuncture needles into five points of each outer ear of the client. The needles are left in place for 30-45 minutes as the person relaxes in a quiet, comfortable setting. This treatment, offered three times a week in combination with either Meditation, Relaxation, or Stress Management, helps reduce cravings and withdrawal symptoms while inducing relaxation.

Life Works group: This group helps clients to organize and move forward in their next level of recovery, addressing areas of their life that have been impacted by their mental illness and/or substance abuse (i.e. education, employment, family, volunteer work, etc.).

WRAP™ (Wellness Recovery Action Plan[28]) Group: WRAP provides a simple system for monitoring and managing emotional and psychiatric symptoms, as well as avoiding unhealthy habits or behaviour patterns. This group is only offered to those in Milestone II. Clients have a workbook they use to determine what they need to do on a day-to-day basis to maintain their wellness. They plan ahead for triggers and external events and early warning signs. They come up with a crisis plan to help their supporters and health care providers know what their preferences would be when they are in crisis. They also plan to avoid crisis altogether.

Men's/Women's Process Groups: These facilitated groups, offered once a week, allow men and women to gather separately to discuss topics and issues relevant to them.

Social Outings: On Wednesdays there is an optional all-day outing for M1 clients. These outings help people learn about community resources and teaches people to have fun without using substances.

Goal Setting and Review Group: In this group, each client identifies a goal for special work and attention during the coming week or weekend. The process of setting goals allows clients the opportunity to establish their own short-term recovery and/or personal goals. The program staff have found personal goal setting to be a very powerful intervention.

Individual Counselling: Clients are usually seen by an ADMIRE Plus counsellor for a brief period, unless it is determined that they need to address a long-term issue. If so, they would be referred for individual counselling with another part of the therapy team within La Frontera.

Motivational Interviewing: All staff members are trained in motivational interviewing. This collaborative, non-confrontational style of interaction between staff and clients increases client self-awareness and decreases resistance to help clients make behavioural changes.

Pharmacological Treatment/Medication: Almost all ADMIRE Plus clients are on medication, which is handled by the psychiatrist in the referring treatment team. Staff monitor clients' symptoms and help them contact their doctors if they seem to be having problems with medications. Medication education groups are also given regularly in the program.

[28] www.mentalhealthrecovery.com

Contingent Reinforcement: Clients receive an "A+ Card" when they reach their goals or for attending outside meetings. These cards get put into a draw for goods and services, which, although small, people really like because they have often never won anything. It also teaches them to be happy for other people.

Linkages to Resources: Because La Frontera is large and comprehensive, there are a lot of linkages within the agency, and La Frontera itself has linkages with other city agencies. A lot of the case-management team's responsibility is to help people get housing. La Frontera has a housing liaison and also an employment specialist/team. Linkages are seamless within the agency. For example, when a client moves into Milestone II and is looking to develop some employment or educational options, the program would simply prepare an internal (within La Frontera) referral for that client to the employment team. They would then interview the client and start working with assessing their needs and setting them up with resources.

Family Services: The ADMIRE Plus program does not have a specific family group, but La Frontera does. Depending on what the family member needed, referrals can be made to other La Frontera services. Staff are in the process of developing more family-oriented social activities and are available if family have questions about mental illness or supporting the client's therapy.

4. Evaluation/Outcome Data

The ADMIRE Plus concurrent disorders program was developed based on available research, and it continues to conduct research on its methods in order to measure outcomes and improve program quality. The following section contains the results of an evaluation of the program conducted several years ago[29]. (A larger and more comprehensive evaluation will soon be available - see web site).

ADMIRE Plus Pilot Project Final Report Summary

Clients were accepted into the program were studied throughout a 12-month period. Clients remained in the program regardless of their functional status for the entire year, unless they chose to be dis-enrolled. Most of the clients accepted were severely impaired in many functioning areas, and were some of the agencies' most difficult clients.

Assessment Methods

Interviews and assessments were done during intake, midpoint, and final month of the year-long grant. These interviews included:

- The Brief Symptom Inventory (BSI), to assess psychiatric symptomology on ten dimensions, based on client reports of how much they were distressed in the past week.
- The Lehman Quality of Life Scale-Short Form, to determine how clients felt about several life areas (housing, finances, social support, family, legal and safety issues, etc.).
- Survey of Family Involvement and Functioning. Each client and a staff member assigned a rating based on descriptions of how involved in treatment the family was, and if there was significant dysfunction in the family influencing the client's overall well being.
- The Client Assessment Form and the ADHS/BHS Service Level Checklist (ALFA), to assess substance use history, housing, employment and income, nine levels of functioning, and overall functioning (GAF).

[29] This evaluation section was taken directly from La Frontera's website**:** www.lafrontera.org

- Selected items from the Addiction Severity Index (ASI), to measure past month drug and alcohol use/abuse, how much money was spent in the past month on substances, and how much each client was bothered by physical and emotional problems related to using.
- American Society of Addictions Medicine (ASAM) Patient Placement Criteria for persons with co-occurring disorders, as evaluated by the interviewer/program coordinator.
- La Frontera Center, Inc. Client Satisfaction Survey, to assess 12 areas of service quality.
- A focus group (held by evaluator, with staff present) to obtain responses from clients regarding what works, what doesn't work, and what needs to be added to the program.
- Determination of which clients were engaged in treatment, according to the treatment team.

Final Results

- Final assessment data were available for 81% of all clients (36) enrolled in the program.
- Over half of the clients remained actively engaged in the program throughout its duration, and several of the clients who disengaged from treatment were gainfully occupied in work/school.
- 67% of the clients were male; 53% of all clients were Anglo American, and 21% Hispanic.
- Almost a quarter of the clients were employed and/or attending school by the final assessment (only one client was at intake). The rest were receiving Federal entitlements.
- All of the clients reported a source of income at the final assessment (14% had none at intake), and a 21% increase in income occurred overall.
- For the duration of the program, clients were not homeless and had a stable living arrangement.
- Almost half of the clients had schizophrenia and this group showed a trend toward less hospitalization during the program.
- There was an increase in the average satisfaction by the clients with their social network.
- The percentage of clients with an arrest decreased at the final assessment.
- Non-violent crime victimization of the clients decreased throughout the program.
- Engaged clients reported using substances significantly less frequently at the midpoint and final assessments than clients not engaged in treatment.
- The percentage of clients having positive urinalysis drug screens remained the same from intake to endpoint, but other data suggest that harm reduction was taking place nonetheless. The majority were substance free.
- Of those still using substances at end point, fewer clients tested positive for more than one substance, and no clients tested positive for three or more substances, which is a large change from intake and supports that harm reduction was occurring.
- All of the clients improved significantly on two thirds of the Arizona Level of Functioning (ALFA) indicators, with the greatest improvements occurring between the intake and midpoint assessments.
- There was an overall trend for decreased depression on the Brief Symptom Inventory.
- Client satisfaction with the program was consistently very high on multiple measures.
- Several program enhancements were made as a result of the data and client feedback.

Even with the small number of clients for analysis (n=36) and relatively short treatment time period for this group of clients with severe impairments, some significant improvements were made and other trends were noted.

For more information on this program, contact: Patricia Penn, Ph.D. (Clinical and Research Psychologist), 520-594-6310, ppenn@lafrontera.org*. Or contact: Cristina Plascencia, CSAC, CPRP, NADS, CCHT (Program Coordinator), 520-741-2351,* cplascencia@lafrontera.org

Lakehead Regional Family Centre – New Experience Program

Thunder Bay's New Experiences Program, part of the Lakehead Regional Family Centre, is a community-based concurrent disorders program which provides a range of comprehensive culturally sensitive services to Aboriginal and non-Aboriginal youth who are experiencing severe social, emotional, and behavioural difficulties.

1. Organizational and Service Delivery Setting

The New Experiences Program (NEP) is part of a well-integrated addictions system called the *Thunder Bay Integrated Youth Addiction Services*. The three partner agencies involved are:

1. *St. Joseph's Care Group (Sister Margaret Smith Centre) - Youth Addiction Services*: Programs range from intensive residential or day treatment to community counselling and outreach.
2. *Family Services Thunder Bay - Assessment and Referral Program*: This program offers intake, assessment, education screening and referral of youth with substance use issues.
3. *Lakehead Regional Family Centre - New Experiences Program*: This program provides community-based services for youth struggling with a complex combination of mental health issues and substance use problems. Although NEP is operated by the Lakehead Regional Family Centre (a children's mental health organization), it is actually located in the Sister Margaret Smith Centre (the addictions organization).

The New Experiences Program serves about 70 youth and their families at any given time. Services offered include: screening, comprehensive mental health and drug and alcohol assessments, individual counselling, family therapy, parent consultation, psychiatric services, psychological services, intensive case management, and the Aboriginal Cultural Program, which includes the use of traditional healing methods. Services are not time-limited – some youth stay in the program for years.

Target Population: The program targets youth aged 12-17 living in the District of Thunder Bay who either are experiencing a combination of mental health and substance abuse problems, or are at high risk because of their substance using behaviour. About 50% of NEP clients are Aboriginal, and although many youth do not have an official diagnosis, they typically struggle with conduct disorder, depression, anxiety, and ADHD.

Staffing: The New Experiences Program is staffed by two full-time Case Managers (MSWs), one of whom is a family therapist. The program also has a full-time Native Family Worker/ Cultural Coordinator (RSW), as well as a half-time Psychologist.

2. Referral, Screening and Assessment

Referrals can be made to the New Experiences Program by youth, parents/guardians, physicians, or other service providers and professionals in schools or the community. To request services, a person can call any of the three organizations in the integrated system. No matter which agency receives the request for services, the same process will occur: Whoever takes the first phone call puts the youth on a list for the next upcoming Youth Education and Screening (YES) group, which operates every month.

Youth do not need to have a psychiatric diagnosis to enter NEP. However, many of them come in with diagnoses already, and some are on medication. If required, the agency can arrange for a full assessment with their consulting psychologist. The program also has access to a psychiatrist for consultation and for pharmacological intervention.

Youth attend the 3-session YES group. Every youth in the New Experiences program has a case manager, and while attending YES, youth are screened for mental health issues using the Brief Child and Family Phone

Interview (BCFPI) and also receive an alcohol and drug assessment using the Ontario Ministry-mandated tools[30]. Discussions take place with the youth regarding what they want to do and whether they want to look at their mental health or their substance use, or both.

Following completion of the YES group, clinicians from all three agencies get together for integrated case reviews, where the team discusses which treatment options would best suit each youth (e.g. day program, residential, community-based). The youth are then asked to return to the agency for an individualized appointment to receive feedback and to explore their options. The youth's family is encouraged to be part of the follow-up meeting.

If the youth attends the appointment and wants to proceed with treatment, the clinician completes a written assessment based on the information gained during the YES group and through the screening and assessment tools. The case manager learns about the youth's needs, goals, and family context. A more detailed assessment may be performed, if warranted. Following this, an individualized treatment plan is negotiated with the youth and his or her family. Suggested interventions may include day or residential addiction treatment as well as group, individual, and family therapy. If the youth's assessment indicates a possible concurrent disorder, a referral to the New Experiences Program would take place.

3. Treatment Approach

The New Experiences Program operates from a bio-psychosocial, cultural, and spiritual framework. The belief is that, if clients are willing to address one element of the framework, they will often see gains in the others areas. The program runs activities three evenings a week. Each has a different focus: one is the cultural healing program, one is the homework club dinner and recreation night, and the other focuses on arts and crafts. The philosophy from the program is: "What can we do to hook the youth into our system in any way, shape or form?" Once a youth steps through the agency door, even if it is only for the recreation group, the staff can work on addressing the multiplicity of issues that he or she comes in with.

Abstinence vs. Harm-Reduction: NEP staff do not believe that abstinence and harm-reduction are mutually exclusive. As a result, staff support and encourage abstinence, while also meeting youth where they are at. Although staff believe that youth need to be abstinent in order to move forward with their mental health or other life issues, or to get back on track in school, they do not require youth to be abstinent for the duration of treatment. However, youth are asked not to attend activities while under the influence.

Treatment Interventions

Youth Education and Screening (YES) Group: The YES Group is a closed three-session group with a heavy focus on education. In addition to informing youth about substance use and its consequences, the purpose of the group is for the clinicians to get to know the youth in order to better determine what level of treatment they require. The groups also allow the youth to demonstrate their willingness to attend treatment.

Located at Family Services Thunder Bay, the group is jointly resourced by the three agencies in the Integrated Youth Addiction Services. Each YES group is jointly facilitated by two clinicians, one from either the Sister Margaret Smith Centre, Family Services Thunder Bay, or Lakehead Regional Family Centre. At the completion of the YES group, each facilitator follows-up on half of the group members through individual meetings (see previous section).

[30] See Appendix B for list of Ontario Ministry-mandated tools.

Aboriginal Cultural Program: The Aboriginal Cultural Program incorporates Native spiritual practices and traditions, including recreation, dance, arts and crafts, and music. Both Aboriginal and non-Aboriginal youth may attend this program.

In the Aboriginal Cultural Program, a Native Social Worker provides culturally sensitive services which bridge concurrent disorders, substance use, and cultural healing. The worker meets with the youth at least once a week. Through the use of story-telling, visits from elders, the making of drums and dance regalia, drumming circles, trips to sweat lodges and to sobriety Pow-Wows, the youth learn to have fun without substances and learn to find meaning in something larger than themselves.

Substance abuse is at the forefront of NEP's work. It is dealt with in individual and group format - sometimes directly, sometimes indirectly. For example, the Native worker will sometimes tells stories in true Aboriginal cultural form that will get the message across, but the youth may not even realize they are talking about drug issues. In addition to working at an individual and group level, the Native Worker does family work and family interventions.

Individual Counselling: Youth at NEP often receive individual sessions with their case managers. The program uses motivational interviewing, client centred, and cognitive behavioural interventions when possible. Stages of Change are used not as a rigid framework, but as a way of thinking about youth. Staff work with clients where they are at and use harm reduction in several areas. For example, NEP is very focused on keeping youth safe. In reducing risk for youth, they will do everything from helping them get on birth control to transporting them to the agency to attend activities.

Family Services: As part of the Lakehead Regional Family Centre, NEP is able to offer a variety of services to family members. Family therapy is recommended for all clients. In addition, the agency offers a parent consultation service to parents who need advice because their child will not come in. The consultation service consists of two to three sessions with parents to strengthen the parenting system and to give them some education and information on youth and substance use.

NEP prefers to work from a family systems perspective. Staff try to involve family at the earliest possible moment. NEP staff also try whenever possible to raise the consciousness of parents, teaching them how addiction must be tackled at a family level, and how the substance use of the youth is often tied to a substance-using parent or sibling.

Linkages: The New Experiences program works closely with Family Services Thunder Bay and Sister Margaret Smith Centre in order to offer a breadth of services to youth and their families. They also work closely with Children's Aid Societies, school social workers, and the probation system to help benefit youth.

Discharge: Lakehead Regional Family Centre has very stringent admission and discharge criteria related to accreditation (Ontario Ministry of Health's Admission and Discharge Criteria). Youth are discharged from service if they move away; they no longer require mental health and/or substance abuse services since the treatment goals have been achieved or the problem has been resolved; they no longer desire mental health and/or substance abuse services; or they need to be transferred to another service organization to address their mental health and/or substance abuse needs.

Follow-Up: Aftercare and follow-up services are developed as part of the individual or group treatment. The Aftercare Worker provides follow-up services for a limited period of time until other community resources are accessed for continued support. Discharge and follow-up ensure that family, community and/or other supports

are in place for the youth. Aftercare services are primarily delivered in a facilitated group focusing on peer support and relapse prevention.

4. Evaluation/Outcome Data

The New Experiences Program has not been formally evaluated at this time.

For more information on this program, contact: Diane Walker (Program Manager), 807-343-5006, dianew@lrfc.on.ca

McNeil Island Corrections Center – Co-occurring Disorders Program

The McNeil Island Corrections Center/Washington Department of Corrections has developed and implemented a co-occurring disorder treatment program within a major men's prison[31]. The program addresses criminality, mental illness, chemical dependency and their interactions and effects upon one another.

1. Organizational and Service Delivery Setting

Since 1995, the McNeil Island Corrections Center (MICC), located in the state of Washington, has been providing treatment to seriously mentally ill offenders through its Mental Health Program. During this time, this residential program transitioned over 500 offenders into the surrounding communities with mental health aftercare having been arranged prior to release. Through relationships with community mental health providers, community corrections officers and community programs, MICC recently expanded its services to include a comprehensive co-occurring disorder treatment program within its Mental Health Program.

The Mental Health Program at MICC is considered 'residential' because it provides treatment in specific living units within the general population setting. Educational programs, as well as mental health programs, are delivered within the residential unit. The Mental Health Program has an occupancy of 102 offenders with 24 housed in the Assessment Unit (Close custody) and 78 housed in Medium custody. Up to 90 of these beds are used for offenders with co-occurring disorders.

Program Goals: The goal for the program is not necessarily to keep people psychiatrically stable and completely free of drugs and alcohol. Rather, the stated goal is to create safer communities and to reduce incarceration costs. MICC attempts to keep that in the forefront at all times, and also to determine how offenders' criminal thinking actually interplays in their chemical dependency and their lack of participation in mental health treatment.

Target Population: The program targets male offenders who meet the criterion of Seriously Mentally Ill (typically Axis I disorder) and Chemically Dependent. The program does not require *current* chemical dependency to enter the program. Rather, chemical dependency refers to an inmate's pattern of use and abuse in the community prior to incarceration. Prioritization of admittance into the program is given to those who have four years or less in their sentence.

Staffing: MICC program staff includes a Program Manager, a Clinical Coordinator, a Chemical Dependency Professional, a Psychologist, a Psychiatrist, several Registered Nurses and several Case Managers/Correctional Mental Health Counsellors.

2. Referral, Screening and Assessment

Referrals to the program are accepted from any major Department of Corrections (DOC) facility throughout the State of Washington that is for males only. Offenders are referred to the program through their Facility Risk Management Team (FRMT) for screening. Every offender has an assigned counsellor who is responsible for determining areas of need. Inmates also receive psycho-diagnostic assessments with a psychiatrist in order to determine their diagnosis. If it were found that an offender's needs included mental health and/or chemical dependency treatment, then the offender would be referred to the appropriate program, such as the Co-occurring Disorders program.

[31] Prison vs. Jail: A prison houses individuals whose sentence is over 18 months. Jails house those who are in custody while awaiting trial, or who have a sentence of less than 18 months.

The referral for treatment goes to the MICC program manager. The referral includes a packet containing information regarding the inmate's current diagnosis, medication, current treatment that the individual might be involved in, compliance with that treatment program, any concerns that the referring clinician has about the person's functioning, and a general rationale for why the offender has been referred to the program.

The program manager then screens the referral for indication of the inmate's ability to function in a treatment setting. Through the use of the DOC computerized records, the program manager will look at the inmate's criminal justice history and behaviour patterns, such as any tendency towards predatory behaviour, violence towards others, or disruptive behaviour. Also, because the treatment program takes up to a year to complete, inmates are screened for the length of time remaining in the sentence. Those with the shortest times remaining have priority – as a result, inmates need to have between 1-4 years left in their sentence to be accepted (some exceptions are made). Based on that information and the clinician's referral, the program manager will make a determination about whether that the offender would likely benefit from, and be an active participant, in treatment.

Upon initial acceptance and arrival at MICC's Co-occurring Disorders Program, the inmate is brought to the Admissions and Assessment Unit, which is a 24-bed unit than can house offenders with a Close custody status or lower. The program staff meet each inmate and provide him with some orientation about the program and the facility's expectations. Demographic data are collected, including race/ethnicity, age, primary drug of choice, convicted offence, and education level. In addition, a needs assessment score and their risk to re-offend assessment score is obtained, typically using the Level of Services Inventory-Revised (LSI-R).

Inmates are segregated from the rest of the population while they are in the Assessment Unit. All of their meals, recreation, etc, happen on this unit. This is a safety step implemented for any mental health client coming into the institution that may not be stable - staff want to make sure that new inmates are psychiatrically and behaviourally stable before giving them access to the general population.

Every program resident is assigned a Correctional Mental Health Counsellor to serve as their case manager and primary treatment provider. A psychiatric nurse is assigned to address their health care needs. They are also assigned a psychologist to direct their mental health treatment. These treatment providers work in conjunction with the program's psychiatrist as the offender's Treatment Team.

While in the Admissions and Assessment unit, the treatment team performs a thorough assessment of the inmate's chemical dependency issues, a psychological evaluation to address psycho-diagnostics and risk factors, an assessment of criminogenic factors and criminal behaviour, a complete psychosocial evaluation, a thorough health assessment, and a psychiatric evaluation to determine course of treatment for the psychiatric disorder(s). The inmate is also asked to complete a number of assessment tools, which serve as part of the program evaluation component (see Evaluation section), as well as for treatment planning.

Assessment instruments administered include: the Brief Symptom Inventory (BSI); the Comprehensive Review of Addiction Variables and Effects (CRAVE); the SOCRATES, which is an instrument to measure readiness for change; the Drug Dependency Scale (DDS); the Coping Behaviors Inventory (CBI) - to determine what behavioural skills and confidence in utilizing those skills participants use to avoid relapse; the Criminal Sentiments Scale (CSS) - to assess participants' levels of criminal thinking, and the Buss-Durkee Inventory (BDI) - a "hostility" index utilized to determine a participant's skills in anger management.

The treatment team then combines their assessment information into a treatment plan to address the mental illness, chemical dependency and criminality of the offender. Treatment plans are as specific and unique to the individual as possible, including goals that are specific to what the inmate needs to do to better manage his mental illness, goals that are specific to addressing factors of his substance abuse, and goals that are specific to addressing his criminal thinking and behaviour.

Inmates remain in the Assessment Unit for about eight days, when, if they are stable, they are moved to 'Lower E', the location where the treatment program resides. The inmate's case manager is their primary

counsellor, who will provide program orientation, as well as weekly counselling. The counsellors also function as group leaders for the treatment groups. Closed groups and classes operate on a recurring, rotating basis, so inmates may need to wait up to six weeks to begin the group portion of treatment.

3. Treatment Approach[32]

The Co-occurring Disorders program is referred to as the "Choices Program" by program staff. The philosophy of the program is that inmates with co-occurring disorders have many choices to make. Once choice is to be in treatment or not. Inmates have the choice to either succeed in the program or the choice to fail. They also have choices to make as far as committing crimes. The program offers inmates the opportunity to address these choices before they either use or commit a crime. Another philosophy of the program in dealing with inmates is 'offender accountability' -- staff hold inmates accountable for their decisions and their behaviours.

The Choices program addresses criminality, mental illness, chemical dependency and their interactions and effects upon one another. Each component is addressed through a psychosocial perspective and identifies behavioural options. This cognitive-behavioural approach allows the offender to recognize and make better choices. The reinforcement of making healthy choices is the goal of every treatment interaction and the philosophy of the treatment community.

Abstinence vs. Harm-Reduction: The ultimate goal of the program is abstinence from drugs and alcohol. The point that staff try to get across to inmates in the program is that using illicit drugs and alcohol will compromise their mental health treatment, and when that gets compromised, their drug usage will go up - and at that point they are going to find themselves involved once again in criminal activity.

Treatment Phases

The Co-occurring Disorders program is a multidisciplinary treatment program with four residential phases, which integrate chemical dependency and mental health treatment. Phase One is Assessment and Engagement, lasting approximately six weeks; Phase Two is a twelve-week program focused on education and identification of treatment needs; Phase Three is a twelve-week intensive treatment of the co-occurring disorders and individual treatment; Phase Four is a six-week focus on transition and relapse prevention. The total time in the program is nine to twelve months, allowing for extended time frames for individual treatment.

The Residential unit provides treatment through the Modified Therapeutic Community (MTC) model. The core of the treatment program, Phases 2-4, requires that the offenders be housed in a separate unit. This allows for development of a treatment community. Small group work is a major component of the treatment program. Group size is a maximum of 8-10 offenders, dependent on the subject matter. Once groups begin, the inmates attend groups one hour a day, four days a week.

Phase One of treatment (engagement) starts in the Assessment unit. Length of stay in this phase of the program varies based on assessment results, the offender's engagement into treatment, and stabilization of symptoms. The treatment team determines transition from the Assessment Unit to the MTC. Upon transfer to the MTC the offender continues Phase One until it is determined that they are ready to enter the next phase. Anticipated length of stay in Phase One is six weeks.

[32] Though MICC's CD program is based on their successful Mental Health Program, at the time this facility was interviewed, the CD program was in its first run-through and the first group of inmates was only halfway through the Phase II of Treatment. Therefore, the information regarding treatment and follow-up represents MICC's *planned* activities for concurrent disordered inmates.

The first group that an inmate in Phase One attends is 'What is Dual Diagnosis?' It lasts eight sessions (two weeks) and focuses on providing a large amount of information and on helping inmates better self-manage their mental illness and address their substance abuse issues. In addition, this 'dual diagnosis' group begins to address the criminal thinking and criminal behaviour that is particular to this clientele.

The second course in Phase One, 'Mental Illnesses and their Relationship to Substance Abuse' lasts seven sessions. This is followed by a four-session course - 'Recognizing and Solving Problems'.

In addition to developing new curriculum for their groups, MICC uses curriculum provided by the GAINS Centre[33], which they are revising it as they go along to make it more specific to their institution.

Phase Two of the program focuses on the various components of co-occurring disorders and the identification of the individual's treatment needs. This phase consists of two 13-week cycles, and contains the bulk of the programming. Role-play is utilized throughout the treatment process to practice new behaviour. Courses and number of sessions include: 'Stress and Coping' (8 sessions); 'Anger Management' (8); 'Changing How we Think about Ourselves' (6); 'Managing Triggers' (8); 'Staying Connected to the Family' (6); 'Introduction to Relapse Prevention' (8); 'Learning to Communicate Effectively' (14); 'Managing Your Daily Life' (7); 'Managing Your Dual Diagnosis' (12); and 'Preventing Relapse' (19).

Phase Three continues the concurrent disorder treatment with more of a focus on the individual's specific needs to address their mental illness, chemical dependency and criminality. Groups include: 'Positive Relationships' (8 sessions); 'The Importance of Work' (12); 'The Importance of Play' (8); 'Being an Effective Parent' (12); and then 'Anger Management - Part 2' (8).

Phase Four focuses on the development and implementation of a relapse prevention plan and transition plan. The treatment team provides access to follow-up services for all offenders who graduate from the program. This phase has three courses: 'Finding Support in the Community', 'When You Get Out', and 'Maintaining Treatment Gain'.

Treatment Interventions

MICC offers a unique environment that is a major factor in the successful transition of mentally ill offenders: Although the treatment groups occur within a residential unit, and are exclusive to the inmates that are part of the Choices program, much of the other programming and activities that the men participate in, including recreation, chapel, library, and their education programs or jobs, are all integrated with the general population. Inmates in the Co-occurring Disorders program go to work or school with all other inmates, but also receive treatment by attending a Choices group in their residential unit. The objective is to make the treatment program resemble what they would experience in the community on release from prison.

Philosophy Regarding Abstinence: MICC believes that the ultimate goal with this particular population is abstinence. The point that staff try to get across to the individual is that using illicit drugs and alcohol is going to compromise their mental health treatment, and when that gets compromised their usage will go up, and at that point they may find themselves involved once again in criminal activity.

[33] The National GAINS Center for People with Co-Occurring Disorders in the Justice System was created in 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system (see http://www.gainsctr.com/b/about/Default.asp)

Individual Counselling: Each offender is assigned a primary counsellor, who is responsible for monitoring their participation and success in the program. Inmates are expected to meet with their counsellor for at least half an hour each week. Counsellors are responsible for making sure that the inmate's programming needs are being met. For example, if the inmate needs to get signed up in a new educational program or vocational training program, or needs to change jobs, the counsellor is responsible for setting that up. Inmates may also work with their counsellor on particular goals and objectives that the treatment team has identified for the individual, such as being consistent with their hygiene or working on stress-management.

For more in-depth therapy issues, the program manager and the other psychologist are each assigned half of the population and are able to work with individuals who want psychotherapy for issues such as PTSD, childhood sexual abuse, childhood neglect, Vietnam veteran concerns, etc.

Pharmacological Treatment/Medication: The program has its own a psychiatrist who provides medication management for the inmates and works closely with them to try to meet their needs. Medications are offered to inmates three times a day through a 'pill line' -- inmates line up and are administered their medications by the nurse, who can track who is taking it and who is not, which can be important when looking at any change in behaviour pattern or making sure people are compliant.

Vocational or Employment: Nearly everyone in the co-occurring disorders program is expected to do some outside programming, be it an educational program or vocational training, or they are expected to have a job. In terms of training, MICC offers a welding program, building-maintenance programs, and other rotational programming, as well as Graduate Equivalency Diploma (GED) courses. Employment, for some of the lower functioning inmates in the program, might consist of doing janitorial work on the unit, so that they are not experiencing too much stress being off the unit and having to interact a lot with the general inmate population. The higher functioning inmates may hold jobs landscaping or in the kitchen, or in Correctional Industries, which constructs furniture at the institution.

Family Services: The program offers a family program based on the Alanon model. Those offenders who have approved visitation are encouraged to elicit family involvement during Phase Four of the treatment program. Program counsellors and clinicians are available to work with individual families, and also groups, focusing on couples, parenting and family relationships. Program staff can also make referrals for those families that want to pursue on-going community support.

Other: All inmates at MICC have access to a variety of other classes or groups. MICC offers a traditional chemical dependency program, as well as anger management and victims awareness classes. There are also AA and NA meetings in the prison. In addition, there are groups for inmates who have lost friends or family members due to violent death (homicide or suicide).

Discharge/Follow-up: Offenders who complete the program may either remain on the unit until their release, or may be returned to the general population. Based on clinical assessment, the treatment team, in consultation with the inmate, determine what is the best direction to go in. The decision partly depends on how long it is until their release, and partly depends on their level of functioning.

Offenders who are transitioned to the MICC general population have the opportunity to engage in outpatient treatment through the Mental Health Program. For those offenders released to the community, referrals for ongoing mental health and chemical dependency treatment, and community support groups are provided. Monthly follow up checks, via phone and/or mail, are conducted by the program support staff.

4. Evaluation/Outcome Data[34]

The McNeil Island Corrections Center has a Continuous Quality Improvement (CQI) Committee that collects, analyzes and reports program outcome data, based on validated pre-and post-test instruments administered to every program participant. Performance measures being collected fall into two major categories: institutional and community. Institutional measures include program attendance and participation, infraction data, assault data, symptom management, level of functioning, involvement in support programs and self-report. Community measures include arrest and conviction records, involvement in mental health and chemical dependency treatment, employment history, participation in community support networks and abstinence history. See 'Referral, Screening and Assessment' section, above, for the list of instruments being administered.

Participants are administered the instruments at the beginning of the treatment program to create a baseline for test scores in each category. At the six-month mark and again at program completion, each participant is re-tested using the same instruments. The CQI Committee compiles and extracts data on individual participant's knowledge, attitudes and behaviours from admission to completion, and compare these responses with other participant responses in each pre- or post- category. Analyses are performed to determine the overall effectiveness of treatment programs in reducing the risk to recidivate, as determined by coping behaviours, relapse prevention skills, anger management and other factors known to impact recidivism rates. (Recidivism rates include relapse to criminality and to substance abuse). Post-release status, re-arrest data, and rate of return to prison data are also collected and correlated to program effectiveness specific to reducing recidivism. Post-treatment survey data are collected via phone interviews and/or mailings on the status of program graduates released at 30 day, 60 day, 90 day, and 180 day intervals.

For more information on this program, contact: Mike Walls (Program Manager), 253-512-6614, mtwalls@DOC1.WA.GOV

[34] At the time of the interview, no results were available.

Modified Therapeutic Community

Treatment for MICAs: Design & Implementation of the Modified TC

(submission draft revised 2.1.99)

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Abstract

This paper describes the main features of an innovative therapeutic community (TC) model adapted for use with mentally ill chemical abusers (MICAs). The paper describes the rationale for use of the modified TC with MICAs, the treatment structure and environment created, the essential components of the modified TC program, staffing, and the process and goals of client change. Details are given regarding issues and strategies for the implementation of the new program in terms of program planning, staff training, and system initiation. Evaluation data from the authors' research is summarized to support the adoption of the modified TC model. The paper makes clear the feasibility of a modified TC model of established effectiveness with a MICA population. This model has now been successfully introduced into mental health, drug treatment, shelter, and correctional settings.

Introduction

The co-occurrence of psychiatric problems and substance abuse (often termed "dual disorder") has received increasing attention over the past decade as the drug treatment and mental health fields strive to develop methods of coping with this difficult population. Comorbidity represents a particularly intractable problem and successful treatment strategies remain elusive. As the drug treatment and mental health fields begin to bridge gaps in knowledge, cooperate and coordinate treatment efforts, standardize definitions and diagnoses, and address system concerns, advances have been made in program design. (See S. Sacks, J. Sacks, De Leon, Bernhardt, & Staines, 1997, for a summary of studies of dual disorder prevalence and treatment.) Elevated awareness of dual disorder among adolescents, the homeless, prison inmates, and those with HIV/AIDS underscores the high social cost of this problem. This diversity within the dual disorder population further Implement Mod TC 2/1/99 print date 11/19/01 2 complicates treatment, raising unique concerns and considerations in designing treatment models. The distinction between Axis I serious and persistent mental disorders, and Axis II antisocial and other personality disorders is essential to program planning.

Clearly, treatment models constructed from sound theoretical foundations, documented methods, and established empirical findings are urgently needed. Effective programs must not only ameliorate psychological dysfunction and substance abuse, but also provide solutions to clients' needs for housing, health care, access to and utilization of social services, life skills development, and employment. The disaffiliation of the dual disorder client is fundamental; treatment programs must endeavor to connect the client to a social structure.

The modified TC described in this paper is based on the theoretical framework of the generic TC model established in previous publications (*e.g.*, De Leon, 1984; 1989; 1996a; De Leon & Rosenthal, 1989; De Leon & Ziegenfuss, 1986). This paper focuses on modified TCs for mentally ill chemical abusers (MICAs), describing program modifications for a seriously disturbed population with extensive psychiatric histories. The core principles and methods of the TC are especially relevant to the treatment of MICAs. These include: providing a highly structured daily regimen; fostering personal responsibility and self-help in addressing life difficulties; using peers as role models and guides, the peer community as the healing agent, and a core strategy of community-as-method (the community provides both the context and mechanism for change); viewing change as a gradual,

developmental process and moving clients through treatment stages; stressing work and self-reliance through the development of vocational and independent living skills, and the promotion of prosocial values within healthy social networks to sustain recovery.

A series of studies by the authors has shown that the modified TC provides an effective treatment model. The studies employed a minimal bias sequential assignment design (Staines, Perlis, McKendrick, Sacks, & De Leon, 1999) to compare the modified TC group with a group of homeless MICAs who received a variety of services typically available, or "treatment-as-usual" Implement Mod TC 2/1/99 print date 11/19/01 3 (TAU). Significant outcome differences in favor of the modified TC group were noted in illegal drug use, non-drug related crime, and employment (De Leon, Sacks, Staines & McKendrick, 1999).

Improvements in clients' use of illegal drugs and participation in criminal activities (and for other negative behaviors) occurred early during the residential TC program and stabilized during supported housing. Improvements in psychological functioning (such as Beck Depression scores) and prosocial behavior (such as employment) were incremental and continuous during both the residential and supported housing programs (S. Sacks, Staines, J. Sacks, McKendrick, Bernhardt, & De Leon, 1997).

Results of economic analyses to date show that the average cost for modified TC clients remaining in treatment for 12 months, including the use of ancillary services, is $29,255, approximately equivalent to the costs of services for TAU clients ($29,638). Combined with the outcome data, the economic analysis indicates that improved functioning for homeless MICAs can be obtained through modified TC treatment at a cost equivalent to standard services (French, Sacks, De Leon, Staines, & McKendrick, 1999).

Program Model

TC Treatment Structure Modified for MICAs

This section summarizes ten essential structural features of the modified TC program for MICAs, describing similarities to traditional TCs and the adaptations specific to MICAs. The program structure provides the framework within which the program elements (stages and activities) occur.

Community Affiliation: The peer community is central to most program elements and activities. Affiliation with the community mediates change. A climate of mutual responsibility between the client and the peer community is established, with consistent stress placed on stabilizing, building, and sustaining the community and its integrity. An environment of physical Implement Mod TC 2/1/99 print date 11/19/01 4 and psychological safety is maintained, enabling clients to concentrate on change, growth, and development. Affiliation with the community is maintained from institutional to independent living, providing continued reference and identity, and a mechanism that clients can apply to a larger society. In the modified TC for MICAs, more time is spent developing mechanisms for clients to encourage their affiliation with the community. A greater variation in level of commitment to the community is also tolerated.

Program Stratification: The program comprises a stratified system of stages and phases corresponding to the progression of the client, from entering the residential modified TC program (Stage One) to living in a supported housing apartment (live-out re-entry—Stage Four). At each stage, clients have increased responsibility (especially work responsibility) and greater autonomy. Advancement from one stage to the next is determined by time-in-program and improvement in patterns of behaving, thinking, and feeling as assessed by both clients and staff. The individual's identification with an ordered network is strengthened, and relationships of mutual responsibility with others are arranged through program stratification. When applied to MICAs, program stratification involves a more limited number of program and work levels, and weighs individual factors even more systematically in determining client stage and work assignments.

Atmosphere: Within the program facility, clients create a cordial, hospitable atmosphere, and learn to think of the community of members and staff as a family. Apart from the front door and medication storage, no area of the facility is locked; clients are responsible for its safety. Clients maintain communal areas, taking pride in the appearance and ambiance of the facility. The walls are used to post essential program information (date, census, peer work assignments, stage, and particular status information such as hospitalizations), a daily concept, the Serenity Prayer, as well as pictures of the residents at special events such as a graduation ceremony. The physical environment reflects the program, reinforcing the associations and relationships of family Implement Mod TC 2/1/99 print date 11/19/01 5 and community. Overall, the atmosphere of the modified TC for MICAs is similar to that of any TC, although staff recognizes the psychiatric symptoms of the members with a consequent focus on the treatment of mental illness.

Active and Structured Program: The daily regimen consists of community groups, educational and therapeutic groups, work assignments, recreational activities, and individual contacts throughout the day and evening. Isolation is discouraged; meaningful social interaction is encouraged. All program elements, program activities, and individual contacts are part of the program. Because every interaction provides a learning opportunity, the client is expected to attend and to participate in all aspects of the program, presenting his/her feelings, thoughts, and behaviors for feedback and modification. In the modified TC for MICAs, the number and duration of activities are reduced, and expectations of participation are adjusted to the individual. Peer Work Hierarchy. Clients are charged with the task of operating the facility, working together under staff supervision in departments including house communications/expediter, food service, maintenance, and education/graphic arts. All residents have a work assignment and contribute to the management of the facility, with upper-level residents assuming department head functions, while lower-level residents perform line duties. When adapted for MICAs, the traditional TC work schedule is reduced, and incorporates frequent breaks. The intensity of work assignment interaction is less, greater instruction is provided on expected job performance, and more concrete emphasis is placed on reinforcing actual learning. The modified TC is distinguished from other mental health models by the greater degree of responsibility residents assume for operating the facility and the program, although to a lesser degree than is true for traditional TCs.

Self-Help: Clients constantly communicate the essential interpersonal dynamic of mutual self-help to each other in their jobs, groups, meetings, recreation, personal, and social time. Clients perform self-help functions autonomously to the limits of their capacity; those with more Implement Mod TC 2/1/99 print date 11/19/01 6 time-in-program help the newer residents. Staff provide more direct assistance, as dictated by MICA clients' impairments, model all activities before implementation, and assist clients' in conducting groups (some activities remain under staff direction). Nevertheless, the essential ingredient of self-help remains; clients help themselves and one another to the extent of their ability.

Role Models: Role models demonstrate appropriate behavior, the attitudes and values of the community, and confront those whose behavior is contrary to program rules, the spirit of the community, or growth and rehabilitation ("responsible concern"). All program members, peers and staff, are expected to be role models, and, as such, become primary mediators of the recovery process. Personal stories illustrate the recovery process and provide guidelines for others to follow. New programs draw role models from staff members who were formerly modified TC clients, and from clients who had completed other non-TC MICA programs, adding current clients as they progress to the upper stages of the program.

Rational Authority: Staff members use their managerial and clinical duties to teach, guide, facilitate, and correct, rather than punish, control, or exploit. By acting as rational authorities, giving reasons for making certain

decisions, with explanations of the consequences, staff members personify credibility, support, and protection, and thus counteract the problems many MICAs have with authority, as rational authorities.

Staff as Guides: In performi. Through affiliation with such authority figures, MICAs learn to gain authority over themselves. In the modified TC for MICAs, greater emphasis is placed on staff, as compared to upper level peers ng their traditional functions of counseling and developing service plans, staff members act primarily as guides. Clients develop their service plan with staff coaching and individual counseling often consists of staff helping to clarify matters for the client to present to the community. Staff is always present as the clients go about the daily routine of managing the facility and conducting its activities, lending assistance as needed, providing a Implement Mod TC 2/1/99 print date 11/19/01 7 feeling of security, and helping clients help themselves. In the modified TC for MICAs, staff function as coaches, providing "hands on" guidance in assisting the member to navigate the program. As in all TCs, the modified TC for MICAs hires staff from a pool of program graduates. Initially, when the numbers of graduates are low or non-existent, MICA programs can use graduates from other TC programs who have particular abilities with, or interest in, the MICA population.

Respect for Others: Respect for ethnic/racial and gender differences is taught as part of the general lesson of respect for others. The TC model and methods encourage integration of all ages, genders, racial/ethnic backgrounds, and social classes; learning to understand and accept others is essential to self-understanding and self-knowledge. The program uses community to foster cultural integration in a context of pluralism and egalitarianism, and teaches compassion, empathy, and responsible concern. The modified TC for MICAs is similar to other TC programs in its emphasis on respect for others; a distinctive addition is empathy for mental illness.

The TC Stage and Phase Treatment Process for MICAs

The treatment process involves stages and phases (see De Leon, 1984; De Leon & Rosenthal, 1989; De Leon, 1996b) as adapted for MICAs. The four stages are admission and engagement (Stage One), primary treatment (Stage Two), live-in re-entry (Stage Three), and live-out re-entry (Stage Four). The first three stages mark the residential portion of the program; the fourth stage takes place in a supported housing apartment complex. (S. Sacks, De Leon, Bernhardt, & J. Sacks, 1996, describe the modified TC model in detail.)

The stage and phase format, which is both clinically relevant and potent, is widely accepted in the drug treatment and mental health fields. The format allows gradual progress, rewarding improvement with increased independence and responsibility. The client is given a clear road map for progression through the program, with explicit program expectations, and an outline of Implement Mod TC 2/1/99 print date 11/19/01 8 program and client goals, objectives, methods, and outcomes. Broad criteria are supplied for movement from one stage to the next, and the clinical decision-making process is informed on matters such as increased responsibility, needed supervision, and discharge.

Table 1—Stages and Phases of Treatment

Stage 1—Admission & Engagement (Months 1-3)

The aim of this stage is to assimilate the client into the community.

- ***Phase 1 Orientation:*** To ensure the client understands, accepts, and adjusts to the community.
- ***Phase 2 Stabilization:*** To ensure satisfaction of the client's immediate needs (e.g., health, entitlements, etc.) and to foster active involvement in the community.
- ***Phase 3 Assessment:*** To assess client strengths and deficiencies with particular reference to their mental illness and chemical abuse as well as vocational and other life skill deficits.

At the end of Stage One, the client is stabilized in the program, familiar with all program routines and requirements, aware of personal strengths and deficiencies, and motivated and ready to begin Stage Two, Primary Treatment, an in-depth process of self-examination and change.

Stage 2— Primary Treatment (Months 4-6)

The aim of this stage is to promote the psychological and social growth of the client.

- ***Phase 4 Awareness and Acceptance:*** To facilitate client confrontation of self-defeating characteristics and acceptance of guidance to change.
- ***Phase 5 Planning and Action:*** To resolve personal issues necessary for transition to the next stage.

At the end of this phase, the client's progress should reflect movement beyond compliance with the program toward internalization of the program goals and commitment to personal recovery. The program establishes these outcomes on the basis of the individual's verbal reports and behavior. The individuals who successfully complete this stage report that they understand and accept responsibility for themselves, feel a strong desire to improve themselves, and see a path for change based on a commitment to recovery principles. The clients who complete Stage Two are drug-free, psychologically stabilized, community affiliated, and committed to recovery.

Stage 3— Live-In Re-Entry (Months 7-12)

The aim of the stage is to facilitate the re-entry process and prepare the client for the next level of care.

- ***Phase 6 Early Re-Entry:*** Preparation for graduation from community residence living and include a focus on adjustment to pro-social living, daily living skills and maintaining sobriety.
- ***Phase 7 Late Re-Entry:*** Planning for the client's movement from community residence living to community-based housing.

The Stage Three client meets the following criteria: completes, on the average, 12 months of residential living; is drug- and alcohol-free; has improved psychological status; remains affiliated; and has the skills necessary for community living. In addition, commitment to the recovery process and to the integration of housing and treatment is firm; the client accepts the need for continued treatment, can identify problem areas that must be addressed, and has formed relationships and connections to other members of the community who have progressed to community-based housing.

Stage 4: Live-Out Re-entry (Months 13-18)

The aim of this stage is stabilized, productive community living.

- ***Phase 8 Adjustment:*** Focusing on stabilization in the community.
- ***Phase 9 Productivity:*** Emphasizing work in the community.

The persons who complete Stage Four are considered graduates of the modified TC program. Their observed and reported change in self-image, values and identity reflects a demonstrated commitment to a recovery oriented lifestyle. Program graduates are now prepared to generalize their acquired independent living skills and move into Post-Treatment — Stage Five. The ongoing task for Stage Five persons is integration into the larger community while maintaining a healthy independent lifestyle that is consistent with "right living" and the principles of recovery.

Stage 5: Independent Living (Months 19+)

The aim of this stage is fostering personal integrity and independent, community living.

The stage and phase format for MICA clients differs from other formulations as follows:

1. more time and effort are spent on engaging and stabilizing the client in the community;
2. the rate of program movement is individualized to take into account developmental level, diagnostic differences, and variability in rates of learning (clients sometimes return to an earlier phases to solidify gains before progressing); and
3. phase criteria have sufficient flexibility to allow even low-functioning clients to move through the program system.

The program adapts to the individual, without any compromise in integrity, by maintaining core minimum standards for stage movement and allowing other criteria to be adjusted to the individual's level of functioning. Table 1 provides an outline of program goals and objectives and presents a clinical summary of the functioning of a typical client at the end of each stage.

Summary of Program Modifications for MICA Clients

The alterations from the traditional TC approach are made by the modified TC program in response to the MICA client's psychiatric symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor control of urges. A key alteration is the change from encounter group to conflict resolution group. As compared to a standard encounter group, the conflict resolution group has shorter duration, reduced intensity of interaction, more emphasis on instruction, and increased modeling by staff and more experienced clients. The conflict resolution group focuses on personal conflicts, conflicts between people, and conflicts in relation to an individual's performance of program tasks and activities. The goals of this group are the same as those of a standard encounter group; to identify and modify self-defeating patterns of thinking, feeling, and behaving, and to facilitate self-discovery through personal disclosure and direct interpersonal interaction.

Other alterations in the modified TC for MICAs include:

- increased flexibility in program activities;
- shorter duration of various activities;
- less confrontation and intensity of interpersonal interaction;
- increased emphasis on orientation and instruction in programming and planning;
- fewer sanctions and greater opportunity for corrective learning experiences;
- more explicit affirmation for achievements;
- greater sensitivity to individual differences; and
- greater responsiveness to the special developmental needs of the clients.

To summarize, three key alterations were made in designing the modified TC program for MICAs; increased flexibility, decreased intensity, and greater individualization. Nevertheless, the central TC feature remains; the modified TC, like all TC programs, seeks to develop a Implement Mod TC 2/1/99 print date 11/19/01 11 culture where clients learn through self-help and affiliation with the community to foster change in themselves and others.

Program Interventions

All program activities and interactions, singly and in combination, are designed to produce change. Interventions are grouped into four categories; community enhancement (to promote affiliation with the TC community), therapeutic/educative (to promote expression and instruction), community/clinical management (to maintain personal and physical safety), and vocational (to operate the facility and prepare clients for employment). Implementation of the groups and activities listed in Tables 2 and 3 establishes the TC community. Although each intervention has specific individual functions, all share community, therapeutic, and educational purposes.

Table 2— Residential Interventions (Stages One through Three)

Community Enhancement	
Morning Meeting	• increases motivation for the day's activities and creates a positive family atmosphere
Concept Seminars	• review the concept of the day
General Interest Seminars	• provide information in areas of general interest (e.g., current events)
Program-related Seminars	• address issues of particular relevance (e. g., homelessness, AIDS prevention, and psychotropic medication)
Orientation Seminars	• orient new members and introduce all new activities
Evening Meetings	• review house business for the day, outline plans for the next day, & monitor the emotional tone of the house
General Meetings	• provides public review of critical events
Therapeutic/Educative	
Individual Counseling	• incorporates both traditional mental health and unique modified TC goals and methods
Psychoeducational Classes	• are predominant, in a format to facilitate learning among MICAs, and include topics such as entitlements/ money management, positive relationship skills training, triple trouble group, and feelings management
Conflict Resolution Groups	• modified encounter groups designed specifically for MICA clients
Gender-Specific Groups	• combine features of "rap groups" and therapy groups focusing on gender-based issues
Community & Clinical Management	
Policies	• a system of rules & regulations to maintain the physical & psychological safety of the environment, ensuring that resident life is orderly & productive, strengthening the community as a context for social learning
Social Learning Consequence	• a set of required behaviors prescribed as a response to unacceptable behavior, designed to enhance individual and community learning by transforming negative events into learning opportunities
Vocational	
Peer Work Hierarchy	• a rotating assignment of residents to jobs necessary to the day-to-day functioning of the facility, serving to diversify and develop clients' work skills and experience
World of Work	• a psychoeducational class providing instruction in applications and interviews, time and attendance, relationships with others at work, employers' expectations, discipline, promotion, etc.
Recovery & World of Work	• a psychoeducational class that addresses issues of mental illness, addiction, etc. in a work context
Peer Advocate Training	• a program for suitable clients offering role model, group facilitator, and individual counseling training
Work Performance Evaluation	• provides regular, systematic feedback on work performance
Job Selection & Placement	• individual counseling after six months to establish direction and to determine future employment

Table 3— Supported Housing (Aftercare) Interventions (Stage Four)

Community Enhancement	
Community Meetings	• weekly meetings to share concerns regarding the living environment and the supported housing • program
Community Activities	• regular visits to the community residence site to act as mentors to community residence residents • and peer advocates, assisting with the operation of the program as trainees and as group cofacilitators
Therapeutic/Educative	
Psychoeducational	• Basic Skills: orientation, independent living skills, and financial management classes to assist clients in the transition to independent life
Classes	• Relapse Prevention Training: early identification of internal states that are cues for relapse • Triple Trouble Recovery: mental illness and chemical abuse in the context of relapse & recovery
Psychotherapeutic Groups	• Supported Housing Group: self-monitoring and self-management of medication, finances, & daily affairs • 12-Step Self-Help Meetings: clients attend at least two weekly meetings, one at the community residence site and one in the community, connecting MICA individuals in the current program to a larger world-wide recovery network that is essential for successful recovery in the community • Individual Counseling/Case Assistance: each client meets with a counselor on an as-needed basis to help with concrete life problems from a self-help perspective • Psychotherapy: clients meet with staff at the day treatment program for psychotherapy, on a regular basis, to monitor medication, assess mental status and psychiatric symptoms, and explore relevant personal issues
Community & Clinical Management	
Re-Entry Board	• comprised of senior members, graduates, and staff, the Re-Entry Board has increasing responsibility for the design, policies, and development of the supported housing program
Vocational	
Recovery & World of Work	• a psychoeducational class that addresses work-related issues in the context of homelessness, mental illness, addiction, etc. from a recovery-based perspective
Peer Advocate Training	• a program that trains suitable MICA clients to provide counseling to other MICA clients
Work Performance	• provides regular, systematic feedback on work performance
Job Selection & Placement	• individual counseling to establish direction and to determine future employment • agency jobs such as counselor/group leader, outreach worker, front desk counselor, & janitor • vocational counseling that includes assessment, assistance with job searches, and job placement

Relationship of Interventions to Stages

Table 4 depicts the relationship between interventions and program stages. The table shows that most program interventions begin early and are maintained throughout the residential phase. Additional elements are added during the live-in re-entry stage to prepare the member for community-based living. The table also depicts the integrated program interventions of the liveout re-entry (aftercare) phase.

Table 4— Interventions by Stage & Phase

Stage		One Admission & Entry			Two Primary Treatment		Three Live-in Re-Entry		Four Live-Out Re-Entry	
Phase		1	2	3	4	5	6	7	8	9
Community Enhancement	• Morning Meeting									
	• Seminars									
	• Evening Meeting									
	• General Meeting									
	• Supported Housing Meeting									
	• Community-Sustaining Activities									
Therapeutic/ Educative	• Individual Counseling									
	• Conflict Resolution									
	• 12 -Step Self-Help									
	• Gender-Specific Groups									
	• Stage Three Group									
	• Stage Four Groups									
	• Case Assistance									
	• Psychotherapy									
	• Entitlements/Money Management									
	• Positive Relationship Skills									
	• Triple Trouble Group									
	• Feelings Management									
	• Basic Skills									
	• Relapse Prevention/Triple Trouble									
Community /Clinical	• Policies									
	• Monitoring of Whereabouts Management									
	• Social Learning Consequences									
	• Breathalyzers/Urinalysis									
Other/ Vocational	• Peer Work Hierarchy									
	• World of Work									
	• Recovery & World of Work									
	• Peer Advocate Training									
	• Work Performance Evaluation Group									
	• Job Selection & Placement									

Implementation

System Support

Programs are implemented in existing systems and planning must, therefore, be responsive to the policies and guidelines of those systems. To that end, it was found useful for the project team to form an active partnership with key state system personnel, including the system director. Regular and periodic meetings were held to review the status of the project, and were supplemented by the exchange of written information, letters of support, updates, and site visits. In this fashion, system representatives came to share ownership of, and credit for, the program, and a strong cadre of stakeholders was created, with leadership assumed by those at the highest level of program and the state systems.

Planning

The basis of successful programming is the development of a participatory strategic planning group consisting of key project staff. Strategic planning provided a mechanism for active learning, for the discussion of central issues, and for the immediate program modification appropriate to the current situation. In the present context, the main goal of the group was to design, develop, and implement a modified TC program for homeless MICAs. The group was composed of all those with a key role in the program.

The strategic planning group follows an agenda that focuses on issues such as the rationale for program modification, the timing of programmatic changes, regulatory requirements, the introduction of program change to clients and staff, and the integration of program development and research evaluation. The group has three agenda goals: a) to design, develop, and implement a modified TC program for MICAs; b) to train staff in the new model; and c) to ensure staff input and ownership of the program.

Program Eligibility & Selection

Eligibility for admission should be clearly defined on the basis of mental illness and substance abuse disorders, using referral diagnosis, available measures, clinical review of records, etc. The distinction between Axis I, serious (Schizophrenia, Mania, Major Depression), and Axis I, other than serious, plus Axis II disorders (Post-Traumatic Stress, Personality Disorders) is critical to program planning.

The program model described was designed for a stabilized MICA population, and is more effective for chronic disorders that are currently stable, with no significant acute symptoms. A balance between acute and chronic disorders, weighted significantly toward the chronic, is believed appropriate for client selection. Those with Axis II disorders have been served by traditional TC treatment

Recruitment

Standard Referral Sources: MICA clients for the modified TC program described in this paper were referred from New York City shelters and psychiatric facilities through traditional professional channels, and collaboration between program and referral staff. Program staff established connections with referral agencies by orienting referral staff to the TC program, transmitting program rationale, goals, and methods. When the number of clients referred exceeds the available treatment slots, such traditional efforts can be sufficient; however, supplementary methods that more aggressively recruit potential clients are often needed to launch a new program.

Staff Outreach Approaches: The program used regular outreach visits to shelters and psychiatric facilities to inform both the referral source and prospective clients about the nature of the modified TC treatment program. The first step in a process of engagement, visibility at the referral setting and multiple outreach contacts are often essential to encourage clients to enter treatment. Personal bonds are formed with some clients in these facilities; such a bond is often necessary before the client will consider treatment programs in general, and the modified TC in particular. Formal and Informal Orientation— Formal orientation to the program is given to small groups of potential clients, providing information on the program structure, group activities, immediate needs (e.g., housing), and program staff (including those who are recovering addicts), setting a positive tone for starting over, personal change, and recovery. Since recruitment depends upon connections formed between client and at least one staff member, the formal orientation is supplemented by informal conversations after orientation, drop-in sessions, and other discussions more specific to individual client concerns. Orientation efforts set a positive tone, encouraging even those who are most discouraged, terming the past as a prelude for the success of change in the present.

Peers as Recruiters: Peers who have, or who have nearly, completed the MICA program are valuable in recruiting new clients. They are credible and can speak directly to client concerns about the nature of the program. Most

importantly, as role models they can offer hope and positive encouragement about how the client may use the program to bring about personal change.

Launch: Create a Positive Peer Culture

The weight of client problems (drug use, high-risk sexual behavior, poor psychological functioning, unstable family and living situations) and a variety of other practical issues can overwhelm creation of a positive peer culture. Under-productivity, non-participation, and mutual involvement in destructive activity are endemic to this population, fueling a powerful negative sub-culture.

To counteract negative forces and to create a positive peer culture, a strategy of "culture planning and development" was employed. Prior to the inclusion of clients with higher problem profiles, a "seedling group" was assembled of motivated, higher functioning clients who were trained to facilitate transmission of the peer self-help culture to other clients. Over a three to six month period, the seedling group was exposed to a rigorous and accelerated TC regimen designed to strengthen them individually and collectively. This special regimen consisted of all of the basic TC elements, especially highlighting their roles as "pioneers" in the establishment of a self-help culture, and their training to provide leadership to other clients.

During culture planning and development, each client had to meet certain criteria; specifically, assimilation of TC concepts, significant individual progress, and semi-autonomous management of key program activities. Each client was asked to contribute to the establishment of a self-help TC culture; i.e., identifying the program site as "home" and the program membership as "family," thus forming the context for individual development. When these individual and group criteria were met, and the culture was judged sufficiently strong, recruitment was opened to other, more problematic clients.

Introduce New Elements Gradually: Directors and supervisors use gradual and guided implementation (Table 5) to introduce new program elements and to refine the program. New program elements are planned in a pre-implementation phase, then gradually applied in the program. Both clients and staff plan, discuss, and review each step, allowing at least a week for all to understand and accept the change. Each change is implemented, reviewed, and adjusted to the needs of the community. The process takes, on average, four to six weeks (excluding the time for review and refinement).

Follow a Standard Sequence: In general, a MICA program can be implemented over a six month period in three distinct phases. Implement all of the community enhancing elements, the peer work-structure and some basic educational classes in the first phase (months 1-2). In the second phase (month 3-4), implement most other education classes (especially Feelings Management and Double Trouble Classes) and the Conflict Resolution Group. Implement the remainder of the therapeutic elements and those activities specific to live-in re-entry in the third phase (months 5-6).

Establish a Highly Structured Program: A typical modified TC program for MICAs is represented in the daily/weekly schedule presented below. The program consists of all of the elements described in Table 5.

Table 5 — Weekly Schedule

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
06:00-07:00	Wake up / meds						
07:00-08:00	Breakfast						
08:00-09:00	Morning Meeting						
09:00-09:30	Break						
09:30-10:30	Core Group	Feelings Management	Live Skills	Core Group	Feelings Management	Free Time	Spiritual Enrichment
10:30-11:00	Free Time	Free Time	Free Time	Free Time	Free Time	Concept Seminar	
11:00-11:30	Concept Seminar	Film & Discussion	Money Management	Work	Big Brothers meeting	Men/women's Group	
11:30-12:00	Cooks cook						
12:00-12:30	Lunch						
Afternoon							
12:30-01:00	Free Time	Free Time	Free Time	Free Time	Free Time	Family Visiting/ Free Time	Free Time
01:00-02:00	Work	Triple Trouble Group	Work	Concept Seminar	Self Management Skills		Leisure/ Recreation Activity
02:00-03:00	Conflict Resolution	Medication Management Seminar	Positive Relationship Skills	Relapse Prevention	TC staffing	Leisure Activity	
03:00-04:00	Free Time	Free Time	Free Time	Free Time	Free Time		Free Time
04:00-05:00	Cooks cook						
05:0005:30	Dinner						
05:30-06:00	Break						
Evening							
06:00-07:00	NA/AA Meeting	Library Visit	Recovery & Work	NA/AA Meeting	Recreation Activity	NA/AA Social Activity	News Seminar
07:00-08:00	Break						
08:00-09:15	Evening Meeting						
09:15-10:00	Free Time meds	Free Time meds	Free Time meds	Free Time meds	Free Time meds	Free Time meds	Free Time meds
10:00	Curfew Lights Out	Curfew Lights Out	Curfew Lights Out	Curfew Lights Out			Curfew Lights Out
11:00					Curfew Lights Out	Curfew Lights Out	

Staffing

Developing a new treatment model for a particular population in a specific setting places unique demands on the provision of adequate staffing. A cadre of staff experienced with both TC Implement Mod TC 2/1/99 print date 11/19/01 20 methods and MICA clients is not readily available. The program described in this paper was staffed by mental health and TC personnel; only a few staff members had both TC and MICA expertise.

A typical 25-bed residential program should consist of about 15 staff, as follows: a) a Program Director (preferably with an advanced degree in the human service field), a Secretary, a Program Supervisor (preferably with a BA degree), and ten line staff (with high school diplomas or college associate degrees); b) a Clinical Coordinator (a TC specialist), a Nurse Practitioner (0.5), an Entitlements Counselor (0.5), and a Vocational Rehabilitation Counselor (0.5). The optimal staffing ratio for morning, afternoon, and night shifts is 3:1, 3:1, 1:1, respectively. The critical position is the Clinical Coordinator (TC Specialist) who leads program implementation.

Staff Training

Launch: The overarching principle of staff training for the modified TC is to provide the initial training and continuing technical assistance, both didactic and experiential. A didactic presentation of the written pre-launch TC training curriculum was conducted at the program site for five days prior to program launch, including an overview of the philosophy, history, and background of the TC approach; a review of structure, including the daily regimen, role of staff, role of peers, peer work structure, privileges, and sanctions; and treatment process, including a description of the stages and phases of treatment. This curriculum also included special training in the assessment and treatment of MICA patients and in the key modifications of the TC for MICA clients (see Table 6). Due to the lack of availability of other comparable MICA programs, experiential training comprised visits to standard TCs, role-playing of mock groups, and activities such as morning meeting, concept seminar, and evening house meeting. Once established, the flagship program becomes the model for subsequent experiential training.

Table 6— Sample Training & Technical Assistance Curriculum

What is a Therapeutic Community?	• Describes the theory, principles, and methods of the TC • Presents the TC perspective of four views: person, disorder, recovery, & "right living" • Describes the fundamentals of the TC approach with an emphasis on community-as-method; i.e., the community is the healing agent
What do we know about the treatment of MICAs?	• Reviews the literature on the increased prevalence of MICAs in the mental health, drug treatment, and criminal justice systems • Presents a selected review and classification of treatment approaches and principles. Provides a review of the research literature and its implications for practice • Describes research establishing the effectiveness of modified TCs for MICAs
What is a Modified TC?	• Describes the seven main modifications of the TC for MICAs • Elaborates key changes in structure, process & interventions of MICA modified TC
How do we assess/diagnose the MICA?	• Describes the main signs and symptoms of serious mental illness for schizophrenia, major depression, and mania • Presents critical differences between Axis I and Axis II disorders and their implications for program design • Describes the ten main characteristics of addict populations • Presents a classification of criminal behavior and criminal thinking • Presents three clinical instruments for assessing mental illness, substance abuse, and danger profile • Presents empirical data on MICA client profiles
How do we start/implement the program?	• Presents six guidelines for successful program implementation • Provides practical advice on how to recruit, select, and initially evaluate • Emphasizes how to establishing the TC culture • Describes six techniques for engaging the client in treatment • Presents empirical data from the faculties studies of change • Develops a sequence for implementing the core TC elements
What are the main interventions activities of the TC	• Provides a complete list and brief discussion of all TC interventions in four areas; community enhancement (e.g., morning meeting) therapeutic/educative (e.g., conflict resolution groups, interpersonal skills training), community/clinical management (e.g., learning experiences; and work/other (e.g., peer-work hierarchy) • Delineates the interventions for both the residential and aftercare components • Uses illustrations to teach three main interventions
How do clients change?	• Presents the stages and phases of TC programs • Describes the domains and dimensions of change • Describes an instrument for measuring change • Presents empirical data from the staff studies on the process of change
What is the role of the staff?	• Describes the staffing patterns and job responsibilities of TC staff • Discusses the role of mental health, substance abuse, and correctional staff • Uses exercises to establish teamwork and esprit de corps • Provides the major cross-training experiences
What is it like to be in a TC?	• Discusses the "nuts and bolts" of TC operations • Provides a description of a typical day in the life of a TC residents • Demonstrates a typical schedule for a TC day/week • Addresses the concerns/issues of non-TC trained staff

Training and Technical Assistance: Training and technical assistance takes place in the field, is direct and immediate. Staff members learn exactly how to carry out program activities by participating in the activities. Technical assistance begins with a discussion of TC methods over a period of time (usually several weeks) before implementation, followed by active illustration during the initiation period (several weeks to several months). Supervisors hold briefing and de-briefing sessions before and after each group activity, generally for several months. As staff begins to lead new activities, technical assistance staff provides guidance for a period of several weeks. Monitoring continues until staff demonstrates competency (several weeks, on average), as established by supervisory ratings. Thereafter, quarterly reviews ensure continued staff competency and fidelity of program elements to TC principles and methods.

Summary and Implications

The integrative structure and core components of the modified TC model for mentally ill chemical abusers have been detailed in conjunction with those issues and strategies critical to the implementation of this, and any, new program. The modified TC model described has been successfully adopted in mental health (Galanter, Franco, Kim, Metzger, & De Leon, 1993; S. Sacks, De Leon, Bernhardt, & J. Sacks, 1997), and drug treatment (e.g., Argus Communities) settings. The model is currently being implemented in shelter (The Salvation Army, 1998) and correctional settings (Sacks & Wexler, 1995; Sacks, 1998a). The investigative team has developed a technology transfer protocol for achieving the adoption of the modified TC program and ensuring the quality control of those new applications. This protocol consists of manuals, a training curriculum, and technical assistance capability.[1] Additional planned applications include an aftercare residential program for AIDS patients with co-occurring disorders (Sacks, 1998b). [1] This resource material can be obtained from Dr. S. Sacks, CTCR at NDRI, 2 World Trade Center, 16th Floor, New York, NY 10048.

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Montreal General Hospital – Addictions Unit

The Addictions Unit, affiliated with the Montreal General Hospital Department of Psychiatry, is an addiction program (day and community-based) within a psychiatry department. The Montreal General does not have a specific Concurrent Disorders program - rather, they have a completely integrated program that handles a large population of patients with concurrent disorders.

1. Organizational and Service Delivery Setting

All English language hospitals in Montreal are affiliated with the McGill University Health Centre, which is a teaching hospital affiliated with the Faculty of Medicine at McGill University. The Addictions Unit is located in a building adjacent to the Montreal General Hospital, and is administered as part of their outpatient psychiatry department. The program is the only English language hospital-based Addictions Service in the province of Quebec.

Target Population: English-speaking adults living in the province of Quebec with co-occurring addiction and mental health disorders.

Staffing: Staff of the Addictions Unit is comprised of a Director, a Medical Director, a Research Director, as well as several Psychiatrists, Nurses, Occupational Therapists, and Therapists

2. Referral, Screening and Assessment

A client has to request services by telephone. At that time, the intake secretary goes through a brief list of screening questions about their problem with substance abuse, current medical care and psychiatric care that is being received, medications that are being taken, and any planned follow-up within their own psychiatric sector, if they live outside of Montreal. That information is passed to the Unit's Director and Medical Director to be screened. If more information is needed, that is followed up on. If the person is appropriate for service, meaning that the request is something that the Unit can fulfill, then that person goes on a waiting list. The Addictions Unit receives about 800 new clients/patients per year, thus there is typically up to a three-month waiting period for treatment in the Unit.

Once a client comes for treatment, baseline assessments are conducted by a treatment team consisting of a clinic therapist and psychiatrist: An intake interview (approx. 1.5 hours) is conducted by the therapist to collect information on demographics, referral source, living situation and severity of substance abuse-related problems in a variety of areas. A modified version of the Addiction Severity Index (ASI) is utilized with additional detailed information collected on prior treatment episodes, withdrawal symptoms, consequences of drug/alcohol use, as well as medical and psychiatric history.

After the intake interview, the therapist reviews the case with one of the four Addictions Unit psychiatrists. That psychiatrist will then conduct a psychiatric evaluation (approx. 0.5 hours) with the client to determine current and lifetime diagnoses of substance use, mood and anxiety disorders. Clients also fill out a series of questionnaires measuring psychological distress (Symptom Checklist 90-R, Beck Depression Inventory). Blood tests for standard medical screening to monitor blood (HepC, HIV), liver GGT and thyroid function are often ordered, and a urine sample is collected for toxicology screening.

If this was the client's first time being seen by a psychiatrist, a diagnosis is made and psychiatric treatment may be initiated. If the person is currently psychotic, the psychiatrist will initiate medication and try to stabilize the client. Then, if the client wants to work on the substance use problem, the person can continue with the treatment program.

The information collected during intake and assessment is discussed by the treatment team and a treatment plan is devised together with the client. The recommended program may be of very short duration (individual brief counselling) or extend over a 6-month period (individual and group psychotherapy). In some cases in-hospital withdrawal management is recommended, followed by referral to a longer-term extended care facility in the region.

3. Treatment Approach

All clients are assessed by a psychiatrist on intake, and approximately 60% continue on to receive psychiatric care on-site during their addiction rehabilitation treatment, which runs for 12 months. If needed, in-hospital withdrawal management and/or psychiatric stabilization are offered at the Unit's admission service that is located within the hospital's psychiatry ward.

Treatment Phases

Treatment is divided into two Phases. Phase I lasts approximately 6 weeks, with the treatment focusing on abstinence and engagement in therapy. Phase II continues for a total treatment period of 6 to 12 months and focuses on maintenance of abstinence, relapse prevention, psychological growth, and improved social functioning.

Treatment Interventions

PHASE I: Phase I lasts for about six weeks, and the goal of this Phase is to help the person to get off substances. Patients typically complete withdrawal management during the first two weeks following their initial assessment. Some patients achieve abstinence without medical/psychiatric intervention, some require medication for withdrawal symptoms, some will have community-based monitoring, while others require in-hospital withdrawal management. The Addictions Unit has 4 to 6 beds on the psychiatric unit for patients (not specifically for CD clients) with high-risk withdrawal or severe medical complications.

All clients are assigned a primary therapist at the time of initial assessment. During the 6-week Phase I period, all patients have one individual therapy session with their primary therapist per week and attend either the Regular Phase I group psychotherapy or the Day Program.

1) Regular Phase I Group Psychotherapy: Clients not requiring intensive treatment attend one 60-minute 'Dual Diagnosis group per week. The group is open and ongoing.

2) Day Program: This is a more intensive 6-week Phase I program where patients attend daily from 10:30am to 2:00pm (10 groups per week). This program is typically reserved for severely dependent patients or those with histories of multiple treatment failure, where there is an indication for more intensive community-based treatment. This typically includes patients with concurrent disorders.

The focus of Phase I groups is on helping people to understand and to talk about what is going on regarding addiction. The therapeutic orientation of the group therapy sessions is eclectic with psycho-educational and supportive elements. Some of the topics covered in Phase I groups include: Understanding Dependency; False beliefs about addiction; When is substance use a problem?; The Effects of Mood-Altering Substances; Techniques for Coping with Urges; Relaxation Exercises; Conditioning and Cues - External and Internal Triggers to Use; The Connection Between Thoughts, Feelings, and Behaviors (A-B-C); Myths about Relapse; Strategies to Handle High Risk Situations; and Getting Support from People - 5 Different Kinds of Support.

Abstinence vs. Harm-Reduction: During Phase I, the emphasis of treatment is on establishing regular attendance, learning more about substance dependence, and on establishing abstinence from drugs and alcohol. If clients are able to diminish their substance-using pattern and have some periods of abstinence, they can then move on to

Phase II of therapy. If a person is not able to achieve any period of abstinence during the six-week Phase, an extension may be possible, or a referral to something more intensive may be recommended.

Mandatory Urine Screening Program: Patients in Phase I therapy are required to provide a mandatory urine sample for toxicology screening at each visit. In Phase II, the Addictions Unit has a random urine-screening program that is mandatory for all patients. Results of all urine screens (including refusals) will be forwarded to the psychiatrist and therapist.

PHASE II: Once clients are able to achieve periods of abstinence, they move to Phase II of the program and stay in that part of the program for 6 to 12 months. Phase II consists primarily of group psychotherapy sessions.

There are several different open psychotherapy groups running per week, each with 1-2 sessions/week, and 8 to 12 members per group. The groups are aimed at helping patients maintain abstinence, adjust to a drug-free lifestyle, examine the role drugs played in their lives, develop alternative coping skills, identify and cope with high risk situations, develop a more extensive social support system, and resolve problems which impede psychological growth and social functioning. The therapeutic orientation of the different groups is eclectic, including psycho-educational, supportive and relapse-prevention interventions. Also, because the groups are open and ongoing, clients who are there for the first time are mixed with clients who have been there for nine months, so the groups include a self-help component.

Several of the psychotherapy groups are for specialized sub-populations, including an Opiate Group, a Women's Group, and a "50-plus" group for older patients. One of these groups (the 'Dual Diagnosis Group') is specifically for people who have substance dependence as well as a more severe and persistent mental illness (typically schizophrenia). The group is run by an Occupational Therapist and it is very present-oriented, involving a combination of life skills, psycho-education, and CBT.

Many clients of the Addictions Unit have anxiety and mood disorders, but mixed in with the regular therapy groups. Clients with concurrent disorders may not necessarily attend the Dual Diagnosis group. Rather, they would attend the group that is most likely to address their issues, while having ongoing contact with their psychiatrist for psychiatric intervention (see individual counselling, below). For example, if a client is female and has PTSD or incest issues to deal with, she could go to the Women's Group. If the person is more senior, that person could go to the 50-plus group. If the person wants to work on self-betterment, that person may prefer the twice-a-week discussion group. In Phase I of the therapy, the staff get to know the clients enough to recommend what group would best meet their needs.

The goal of the program is abstinence. In order to stay in the program in Phase II, clients have to achieve periods of abstinence from their substance use. However, if somebody has a lapse or a relapse, they will not be discharged. But, if a client does not improve or make any progress over a period of time, they cannot stay in Phase II of the program.

Relapse Prevention: In Phase II there are several additional closed groups devoted to relapse prevention and stress management run on regular 8-12 week cycles throughout the year.

Individual Counselling: Clients receive six weeks of individual therapy with their primary therapist (typically the therapist who conducted the initial assessment). The role of the therapist is to guide the client and to help the client identify strategies that will be effective for achieving and maintaining abstinence from alcohol and drugs. Individual CBT sessions are available for patients with an identified anxiety disorder (panic attacks, phobias) on an as-needed basis. In addition, cognitive screening and retraining are available for patients who continue to suffer from memory and other cognitive deficits following a sustained period of abstinence (minimum 8 weeks).

Pharmacological Treatment/Medication: All patients are seen by one of four Addictions Unit psychiatrists at the time of initial assessment. The attending psychiatrist remains responsible for that patient's medical/psychiatric care during the course of addiction treatment. This includes the treatment of psychiatric disorders with antidepressants, anti-psychotics or mood-stabilizers. Following withdrawal-management, rational pharmacotherapy may be prescribed for symptoms that persist that might increase the risk of early relapse (e.g. insomnia, anxiety, irritability, mood disturbance, anhedonia and cravings).

Family Services: A time-limited psycho-educational group program (not CD-specific) is offered to family members and significant others of clients in treatment at the Addictions Unit. The group sessions are designed to provide support and information regarding recovery and the family's role in the process.

4. Evaluation/Outcome Data

The Addictions Unit program has not been formally evaluated at this time. However, several treatment outcome studies have been conducted. The results of one study[35] are described here.

At intake, the treatment group (depressed patients) had moderate to severe levels of psychiatric symptomatology, as measured by the Beck Depression Inventory, Hamilton Rating Scale for Depression, and Global Assessment Scale scores.

After six months of treatment at the Addictions Unit, on average:

- Clients' scores were in the mild-to-moderate range on all three measures.
- Clients demonstrated a 31.5% decrease in substance use (quantity x frequency).
- Clients demonstrated 60 days of continuous days of abstinence.

For more information on this program, contact: Gail Gauthier (Director) - 514-934-1934 ext.42396, ggaut5@po-box.mcgill.ca

[35] Integrated Treatment of Comorbid Depression and Substance Use Disorders. J Clin Psychiatry. 2001 Sep; 62(9):672-7.

Muskoka-Parry Sound Integrated Concurrent Disorders Service

Two separate agencies, Muskoka-Parry Sound Community Mental Health Service, and Addiction Outreach Muskoka Parry Sound, work in collaboration to provide a joint community-based assessment and treatment service for individuals with co-occurring mental health and addiction disorders. This service has been created out of the existing funding base provided by MOHLTC through internal re-structuring of existing services.

1. Organization and Service Delivery Setting

Muskoka and Parry Sound are two adjacent rural districts in Ontario, north of Toronto, covering an area of about 16 000 square kilometres. Addiction Outreach Muskoka Parry Sound (AOMPS) provides services such as substance abuse assessment and treatment for individuals across the two districts. Muskoka-Parry Sound Community Mental Health Service (MPSCMHS) is a multi-service agency that provides a variety of clinical mental health services such as intake, referral, 24-hour crisis mobile crisis services, counselling and education, supportive housing, intensive case management and Assertive Community Treatment (ACT) services.

In 1998, AOMPS and MPSCMHS established a joint working group to look at best practices and ways of integrating services for people who had concurrent disorders. In 2000, the group recommended a model of joint consultation resulting in an addiction worker sitting in with the ACT team to provide addiction consultations and a mental health worker sitting in with the addictions team to provide mental health consultations. Subsequently, when the Health Canada Best Practices document came out, the agencies recognized that they could move beyond this consultation model, and the concurrent disorders service grew as a joint initiative.

In order to serve those with co-occurring mental health and addiction problems, the two agencies formed a partnership whereby a mental health worker from MPSCMHS and an addiction worker from AOMPS pair up to deliver concurrent disorders (CD) services in each of the three main areas (Muskoka, West Parry Sound, and East Parry Sound).

Target Population: The CD service is for adults with identified or suspected concurrent substance abuse and mental disorders. (Because of the lack of psychiatrists in the region, consumers do not necessarily need a diagnosis to enter the program. Admission requires that a consumer either: a) have been screened and have been shown to have a mental health problem that requires further investigation or b) be an existing consumer with an identified mental disorder.)

Staffing: The program is supported and directed by a volunteer steering committee consisting of representatives from both agencies, community stakeholders and consumer/survivors. Direct clinical programs are created and delivered by six staff, three from Addiction Outreach and three from Mental Health. These 'Concurrent Disorder Specialists' provide direct clinical and treatment services, as well as clinical consultation to all areas of the agencies and to community partners.

2. Referral, Screening and Assessment

Referrals to the concurrent disorders service can come from the community, from new screenings, or from existing consumers. In 2002, a joint screening tool was developed so that a person who approaches either agency could be screened for both addiction and mental health concerns. The Mental Health screening tool was adapted to include a modified version of the CAGE and TWEAK. Mental Health Intake workers are required to ask about addictions and to record this. Similarly, at Addiction Outreach, mental health screening questions were added to the Addiction Severity Index. The idea of the joint screening was that regardless of which agency that the person walks in, either agency would be able to provide a screening to flag the concurrent disorders and to recommend them for joint service.

If the screening indicated possible concurrent disorders, the Intake worker would consult with the Concurrent Disorder Specialist. If the team decided that the consumer could benefit from the concurrent disorders service, the worker would complete a referral form that collects consumer history, and would send that, along with the completed screening tool, to the CD service. Once referred to the CD service, a consumer is put on a waitlist to join the next available Orientation Group. If the consumer is not appropriate for group service, they may also be put on a waitlist for individual counselling. If a consumer required service while waiting that would be provided by the crisis/intake team of MPSCMHS, or by AOMPS staff.

Enrolment in the program does not depend on having a psychiatric diagnosis. Because there are very few psychiatrists in the Muskoka-Parry Sound area, the majority of consumers have not been able to access psychiatrists and in some cases may not even have a family doctor. As a result, consumers enter the CD Orientation Group based on their screening, and from there may receive a psychiatric assessment from the consulting psychiatrist.

Psychiatric Assessment: Due to the shortage of psychiatrists in the Muskoka and Parry Sound regions, the agencies decided to bring in resources from the outside. As a result, all psychiatric assessments and consultations for the CD service are provided through video-conferencing: Once a week, a Toronto psychiatrist who has experience with concurrent disorders provides direct psychiatric assessment for consumers (i.e. consumers video-conference directly with the psychiatrist). The psychiatrist also provides consultation and supervision for staff through video-conferencing. Each main office has access to the same psychiatrist once every three weeks. If the consulting psychiatrist determines that a consumer needs to see a psychiatrist in person, that would be arranged, through with a visiting psychiatrist.

Pre-Group Assessment: Prior to attending the Orientation Group, all consumers must first have a Pre-Group Assessment to determine whether they are suitable for the group format. The assessment consists of a brief meeting between the facilitator and the consumer to identify concerns, explain the role and importance of the group and to determine the appropriateness of attending the Orientation group. Those who are not willing or able to attend the group are referred for individual assessment and possible treatment.

Orientation Group: All consumers who are appropriate attend the Orientation Group as soon as possible. The Orientation Group is an open-ended psycho-educational group that people can enter having only had a brief pre-group assessment (see Treatment Approach section for more detail). The reason for the quick assessment is that, once consumers say that they want help, the agencies want to move them quickly into a group rather than have them wait for treatment.

Joint Assessment: Following the 8-week Orientation group, consumers may choose to attend the Treatment group. Consumers who are not at the action stage, or are continuing to use substances may remain in the orientation group. If a consumer were at a stage where they are ready to move to the treatment group, then a full joint assessment would be done. The assessment, completed by both the addiction and the mental health worker together, consists of a complete psychosocial assessment including the administration of Ontario Ministry-mandated assessment tools[36], as well as the Global Assessment of Functioning (GAF).

Based on the assessment, the consumer and staff would jointly develop an individualized treatment plan. This plan is discussed and reviewed with the consumer and any other service providers involved in the consumer's

[36] See Appendix B for list of Ontario Ministry-mandated tools.

care. The treatment plan indicates if the consumer needs or wishes additional supports such as individual treatment or a psychiatric assessment. Usually one of the workers takes the lead and works with the consumer, with the other worker providing support and consultation.

3. Treatment Approach[37]

Consumers first attend an eight-week Orientation group. At the completion of this group, consumers may choose to attend a Treatment group, or remain at the orientation level. Consumers moving to the treatment group will receive an in-depth joint assessment. Following the 12-16 week Treatment group, the consumers will either graduate to a relapse prevention program or will repeat the treatment cycle. Consumers may also choose to go back to the orientation group.

Abstinence vs. Harm-Reduction: The service practices a harm reduction model. Abstinence is a desirable goal, but not a mandatory condition. The service strongly recommends abstinence coming into the orientation group, but does not require it. Non-prescription drug use and alcohol abuse is discouraged, but there is no judgment made on people who are choosing to cut back. However, consumers will not be allowed to participate if they attend group under the influence of substances.

Treatment Interventions

Orientation Group: In weekly open-ended Orientation groups, the Mental Health and Addiction workers present a variety of two-hour informational modules to consumers. During the eight-week cycle, the following topics are typically covered: Stigma; Depression; Substance Abuse - What is it?; Anxiety; Drug Classifications and Withdrawal Symptoms; Medications - Video Conferencing; Effects of Different Substances; Psychosis and Personality Disorders; Parallels between Mental Health and Addictions; Substance Induced Mood Disorders; Triggers (mental health and addictions); Alternative Approaches/Stress Reduction and Relaxation; and Effects on the Family.

Directed at those consumers who are considering making changes to their addiction use (Pre-contemplation stage), the major goals of these psycho-educational sessions are to provide information, to raise awareness, and to prepare consumers for treatment. Consumers are asked to provide feedback on the orientation group with regards to both content and presentation. This feedback is incorporated into the group process on a weekly basis. Consumers are encouraged to attend all sessions and can return to the group at any time should they decompensate or withdraw from treatment.

After the consumer has completed the eight-week Orientation group, the Mental Health and Addiction workers have a better understanding of the consumer, and the consumer has begun to develop a relationship with the staff. At this point, a Full Joint Assessment is completed to determine what stage the consumer is at in terms of their desire for change and their willingness to attend treatment. Following the assessment, the consumer and staff would negotiate the type of service that would be best suited to the consumer's preferences and Stage of Change.

The CD service is set up to meet the consumers where they are at and to move them toward treatment and recovery. The service recognizes that individuals will need a variety of supports and that they may be receiving the service at a variety of stages along the Stages-of Change continuum. If the consumer desires treatment and has moved to the Action Stage, the consumer may join the Treatment Group. Otherwise, he or she may have

[37] At the time this agency was interviewed, the CD program was very new and the first group of consumers was only halfway through the 8-week Orientation cycle and Treatment groups had not yet been run. The content of Treatment was still in development at the time of this writing. Therefore, the information regarding treatment and relapse-prevention represents the agency's *planned* activities.

individual counselling, and/or return to Orientation for further sessions. Each step in the process of recovery is jointly determined by the CD staff and the consumer.

Treatment Group: The closed-group treatment program ranges from 12 to 16 weeks. The program is very individually focused, psychodynamic, and consumer-centered. Sessions are generally structured and skill-based. During the weekly 1.5 to 2 hour sessions, staff work with individuals within the group while developing the group process. There are no pre-determined treatment modules or pre-set activities. Rather, the Treatment program is flexible so that staff can work with the needs that consumers present.

At the conclusion of the treatment group, the full joint assessment is completed again, including administration of the assessment tools, to determine where the consumer is at in their process of recovery. Once again, a discussion will take place and consumers will either graduate to a relapse prevention program or will return to the Treatment Group. Consumers may also choose to go back to the Orientation Group. Although the actual programs are time limited (the orientation groups are 8 weeks per cycle and the treatment groups are 12 – 16 weeks per cycle), a consumer may take as many cycles as needed or available. A consumer may stay involved as long as there is a need and this is identified by the assessment tools.

Relapse Prevention: Following completion of the Orientation and Treatment groups, or following individual treatment, the consumer may graduate to a relapse prevention group. The planning for this move is done by the CD staff and the consumer, based on the assessment tools that are included in the joint assessment and the stage wise planning process. Consumers may move rapidly back into the treatment process if required and may continue to attend orientation sessions, as desired.

Relapse Prevention: groups emphasise the peer support process and the idea of individuals finding their own meaning and purpose. The groups are open and ongoing peer-led, self-help support groups for those who have graduated from the CD service. Some facilitation is provided by staff. Consumers may continue in Relapse Prevention as long as they desire. In addition, consumers are encouraged to join the consumer's initiative on the mental health side and to join the addictions support network, which includes Alcoholics Anonymous (AA), and Narcotic Anonymous (NA), and Dual Recovery.

Individual Counselling: The treatment process includes both group and individual counselling as well as case management. If the CD worker discovers during the Pre-Group Assessment that the consumer is unable/unwilling to attend the Orientation group, the consumer can receive an individual assessment and treatment. This service option, however, is limited and a wait list may apply.

Family Services: All family members of CD consumers are invited to attend the Family Support Groups that are offered by both the addictions and mental health agencies. Addictions Outreach provides some family groups and individual support for family members. MPSCMHS offers some groups for family members based on the diagnosis of the consumer (i.e., family groups for bi-polar, etc.). MPSCMHS also offers a Wellness Support Group, which is family oriented. These groups, however, are not CD specific – to date, no need has been identified for a CD-specific family program.

Crisis Support Services: MPSCMHS offers a 24-hour, 7 day a week crisis support service. This service includes telephone support as well as mobile crisis services and on-call mental health consultation to other service providers (including hospital emergency departments). Consumers that are admitted into the CD service are provided with information about the 24-hour crisis service and are given the crisis number.

Crisis Management Guidelines: The Crisis Management Guidelines are a part of the treatment plan. These guidelines are completed in conjunction with the consumer and are forwarded to the crisis support service to be included in the on-call kits. These guidelines are there to provide direction and information to the crisis worker should the CD consumer call after hours in a crisis situation.

Pharmacological Treatment/Medication: All consumers that are accepted into the CD service have access to a psychiatric consult (through teleconferencing, usually) with a psychiatrist who is experienced in concurrent disorders. This consult will review medical and pharmacological issues and will share this information with the family General Practitioner, if there is one available, who can provide medical prescriptions. MPSCMHS also has a psychiatrist and General Practitioner on staff in Muskoka who may provide medical supervision and consultation to the teams in Muskoka.

Linkages: Consumers who are admitted to the CD service may also be in a wide variety of other treatment streams including Intensive Case Management or ACTT. These consumers may continue in these streams while receiving CD treatment. A consumer in the concurrent disorders service can access any of the services of the partner agencies. Consumers may also participate in MPSCMHS groups that are geared toward increasing socialization and recreation.

There are no local withdrawal-management facilities for consumers needing more intensive addictions or mental health services, referrals are made to the Royal Victoria Hospital in Barrie, the Jean-Marie Hill Programs or Nippissing Detoxification and Substance Abuse Programs in North Bay, the North Bay Psychiatric Hospital, the Penetanguishene Mental Health Centre, and Georgianwood, which is a residential 28-day treatment program in Penetanguishene.

4. Evaluation/Outcome Data

Muskoka-Parry Sound's joint concurrent disorders service has not been formally evaluated.

For more information on this program, contact: Pat Walker (Director – Addictions Outreach), 705-645-1311, p.walker@on.aibn.com*. Or contact: Geoff Reekie (Core Program Area Manager – Muskoka P-S Community Mental Health Service), 705-746-4264 ext. 223,* reekie@mpscmhs.on.ca

Phoenix Residential Society – Westview Dual Diagnosis Program

The Westview Dual Diagnosis program provides psychosocial rehabilitation and addiction services in a supervised apartment for adults with serious and persistent mental illness who have ongoing substance abuse issues. Westview provides comprehensive services which meet the psychosocial, medical, housing and financial needs of their clients.

1. Organizational and Service Delivery Setting

The Westview Dual Diagnosis Program is one of five programs managed by Saskatchewan's Phoenix Residential Society, a community-based organization that provides a combination of assertive community treatment and housing/community supports. The Phoenix Residential Society started in 1977 with the opening of the Phoenix House and has grown from a service for seven residents to one that provides supported housing for over one hundred residents. The Dual Diagnosis program has been in operation since January 1993 (before the term 'co-occurring' was in use) and is located in an apartment building referred to as "Westview". The program operates on a 24-hour on-site staffing model. As a program of the Phoenix Society, Westview clients have access to all of the other programs and services provided by the Society.

Target Population: The program is geared to men and women with serious and persistent mental illness who have ongoing substance abuse issues that severely impact on their mental health and their ability to function in the community. Clients of Westview typically have schizophrenia, schizoaffective disorder, or bipolar disorder, and most of them have a personality disorder as well. In addition, the majority of clients meet the criteria for 'chemically dependent'.

Staffing: Program staff at Westview are trained professionals with formal backgrounds in psychiatric nursing and addictions. Their training is supplemented by additional courses relevant to their work with dually diagnosed clients.

2. Referral, Screening and Assessment

All of Westview's referrals come through the Rehabilitation Services side of the Regina Mental Health Clinic. Clients of Rehabilitation Services typically have had repeated hospitalizations or crises over a period of two year, as well as ongoing difficulties managing in the community and a lack of a support system. Prior to referring clients to Westview, the Regina Mental Health clinic will have already completed screening for the mental disorder. In addition, every client will have already had a psychiatric assessment and a comprehensive needs assessment, which is used to develop a community support plan. A community support plan includes a client's goals in terms of their mental health, financial, family, vocational, housing, and physical health. The Clinic will also do addictions screening and, if a client has a serious and persistent mental illness, and their case manager notes that alcohol and drug use is a prominent problem in this person's life, then the client would be referred to the Westview Dual Diagnosis program.

Once Westview is given the client's referral information, including their community support plan and the psychiatric assessment, they look it over, and if it seems like the person is a suitable candidate, then a meeting is set up with the client and their case manager or referring person. Westview staff, the client, and the client's case manager work together to develop an Individual Program Plan - to set their goals in terms of what they want to work on while they are at Westview. The case manager coordinates outside services, such as vocational or psychiatric services.

Westview completes their own assessment of the client, including a comprehensive interview and administration of the SASSI, the ICD-10, the MAST, the DAST, and sometimes an instrument known as the 20

Questions, and the DSM-IV questions. If a criminal record check is required, it will be requested. In addition, a medical exam will be set up or medical records will be acquired.

During this time, the client must fill out an application to the Westview program. Each application is carefully assessed by an Admissions Committee that meets monthly to review the referrals and to decide whether or not the person is appropriate for placement. To be accepted, a client must have goals consistent with what the program can offer them. In addition, clients need to be willing to set a goal of abstinence, give urine screens, and participate in the majority of programming. The client must also be under the care of a psychiatrist in the Regina region.

Because Westview only has ten residential spots, and clients typically stay three to five years[38], the program does not have vacancies very often. When a client has been approved for admission, they are put on a waiting list, which may last several months. However, clients on the waiting list can receive treatment by attending some of Westview's programming on an outpatient basis.

3. Treatment Approach

The Westview Dual Diagnosis program addresses both mental health and substance abuse issues in all areas of their programming. Residents of the Westview program are required to attend a number of structured activities throughout the day. Treatment is not broken into phases or stages. All residents follow a similar program, the main structure of which is described below.

Abstinence vs. Harm-Reduction: The program is viewed as long-term with the goal of achieving abstinence. Although clients do not need to be abstinent to enter the program, they must set a goal of abstinence upon moving in to the residence. Harm-reduction in terms of substance use is not encouraged. However, Westview staff realise that relapse is part of the recovery process and will work with clients who are using substances. For example, Westview often uses in-house withdrawal management when clients are 'slipping'.

Structured Activities

Mornings: Clients get up at 9:00a.m., take their medication and head to the Monday to Friday 'circle check", or 'A.M. reflection group', where they perform or listen to a reading from one of the daily reflection books and also pick an affirmation from the 'affirmation basket'. The group members then discuss their chosen affirmations and their thoughts on the reading. Following this, clients discuss how they are feeling and what have they been thinking and doing for the past 24 hours. Next, everyone is asked to set a goal for something they want to work on for the day, and staff participate in that process. Then, from 10:30a.m. until about 11:30a.m or noon, for those that do not have appointments or are not working or involved in something, there are morning groups.

Afternoons: In the afternoons, clients are free for meetings or for just 'doing their own thing'. If they are not involved in anything else, Westview encourages them to take part in social groups like the 'mental health coffee club'.

Evenings: At 5:00p.m., there is an 'action group', which is essentially a touch-base group. The staff will, once they have done shift change, seek out each resident and check in to see how they are doing. Staff focus on independent living areas. For example, if it looks like a client has not bathed or eaten today (clients prepare their own meals),

[38] When the Westview program was being developed, the research indicated that three to five years was how long it takes to really stabilize a person with serious and persistent mental illness who also has addiction disorders.

they assess the priority for that person for the day and encourage them and follow it up in the evening. Later in the evening, there is always something structured, such as dual diagnosis AA meetings, GA meetings, groups, or a movie night.

Treatment Interventions

Independent Living: Through group and individual work, residents are offered assistance with a number of areas, including:

Financial (trusteeship; budgeting/money management; and shopping/bill paying);
Independent Living Skills (apartment maintenance; laundry; menu planning/grocery shopping; meal preparation; medication management; personal appearance/hygiene; and relationships with others); and,

Physical and Emotional Health (leisure/recreational activities; expanding use of community resources; increasing social network; employment/educational resources; time management; and planning daily activities).

Addiction services: Residents of Westview can access a number of outside addiction-related treatment services, including outpatient day programs at Alcohol and Drug Services and withdrawal management at local Detoxification Centers, inpatient treatment centres like MACSI, Calder Centre, or Alcohol and Drug Services. In addition, Westview provides its own in-house withdrawal management for some clients.

Mental Health Services: Clients are required to have their own psychiatrist (either a private psychiatrist or one at the Mental Health Clinic) before being admitted to the program. Once the client is in the program, Westview staff attend appointments and work together with the client and their psychiatrist. The case manager facilitates the communication between parties if a client is not doing well or if there are concerns.

Individual Counselling: Each resident has a key worker with whom they meet once a week to review their treatment/program plan and to discuss how they are doing. The program plans are reviewed once a month by a team comprised of the program supervisor, the key worker and the resident, and if possible, the case manager attends.

Groups: Westview conducts four groups: the Choice Theory Group, the Addiction Recovery Group, the Symptom Management Group, and the Social Skills Training Group. Two of those are in the morning and two of them are in the evening. The groups, which occur once a week and last about 60 minutes, all center on skills training and psycho-education. They teach the residents choice theory through the group. In the Addiction Recovery Group, they teach a lot of step work and recovery plans and how to establish and develop those. The Social Skills Training Group and Symptom Management Group are about learning skills to function in the community, to manage their symptoms, to problem solve and to communicate.

Linkages to Resources: Residents of Westview can be linked to a number of resources, including:

Social: There is an AA Club House in the city where program residents drop in for coffee once a week. The club also hosts speaker meetings and sometimes dry dances.
Vocational: There are some vocational programs at the Work Preparation Centre and Sask-Abilities Council. The Mental Health Association also has a vocational program and a recreational drop-in centre.
Food: The Good Food Box Program is a community wellness program. Clients are taken to a food bank on Wednesdays. On Thursdays, the Westview program offers a one-to-one cooking time lesson for residents who want to learn how to make a specific dish.

Family Services: Westview does not offer any specific programs for family. However, if a resident has contact with their family, their involvement is encouraged. If the resident wishes, family may attend program planning sessions, weekly meetings, or recreational events.

Discharge and Follow-up: Discharge planning is individualized and dependant on where the client is at and what resources a client has in the community. It is deemed that most Westview clients will always need significant follow-up in order to maintain themselves. Therefore, Westview has an outreach program to keep contact with clients. When possible, Westview links clients to other Phoenix programs. Phoenix has an apartment living program, and also has Phoenix Housing and Supported Services (PHASS), a program for the 'difficult to serve'. If there are vacancies, Westview will refer clients to these programs, who then try to engage clients back into some sort of more structured programming or back into receiving services.

4. Evaluation/Outcome Data

The Westview Dual Diagnosis program has not been formally evaluated at this time.

For more information on this program, contact: Anne-Marie Piniach (Program Supervisor), 306-569-1977, phoenixsociety@accesscomm.ca

DISCUSSION AND CONCLUSION

DISCUSSION

The main goal of this project was to identify and describe a range of treatment and support programs available to individuals living with concurrent disorders (CD). The programs described in this report demonstrate the wide diversity of programs being offered in both Canada and the United States, and reflect the broad array of treatment possibilities that exist for helping people who are experiencing CD. We began the project intending to focus only on specialized CD programs. However, as we proceeded, we found it was not possible to locate a wide range of Canadian programs that fit our selection criteria. Consequently, a few of the programs described in this report do not restrict their services only to those with CD. Nonetheless, the non-CD exclusive programs were included because they treat a specialized population (e.g. Aboriginal or Youth) and because we wanted to maximize our representation of relevant Canadian programs.

The 15 programs differ considerably on many levels: some programs provide treatment to a very specific population, while others provide treatment to a wide range of clients. Some programs are well resourced, while others make do with very little. Some are in rural areas, while others are in metropolitan cities. Some are short-term, while others involve people for several years. Some are residential, some non-residential. Some programs have been running for many years, while others are treating their first group of clients. The fact is that there are more differences between these programs than similarities. As a result, the following discussion will not compare and contrast individual programs. Rather, it will highlight overarching characteristics of programs as well as specific program components that may be of interest to the reader.

Program Characteristics

Integration of Treatment and Support Services: The programs described in this report portray both program and system-level integration of treatment for concurrent disorders. Some agencies offer parallel, yet separate, treatment for substance abuse and mental illness. Some agencies offer treatment that deals with both issues within every group or every interaction with the client. Some agencies have both a mental health worker and an addictions worker facilitate each group. Other agencies employed fully cross-trained clinicians.

For those agencies with few resources, integration at the program level is not always possible. One program cannot always provide every level of treatment to every client. However, combining resources through system-level integration can allow smaller and/or less-funded agencies to provide a broader array of services to their clientele. The programs described in this report share resources or partner in a variety of ways: by pairing two workers with differing backgrounds to facilitate one group; by combining resources of mental health and addictions agencies; and by developing relationships with outside providers of services such as withdrawal management, psychiatric assessment, or employment counselling to provide seamless transitions among services needed by the client.

Program Development has Moved Beyond the Focus on SMI: Much of the early work in CD was focused on developing and evaluating integrated treatment models for people with severe and persistent mental illness. It is clear that specialized programs for concurrent disorders have evolved well past this early 'dual diagnosis' population. For example, the programs focusing on trauma issues and the program focusing on personality disorders in a prison population demonstrate this expanded model of treatment for concurrent disorders.

Staffing: We were not able to obtain staffing breakdowns for all programs. In addition, due to overlapping responsibilities of staff, some agencies had difficulty separating the staff of their CD program from the larger

agency's staff. As a result, some of the programs appear to be better-staffed than others because their clients have access to the staff of the larger agency (e.g. vocational specialists, psychiatrists, etc.).

Overall, the staff of most CD programs work in multidisciplinary teams made up of Master's-level clinicians who specialize in either addiction or mental health, or who are cross-trained in both areas. It is important to note that all programs have linkages to psychiatric resources, either internally or through consultation.

Many program managers reported that their staff is the critical ingredient which makes the program successful. Staff who share the same philosophies and who work well as a team are better able to foster partnerships between agencies or internal service units, and are seen as one of the most important factors in achieving good outcomes.

Target Population – Mental Illness: Some programs specifically target those with serious and persistent mental illness (SMI), while others accept a broader range of diagnoses. All programs accept clients with an Axis I diagnosis. Very few programs accept clients with an Axis II disorder. The majority of programs establish or confirm a client's diagnosis prior to program entry. However, there are a few programs that either do not require an established diagnosis to enter the program, or do not consider having a formal diagnosis a priority for program admission, sometimes leaving it until after other client needs had been attended to. These programs tend to be the programs that service a select sub-group of individuals, such as Aboriginal youth, homeless individuals, or abused women with children. Although some programs offer specialized treatment groups for those with certain diagnoses (e.g. chronic pain or schizophrenia), all programs place the majority of their clients in the same group, regardless of the client's diagnosis.

Target Population – Substance Abuse: Although the concurrent disorder programs often target individuals with specific mental disorders (e.g. PTSD, SMI), none of the programs described here target specific addictions or substances of abuse. Only one program offers a separate group for those with a gambling addiction. As a result, people who are abusing alcohol, cocaine, cannabis, and/or opiates are all included in the same program and all receive the same treatment.

Setting: The majority of CD treatment is either residential or community-based. Few agencies offer day treatment. Only one Canadian program described in this report offers residential treatment; whereas, almost all of the U.S. agencies offer residential services. This may reflect the differing sizes of the programs selected from the two countries.

The selected CD programs are equally likely to be housed in addiction agencies as in mental health agencies. A few CD programs involve partnerships between the two types of agencies, while other agencies specialize in both addiction and mental health services.

Screening and Assessment: Since most of the programs included in this project are specialized CD programs, many of the clients coming into the program have been screened for CD. However, the focus of the programs is more on assessing the nature and complexity of the client's problems than screening for case identification per se. American programs often apply ASAM admission criteria based on substance abuse/dependence. Some programs screen only through a brief telephone interview (i.e. they ask a few questions) and then schedule clients for assessment if there is reason to suspect concurrent disorders. A wide variety of tools are used, many being sub-scales of larger instruments (e.g. psychiatric subscale of the Addiction Severity Index); others are using a combination of mental health and addiction measures.

The assessment instruments used by programs are varied: some programs use only a standardized government-approved set of instruments; some use the same set of instruments on all agency clients, regardless of

the requested service; many programs developed their own assessment tools or adapted standardized tools to be more appropriate for assessing concurrent disorders.

As noted earlier, almost all CD programs seek to establish or confirm clients' diagnoses prior to the start of treatment. Some wait to establish a deeper rapport with clients before conducting diagnostic-oriented assessments. All programs have access to psychiatric resources for diagnostic purposes. Some employ staff psychiatrists or Licensed Social Workers (U.S. programs often use these professionals to provide diagnosis). Other programs have psychiatrists available for consultation, either in person or through video-conferencing.

Harm-reduction vs. Abstinence Philosophies: Residential programs (including jail/prison), hospital-based programs, and programs based in addictions agencies tend to require abstinence from clients while in treatment. Programs based in mental health agencies tend to be more harm-reduction (non-abstinence) focused. A slim majority of both American and Canadian agencies favour non-abstinence philosophies over abstinence.

Outreach: Few programs practice client outreach. However, for those programs targeting homeless clients, the level of proactive outreach is very high. These programs provide proactive outreach by picking up and transporting clients to groups. They also have staff who meet clients in the community and offer practical assistance.

Groups: Treatment for concurrent disorders at all agencies is heavily group-based. Some agencies only offer one group, whereas others offer many groups. Several agencies have stage-based treatment, so they organize groups along these stages. Many programs match their treatment stages closely to the Stages of Change model (e.g. Persuasion stage vs. Active treatment stage), others combine individuals at different stages into one group, and still others refined the Stages of Change to create sub-stages. Some programs with stage-based treatments followed other models altogether (e.g. levels, phases, or milestones) which are not based on the Stages of Change per se, but rather are based on the intensity of treatment. For example, some agencies start with residential and/or full-time treatment and work towards decreasing program contact; whereas, other models require increased program participation as individuals progress through the phases of the program.

Individual Counselling: The majority of programs supplement group treatment with individual counselling. The frequency and duration of this varies greatly, from ongoing weekly appointments to brief short-term therapy. Often weekly therapy is combined with case-management. Few agencies offer intensive one-on-one therapy as part of their CD program. Rather, clients are more likely to be referred to other internal or community resources for individual counselling.

Family Services: About half of the programs offer services to family members of clients with concurrent disorders. The majority of these programs offer psycho-educational and/or support groups in which caregivers and friends can support each other, learn about the symptoms and effects of mental illness and of substance use and abuse, and learn about the challenges that clients face. A few agencies offer couples or family therapy, but this therapy is not specific to clients in CD programs.

Self-help Groups: Many of the programs either host a self-help group (A.A., N.A., or Double Trouble) or encourage clients to attend one in the community. Two of the programs consider attendance at a self-help group a program requirement.

Social Outings: About half of the programs offer clients the opportunity to socialize with others at substance-free events. This is accomplished through a variety of means, such as sobriety dances, clubhouses, Alumni groups, or group outings.

Follow-up and Discharge: The majority of programs develop an aftercare plan with clients and ensure that clients are connected with needed services prior to the end of treatment. Some provide in-person or telephone follow-ups. All of the residential programs offer help with community re-integration, including help accessing social assistance, housing and employment. In addition, many residential programs offer less intensive follow-up services in the form of a halfway house or supervised independent living. Residential programs encourage clients to continue accessing help through community treatment and support. A small number of agencies offer continuing care groups or Alumni groups for those who have finished treatment.

Adaptability and Innovation: Many programs are offering innovative services, such as: providing meals and on-site childcare; allowing clients to access treatment while 'under the influence'; paying for clients' housing; accessing psychiatric expertise through video-conferencing; and, providing treatment at the clients' places of residence. These are only a few examples of how programs demonstrated the flexibility needed to respond to the complex needs of people with CD.

Linkages to Services and Resources: The majority of programs have developed a range of inter-agency partnerships. Almost all of those interviewed said that they need to go beyond their own program to provide a comprehensive package of services, including supplementary addictions treatment (e.g. withdrawal management), counselling, psychiatric, social, housing, and employment services. About two-thirds of the programs provide clients with case managers who coordinate treatment and provide linkages to other needed services and resources. Linkage to housing is particularly important and about half of the programs supply clear supports to help the clients find, and/or apply for housing. In fact, one program stated that finding housing is their first goal, and that they will pay for a client's housing, if needed. A more common strategy is to have case managers or housing workers assist clients with housing searches and support.

Linkage to employment support is another important feature and many of the programs have an employment/vocational specialist or have access to an employment/vocational service to help clients with job searches, provide assessment of their skills, or facilitate access to needed education or skills training. A few of the agencies require their clients to work, volunteer, or attend classes while participating in their program, and provide full support for their clients to that end.

CONCLUSION

Our objectives here were to examine the current situation regarding CD programs in Ontario and other jurisdictions, and to identify a menu of program ingredients that others may find helpful. Although the available resources and resulting project scope did not allow for broad generalizations about the current "state-of-the-art" in CD programs in the US and Canada, we feel we have been largely successful in showing the diversity of program models that currently exist. Notwithstanding our cautions about the representativeness of our selected programs, our assessment of the current situation in Ontario, and Canada generally, is more exhaustive than that in the US, given the comparatively few CD programs in Canada. We are hopeful that more programs will be developed in Canada over the coming years and, further, that this project may contribute to some program ideas and innovative replications appropriate to the Ontario and Canadian context.

We conclude by commenting on the role of research and evidence-based practice in future program development. In part, due to the complexity and mix of different disorders and sub-populations, we feel the CD

field is some distance from reaching the point of having a full menu or tool-kit of evidence-based practices. Progress in this area will require a close relationship between researchers and community practitioners in developing good research questions, accessing research grants and translating the findings into effective practice. In some respects, our US counterparts appear to be ahead of us, both in terms of incorporating evaluation practices into their service delivery models and funding and testing out different dissemination and knowledge transfer strategies. To help guide future development of evidence based CD programs in Canada, additional investment in evaluation research and knowledge transfer will be required.

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APPENDICES

APPENDIX A: Interview Guide

INSTRUCTIONS

Please provide us with information specific to your CD program, rather than information regarding the larger agency.

1. Please describe the organization and service-delivery setting of your CD program (e.g. hospital, community, justice, etc).

SCREENING AND ASSESSMENT

2. Please describe the procedures, protocols, and requirements for *referrals* to your CD program:

3. Please describe your CD program's *screening* procedure:

4. Please describe your CD program's *assessment* procedure:

5. Does your CD program's assessment process include determination of *psychiatric diagnosis*?
   a. If not for diagnosis, please explain why not:

6. Does your CD program refer out for *diagnostic* assessment or conduct it in-house?

7. How long does it typically take for your CD program to get an assessment for a client?

8. Are both Mental Health and Substance Use assessments conducted by the same clinician?
   If not, please explain:

7. What is the frequency of re-assessment for longer-term clients?

ADMISSIONS

10. Please describe your CD program's admission criteria:

11. Does your CD program use standardized admission criteria for substance abuse and mental illness (e.g. for Ontario, using Admission and Discharge Criteria)?

12. Does your CD program require clients to be abstinent prior to treatment? If yes, describe:

THERAPEUTIC TREATMENT SERVICES

13. Does your CD program have specialized components for any of the following sub-populations?
    a. No special sub-populations
    b. Youth? YES or NO (if YES, please specify age range:)
    c. Elder? YES or NO
    d. Women? YES or NO
    e. Specific ethnic/cultural background/language? YES or NO
    f. Aboriginal? YES or NO
    g. Homeless? YES or NO
    h. Gay / lesbian / bisexual / trans? YES or NO
    i. Survivors/abused? YES or NO
    g. HIV / AIDS? YES or NO
    h. Criminal justice? YES or NO
    i. hysically disabled? YES or NO
    g. Other? Please describe:

14. Please describe your CD program's therapeutic treatment activities in terms of the following categories. If your program provides specialized components for any of the above sub-populations, please also describe the unique services you provide to each group.
    a. Groups (type, duration and frequency):
    b. Individual counselling (type, duration and frequency):
    c. Education (re: mental illness and substance abuse):
    d. Skills building:
    e. Vocational or employment:
    f. Self-help groups:
    g. Pharmacological treatment/medication:
    h. Relapse prevention:
    i. Other:

15. Is there a specific *structure* to program activities that all clients must follow (for example, daily activities or compulsory components)? Please describe:

16. To what degree does your CD program's services and treatment/intervention match evidence-based practices? Please provide examples:

17. Are your CD program's services time limited or unlimited? If limited, please describe:

18. Please describe any criteria that clients must meet in order to remain enrolled in your CD program (i.e. not get discharged—e.g. must remain non-violent, abstinence level, relapse equals discharge or transfer to another program, etc).

19. Please describe the level of integration of mental health and substance abuse services in your CD program.

20. Does your program use a harm-reduction approach? If so, what specifically does this involve?

21. Do you develop an explicit individualized therapeutic treatment and support *plan* consistent with each client's assessment and needs? Please describe:

22. What are the critical components of a typical therapeutic treatment and support plan?

23. How are they documented?

24. How often is the treatment and support plan reviewed?

25. How do you incorporate client preferences into the services your program provides?

26. Do you develop a *crisis plan* with clients for both Mental Health and Substance Abuse related crises? Please describe:

27. What provisions does your CD program provide for *family* members?

28. What treatment *philosophies* are incorporated into your CD program?

29. Please describe your CD program's philosophy regarding *abstinence* (for example, required abstinence from all non-prescribed drugs or abstinence from identified problem substance (e.g., cocaine) and reduced use of other substances (e.g., alcohol).

30. Please describe any *linkages* your CD program provides to needed resources such as food, employment, and housing.

GROUPS (If applicable)

31. Do you mix Mental Disorders within a group?

32. Do you mix Substance Use Disorders within a group?

33. What is the minimum and maximum number of people you have in a group?

34. Are your groups to be led by only one therapist?

35. How long do groups last each week?

36. How long do groups last each cycle?

37. Do you encourage socialization outside of group (extra-group socializing)?

38. Are groups open or closed?

DISCHARGE

39. Please describe your CD program's discharge planning process:

40. Please describe your CD program's discharge criteria:

41. Does your CD program use standardized discharge criteria for substance abuse or mental illness (for example, the Admission and Discharge Criteria)?

42. Please describe your CD program's *follow-up* practices (after discharge) in the following areas:
    a. Self-help groups:
    b. Linkages to other agencies:
    c. Crisis plan:
    d. Relapse prevention:
    e. Telephone follow-up:
    f. Medical/psychiatric follow-up:
    g. Other:

SYSTEM RELATIONSHIPS

43. Please describe the nature and type of formal and informal *linkages* between your CD services and other programs and services within your organization, within the community and throughout your region:
    a. within your organization:
    b. within the community:
    c. throughout your region:

44. If more than one agency is involved, do you have formal or legal arrangements or service agreements?

OTHER

45. Define "program success" for your CD program:

46. Define "client success" for your CD program:

47. How do you monitor program effectiveness?

48. Does your CD program monitor client outcomes? If so, please describe the methods for tracking outcome data, the frequency and type of data, and whether you are using standardized outcome measures:
    a. Methods for tracking outcome data:
    b. Frequency and type of data:
    c. Using standardized outcome measures?

49. What do you do with outcome data?

50. Does your CD program collect data regarding service use, client attendance, relapse rate, retention rate, or program completion rate?
    a. Service use
    b. Client attendance?
    c. Relapse rate?
    d. Retention rate?
    e. Program completion rate?

51. May we have copies of the data?

52. Has your CD program been formally evaluated? May we have a copy of the report?

53. What methods of quality improvement has your CD program implemented?

FINAL WORDS

54. Of the things your CD program does, what achieves the best outcomes? In other words, what critical ingredients make a difference?

55. On what basis do you say this?

56. If you could improve or re-design your CD program, what would you do?

THANK YOU VERY MUCH!

APPENDIX B: Screening and Assessment Instruments Referenced in the Report

The following is a list of the screening and assessment tools referred to in the report, including a brief description and information to obtain the instrument..

Note: The authors do not necessarily recommend nor endorse any of these instruments because they may have not been validated, or may have not been validated with CD populations.

1. Adolescent Drug Abuse Diagnosis (ADAD)

The ADAD is a 150-item structured interview that looks at the following content areas: medical status, drug and alcohol use, legal status, family background and problems, school/employment, social activities and peer relations, and psychological status. The interviewer uses a 10-point scale to rate the patient's need for additional treatment in each content area. These severity ratings translate to a problem severity dimension (no problem, slight, moderate, considerable, and extreme problem). The drug use section includes a detailed drug use list and a brief set of items that looks at specific areas of drug involvement (e.g., polydrug use, attempts at abstinence, withdrawal symptoms, use in school). Psychometric studies on the ADAD, using a broad sample of clinic-referred adolescents, provide favorable evidence for its reliability and validity (Frideman & Utada, 1989). A shorter form (83 items) of the ADAD intended for treatment outcome evaluation is also available. [description taken from http://www.drugstrategies.org/teens/screening.html]

Availability: This instrument is in the public domain. View PDF version at: http://adai.washington.edu/instruments/pdf/ADAD.pdf

Reference:

- Friedman AS, Utada A. (1989). A method for diagnosis and planning the treatment of adolescent drug abusers: the Adolescent Drug Abuse Diagnosis [ADAD]. *Journal of Drug Education; 19(4):*285-312.

2. Adverse Consequences of Drug Use

This eight-item instrument provides a checklist of consequences (e.g., emotional, physical, financial) that can be used to assess the adverse impact that substance use (i.e. alcohol and other drugs combined) is having on a client.

Availability: Developed by the Centre for Addiction and Mental Health (CAMH), 33 Russell Street Toronto, Ontario, Canada M5S 2S1, Tel: 1-800-661-1111

3. Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organization to identify persons whose alcohol consumption has become hazardous or harmful to their health. AUDIT is a 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol. [description taken from http://www.niaaa.nih.gov/publications/audit.htm].

Availability: Copyrighted by Thomas Babor and the World Health Organization. Test and manual are free; training module costs $75 Source: View HTM version at:
http://www.niaaa.nih.gov/publications/insaudit.htm
For ordering and pricing information, contact: Programme on Substance Abuse, World Health Organization, 1211 Geneva, Switzerland. E-mail: Publications@who.int. Or: Thomas F. Babor, Alcohol Research Center, University of Connecticut, Farmington, CT 06030-1410 USA.

References:

- Babor TF ; de la Fuente JR ; Saunders J ; Grant M. *AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care*. Geneva : World Health Organization, 1992.
- Saunders JB ; Aasland OG ; Babor TF ; de la Puente JR ; Grant M. (1993). Development of the Alcohol Use Disorders Screening Test (AUDIT). WHO collaborative project on early detection of persons with harmful alcohol consumption. II. *Addiction, 88*:791-804.

4. American Society of Addiction Medicine (ASAM) Patient Placement Criteria-IIR

See Appendix C

5. Addiction Severity Index (ASI)

The ASI is a semistructured interview designed to address seven potential problem areas in substance abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. In 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. The ASI provides an overview of problems related to substance, rather than focusing on any single area. [description taken from http://www.niaaa.nih.gov/publications/asi.htm]

Availability: This instrument is in the public domain. View PDF version at:
http://www.niaaa.nih.gov/publications/asi.pdf. Also available from DeltaMetrics/TRI ASI information line: 1-800-238-2433

References:

- McLellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E. (1980). An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *J Nerv Ment Dis 168*:26-33.
- McLellan, A.T.; Kushner, H.; Metzger, D.; Peters F.; et al. (1992). The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat, 9*:199-213,

6. The Behavior and Symptom Identification Scale (BASIS-32)

BASIS-32 is a client self-reporting tool designed to help assess clients' symptoms, concerns and problems. The 32-item questionnaire is divided into five major areas of difficulty: relation to self/others, daily living/role functioning skills, depression/anxiety, impulsive/addictive behaviour and psychosis. This is a screening tool to determine the need for further psychiatric assessment. The Basis-32 does not provide a diagnosis. The tool measures functioning in various life areas for the previous seven days.

Availability: As the copyright holder of BASIS-32®, McLean Hospital offers an annual site license for psychiatric and mental health providers and organizations. The annual fee for an end-user site license is based on the number of locations at which the BASIS-32® will be administered. You may download the License and Registration forms from this website: http://www.basis-32.org/survey/license.html. If you need more information, call (617) 855-2424.

To view a copy of the survey, see: http://www.basis-32.org/survey/viewsurvey.html

7. Beck Depression Inventory (BDI)

The Beck Depression Inventory is a 21-item test presented in multiple choice format which is used to measure presence and degree of depression in adolescents and adults. Each of the 21-items of the BDI attempts to assess a specific symptom or attitude associated with depression, that association being consistent with descriptions of the depression contained in the psychiatric literature. Although the author, Aaron T. Beck, is primarily involved with the development of the cognitive theory of depression, the Beck Depression Inventory was designed to assess depression independent of any particular theoretical bias. [description from http://adai.washington.edu/instruments/BDIinfo.htm]

Availability: The BDI questionnaire is copyrighted by The Psychological Corporation.

Ordering: The Psychological Corporation, Canada , 55 Horner Avenue, Toronto, ON, Canada M8Z 4X6, Tel: 1-800-387-7278 or www.psychcorp.com

Reference:

- Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561-571,

8. Brief Symptom Inventory (BSI)

The Brief Symptom Inventory (BSI) is designed to reflect psychological symptom patterns of psychiatric and medical patients. This self-report is the short form of the SCL-90-R instrument. Like the SCL-90-R instrument, the BSI instrument can be useful in initial evaluation of patients at intake as an objective method of screening for psychological problems. The BSI instrument is especially appropriate in clinical situations where debilitation results in reduced attention and endurance, in research with limited interview schedules, and in outpatient clinics where testing procedures demand brevity. The BSI instrument is also frequently used in measuring patient progress during treatment or in the assessment of treatment outcomes. [description taken from http://www.pearsonassessments.com/tests/bsi.htm]

Availability: Use of this instrument is regulated by Pearson Assessments. Pearson Assessments, US: 800-627-7271, ext. 3225, Canada: 800-268-6011, pearsonassessments@pearson.com

Reference:

- Derogatis LR & Melisaratos N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13(3)*:595-605.

9. Brief Child and Family Phone Interview (BCFPI)

The Brief Child and Family Phone Interview is a 1/2 hour structured, computerized Intake interview which asks Mental Health questions regarding common behavioural and emotional problems. It then provides 10 standardized scores whereby the subject child can be compared to the average child in Ontario, matched for age and sex. The six core domains correspond to DSM IV-R diagnostic categories, and provide a screening indication of the likelihood that the child would warrant the corresponding diagnosis if clinically assessed (www.bcfpi.com/bcfpi/about.html).

Availability: ©BCFPI Inc. 2004 - c/o Peter Pettingill, 469 Campbellville Rd., RR#2 Campbellville ON, Canada, L0P 1B0. Tel: (905) 659-0800. E-mail: info@bcfpi.com

10. Buss-Durkee Hostility Inventory (BDHI)

The Buss-Durkee Hostility Inventory (BDHI) is a self-rated multidimensional scale of hostility utilized to determine a participant's skills in anger management. http://www.hamfish.org/measures/b/instruments/25/

To view the inventory, see: http://otel.uis.edu/yoder/bussdurk.htm

Ordering: Educational Testing Service Test Collection, ETS Tracking Number: TC009426, Rosendale and Carter Roads, Princeton, New Jersey 08541. Tel: (609) 734-5689 (http://www.ets.org/testcoll/)

Reference:

- Buss, A. H. & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Consulting Psychology, 21*, 343-349.
- Velicer, W. F., J. M. Govia, et al. (1985). Item format and the structure of the Buss-Durkee hostility inventory. *Aggressive Behavior 11*: 65-82.

11. CAGE

The CAGE is a 4-question, relatively non-confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. [description taken from http://www.niaaa.nih.gov/publications/cage.htm]

Availability: ©1974, the American Psychiatric Association. View HTML version on the NIAAA web site at http://www.niaaa.nih.gov/publications/inscage.htm

For ordering and pricing information, contact: Shevona Hicks, American Psychiatric Publishing, Inc., 1400 K Street, NW, Washington, D.C. 20005, E-mail: shicks@psych.org

References:

- Mayfield, D.; McLeod, G.; and Hall, P. (1974). The CAGE questionnaire: Validation of a new alcoholism instrument. *Am J Psychiatry 131*:1121-1123.
- Ewing, JA. (1984). Detecting Alcoholism: The CAGE Questionnaire. *JAMA 252*:1905-1907,

12. Computerized CD screening tool

Being pilot-tested at the Centre for Addiction and Mental Health. Not widely available.

13. Coping Behaviors Inventory (Effectiveness of) - (CBI)

The CBI measures the frequency of use of 36 different strategies to avoid the resumption of drinking after a period of abstinence from alcohol. It is used to determine what behavioural skills and confidence in utilizing those skills participants use to avoid relapse. The CBI measures four domains of coping behaviors: using positive thinking to avoid drinking, using thoughts of negative consequences.

To download the instrument:
http://casaa.unm.edu/inst/forms/Effectiveness%20of%20Coping%20Behaviors%20Inventory.pdf

Reference:

- Litman, G. K., Stapelton, J., Oppenheim, A. M. & Peleg, M. (1983) An instrument for measuring coping behaviours in hospitalized alcoholics: implications for relapse prevention treatment. *British Journal of Addiction, 78,* 269-276.

14. Criminal Sentiments Scale (CSS)

The CSS is a 41-item, self-report questionnaire that measures key dimensions of criminal sentiments. It is designed to identify the antisocial attitudes, values, and beliefs that may play a role in the maintenance of antisocial behaviour. Using 5-point agreement scales, the offender reports on attitudes towards the law, courts, and police; tolerance for law violations; and identification with other criminals. Items are scored using a 5-point Likert scale, (1) "strongly agree" to (5) "strongly disagree". Good reliability and validity are reported (Andrews, 1985). http://canada.justice.gc.ca/en/ps/rs/rep/rr03yj-4/rr03yj-4_a1.htmlI

References:

- Andrews, D.A., & Wormith, J.S. (1984). *The criminal sentiments scale.* Ottawa, Canada: Ministry of Correctional Services of Canada.
- Andrews, D.A. (1985). *Notes on a battery of paper- and-pencil instruments: Part 1: Assessments of attitudes and personality in corrections*. Ottawa, Canada: Ministry of Correctional Services of Canada and Carleton University.

15. Dartmouth Assessment of Lifestyle Instrument (DALI) -

The DALI is an 18-item questionnaire which contains 2 scales: one for assessing current alcohol use disorders and the second for assessing drug use disorders in people with severe mental illness. http://www.dartmouth.edu/~psychrc/alcohol.html

To download the instrument: http://www.dartmouth.edu/~psychrc/pdf_files/DALI.pdf

16. Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST) was designed to provide a brief instrument for clinical screening and treatment evaluation research. The 28 self-report items tap various consequences that are combined in a

total DAST score to yield a quantitative index of problems related to drug misuse. [Description taken from http://adai.washington.edu/instruments/DASTinfo.htm].

Availability: ©1982, Harvey A. Skinner & CAMH. View HTML version at: http://www.schick-shadel.com/drugtesting.asp

For ordering and pricing information, contact: Harvey A. Skinner, Department of Public Health Sciences, Faculty of Medicine, University of Toronto, 12 Queen's Park Crescent West, Toronto, ON M5S 1A8, Tel: 416-978-2040, harvey.skinner@utoronto.ca

Reference:

- Skinner, H.A. The Drug Abuse Screening Test. (1982). *Addictive Behav;7(4):*363-367

17. Drug History Questionnaire (DHQ)

The DHQ collects client-reported quantity and frequency information over a 90 day period . The DHQ assesses 13 different drugs in terms of frequency of use and amount consumed at each drug-taking situation. Individuals receive either a 0 (has not taken the drug in the past year) or a continuous score for each of the 13 drugs. The continuous score (volume) is a product of the number of days the drug was used in the past 90 days multiplied by the amount typically consumed on each day the drug was used in the same 90 days (those who report not using the drug receive a zero).

Availability: CAMH, 33 Russell Street Toronto, Ontario, Canada M5S 2S1, Tel: 1-800-661-1111

Reference:

- Wilkinson, D.A., Leigh G.M., Cordingley J., Martin G.W. & Lei H. (1987). Dimensions of multiple drug use and a typology of drug users. *British Journal of Addiction, 82*, 259-273.

18. Drug Taking Confidence Questionnaire (DTCQ-8)

The DTCQ can be used to assess clients' level of coping and self-efficacy in certain alcohol/drug-related situations. This tool has been shortened to 8 items from the longer version.

Availability: CAMH, 33 Russell Street Toronto, Ontario, Canada M5S 2S1, Tel: 1-800-661-1111

References:

- Sklar, S., Annis, H.M., & Turner, N.E. (1997). Development and validation of the Drug-taking Confidence Questionnaire: A measure of coping self-efficacy. *Addictive Behaviors*, 22(5), 655-670.
- Sklar, S.M. & Turner, N.E. (1999). Two brief measures for the assessment of coping self-efficacy among alcohol and other drug users. *Addiction*, 94, 723-729.

19. Global Assessment of Functioning (GAF)

The Global Assessment of Functioning (GAF) is an integral part of the standard multiaxial psychiatric diagnostic system. The purpose of including the GAF in DSM-IV as a tool for axis V assessment is to enable clinicians to obtain information about global functioning to supplement existing data about symptoms and

diagnoses and to help predict the allocation and outcomes of mental health treatment. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12045311

The GAF scale is on page 32 of the DSM – IV.

20. Lehman's Quality of Life Interview (LQOL)

The QoLI is a structured questionnaire, with three types of reply for each life domain: dichotomous replies (yes, no), open responses to reveal objective information such as type of residence, and replies located on a 7-point Likert scale. The scale explores the social dimension of the quality of life in great detail, measuring it in both subjective and objective terms. It also measures perceived health, but makes no attempt to rate other dimensions often included in quality of life indicators.

Availability: Center for Mental Health Services Research, Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201; Phone 410-706-2490

Reference:

- Lehman AF. (1988). A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning; 11:*51-62

21. Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services

LOCUS is a tool that helps measure and guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes. LOCUS has three main objectives. The first is to propose a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to propose a continuum of service arrays which vary according to the amount and scope of resources available at each "level" of care in each of four categories of service. The third is to propose a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum. http://www.wpic.pitt.edu/aacp/finds/LOCUS2000.doc

Availability: © 2000 American Association of Community Psychiatrists

To download the instrument: http://www.wpic.pitt.edu/aacp/finds/locus.html

22. Level of Services Inventory-Revised (LSI-R)

The Level of Services-Revised (LSI-R) is a structured Risk/Need assessment meant to identify needed level of care and services for a Criminal Justice population, as well as explore 10 subcomponent areas where specific interventions or supervision rules may be needed.

For ordering and pricing information, contact: PSYCH SCREEN, INC., phone (800) 588-9412 FAX (608) 756-5840, (www.psychscreen.com/singletest/sam_lsir.html).

23. Michigan Alcoholism Screen Test (MAST)

The MAST is one of the most widely used measures for assessing alcohol abuse. The measure is a 25-item questionnaire designed to provide a rapid and effective screening for lifetime alcohol-related problems and alcoholism. The MAST, which can be used in either a paper-and-pencil or interview format, has been productively used in a variety of settings with varied populations. [description taken from http://www.niaaa.nih.gov/publications/mast.htm]

Availability:

Copyrighted by the American Pyschiatric Publishing, Inc. and Melvin L. Selzer, M.D.

For ordering and pricing information, contact: Melvin L. Selzer, M.D., 6967 Paseo Laredo , La Jolla, CA 92037 . Or: American Psychiatric Publishing Inc., John McDuffie, tel: 202-682-6221, jmcduffie@psych.org

References:

- Selzer, M.L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *Am J Psychiatry 127*:1653-1658,
- Pokovny, A.D.; Miller, B.A; Kaplan, H.B. (1972). The Brief Mast: A Shortened Version of the Michigan Alcohol Screening Test. *American Journal of Psychiatry, 12*9: 342-345.

24. The Multnomah Community Ability Scale

A social assessment questionnaires to evaluate the health and social functioning of individuals suffering from a severe mental illness. It was developed by a team in Multnomah County, Oregon, to assess impairments and abilities among individuals with severe mental illness living in the community. The measure assesses how the person has been doing, on average, for the past three months. It is usually completed by a provider familiar with the consumer.
http://www.ontario.cmha.ca/cmhei/newsletter/2000_05/2000_05_5.asp

Availability: Sela Barker, Nancy Barron, Bentson McFarland, Douglas Bigelow, Network Behavioral Health and Multnomah County, Oregon, 1994. A training package can be ordered from Sela Barker at (503) 238 0769.

To download the instrument: http://www.sheppardpratt.org/Documents/MCAS%20Anchors-Aug-2000.pdf, or http://www.ontario.cmha.ca/cmhei/instruments/modules/cm/CEf2_PROXY_cm.pdf

Reference:

- Barker et al. (1994). A community ability scale for chronically mentally ill consumers: Reliability and validity, *Community Mental Health Journal, 30(4),* 363-383.

25. Ontario Ministry mandated Admission and Discharge Assessment tools: includes

- Drug History Questionnaire (DHQ)
- Adverse Consequences of Drug Use
- Drug Taking Confidence Questionnaire (DTCQ-8)
- Socrates
- Treatment Entry Questionnaire (TEQ)
- Behaviour and Symptom Identification Scale (BASIS-32)
- Perceived Social Support (PSS), Friends and Family

26. Personality Assessment Inventory (PAI)

This 344-item instrument provides information relevant for clinical diagnosis, treatment planning and screening for psychopathology. Each item is rated on a 4 point scale ranging from false, not at all true, to very true. The PAI consists of 22 non-overlapping full scales covering the constructs most relevant to a broad-based assessment of mental disorders: 4 validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales. http://www.sigmaassessmentsystems.com/pai.htm

Availability: The PAI was authored by Lesley C. Morey and made copyright in 1991 by *Psychological Assessment Resources.*

To order, go to: http://www.parinc.com/product.cfm?ProductID=148

27. PSR tool kit - The Canadian Toolkit for Measuring Psychosocial Rehabilitation Outcomes

Contains a set of core outcome indicators, including: Diagnostic History, Client Contacts, Client Referrals, Hospitalization, Residential, Employment, Education, Incarceration/Legal, and Financial Information.

For more information, see: http://www.psr.ofcmhap.on.ca/

28. Perceived Social Support, Friends and Family (PSS)

This standardized instrument assesses the subjective quality of relationships with friends and family rather than objective indicators such as marital or employment status. The instrument asks for the client's perceptions about the level of social support from family and friends.

Reference:

- Rice, C. & Longabaugh, R. (1996). Measuring general social support in alcoholic patients: Short forms for perceived social support. Psychology of Addictive Behaviours, 10(2), 104-114.

29. Quality of Life Interview (QOLI)

See Lehman's Quality of Life Interview

30. Resident Assessment Instrument (RAI)

The Resident Assessment Instrument (RAI) helps staff to gather definitive information on a resident's strengths and needs which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status.

The RAI is an international care tool that consists of three separate but interrelated processes. They are: The "Minimum Data Set" (MDS). A clinical assessment tool that has been validated internationally and differentiates into 44 care levels based on psychological, cognitive, medical & activities of daily living needs; Resident Assessment Protocols (RAPs); and "Triggers" that identify areas to be further considered and assessed regarding 18 common problems.

Availability: © interRAI 1997, 1999,

Order by e-mail at orderdesk@cihi.ca, by phone at (613) 241-7860 Ext. 4088, or by fax at (613) 241-8120.

To view a version of the RAI, see: http://www.careplans.com/pages/library/RAI_User_Guide.PDF

31. Short Form Health Survey (SF12)

As a brief, reliable measure of overall health status, the SF-12v2 measures eight domains of health: Physical functioning, Role limitations due to physical health (role-physical), Bodily pain, General health perceptions, Vitality, Social functioning, Role limitations due to emotional problems (role-emotional), and Mental health

Co-copyright Holders: Medical Outcome Trust (MOT), Health Assessment Laboratories (HAL) and QualityMetric Incorporated.

Licensing: Fee for use of the SF- 12 is paid by companies and organisations who will profit from the use of the instrument. This allows the MOT, HAL and QualityMetric Inc "to make surveys available royalty free to individuals and organisations for academic research". Permission or a commercial license available online at: http://www.qualitymetric.com/products/descriptions/sflicenses.shtml

32. Stages Of Change Readiness and Treatment Eagerness Scale (SOCRATES)

The SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (Ts). The SOCRATES differs from URICA, also a stages of change measure, in that the SOCRATES poses questions specifically about alcohol or other drug use, whereas URICA asks about the client's "problem" and change in a more general manner. Version 8 is reduced nineteen item scale based on factor analyses with prior versions. [description taken from http://adai.washington.edu/instruments/SOCRATES8Dinfo.htm]

Availability: This instrument is in the public domain. View PDF version on the CASAA web site at http://casaa-0031.unm.edu/inst/forms/socratesv8.pdf

For ordering and pricing information, contact: William R. Miller, Ph.D., University of New Mexico, Center on Alcoholism, Substance Abusee and Addictions, 2350 Alamo SE, Albuquerque, NM 87106

Reference:

- Miller, WR, Tonigan, JS, Montgomery HA, et al. (1990). Assessment of client motivation for change: preliminary validation of the SOCRATES (rev) instrument. Albuquerque, NM: University of New Mexico.

33. Substance Abuse Subtle Screening Inventory (SASSI)

The SASSI is a short, one-page self-report screening tool for chemical dependency. It can be objectively scored and plotted by support staff in 1 minute and has objective decision rules to classify individuals as chemically dependent (CD) or nonchemically dependent (non-CD). It is available in paper form, computer disk, and optical scanning form for both adults and adolescents. The SASSI's resistance to efforts at faking may well be its most important attribute. It is especially effective in identifying early stage CD individuals

who are either in denial or deliberately trying to conceal their chemical dependency pattern. In addition to its validity as a screening tool in classifying individuals as CD or non-CD, the configuration of the eight subscales also adds clinical insights into the client's defensiveness and other characteristics. [description taken from http://www.niaaa.nih.gov/publications/sassi.htm].
Availability: © May 1985 by Glenn Miller. Some items are taken from the Psychological Screening Inventory, © 1968 by Richard I. Lanyon, Ph.D.

View PDF version at http://www.niaaa.nih.gov/publications/sassi.pdf

For ordering and pricing information, contact: The SASSI Institute, tel: 800-726-0526

Reference:

- Miller, G.A. (1985). *Substance Abuse Subtle Screening Inventory (SASSI): Manual.* Bloomington, In: Spencer Evening World.

34. The Substance Abuse Treatment Scale (SATS)

The Substance Abuse Treatment Scale (SATS) is a tool that combines a motivational hierarchy with explicit substance use criteria to form an eight-stage model of the recovery process. The eight stages are: pre-engagement, engagement, early persuasion, late persuasion, early active treatment, late active treatment, relapse prevention, and full recovery.

View PDF version at http://www.dartmouth.edu/~psychrc/pdf_files/WebSATS.pdf

Availability: New Hampshire-Dartmouth Psychiatric Research Center, c/o Karen Dunn, 2 Whipple Place - Suite 202, Lebanon, NH 03766. Tel: (603) 448-0126

Reference:

- McHugo, G.J., Drake, R.E., Burton, H.L., et al (1995). *A scale for assessing the stage of substance abuse treatment in persons with severe mental illness.* Journal of Nervous and Mental Disease 183:762-767.

35. Symptom Checklist 90-R

The Symptom Checklist-90-R (SCL-90-R) instrument is a brief, multidimensional self-report inventory designed to screen for a broad range of psychological problems and symptoms of psychopathology. The SCL-90-R instrument is also useful as a progress or outcomes measurement instrument.
http://www.pearsonassessments.com/tests/scl90r.htm#reports

Author: Leonard R. Derogatis, PhD

Availability: Pearson Assessments, US: 800-627-7271, ext. 3225, Canada: 800-268-6011
pearsonassessments@pearson.com

36.Tolerance, Worried, Eye-Opener, Amnesia, Cut-Down (TWEAK)

TWEAK is a five-item scale developed originally to screen for risk drinking during pregnancy. It is an acronym for the questions below: T-Tolerance: "How many drinks can you hold?" W-Worried: "Have close friends or relatives Worried or Complained about your drinking in the past year?" E-Eye-openers: "Do you sometimes take a drink in the morning when you first get up?" A-Amnesia (blackouts); "Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?" K(C)-Cut Down: "Do you sometimes feel the need to Cut Down on your drinking?" http://adai.washington.edu/instruments/TWEAKinfo.htm

Availability: This instrument is in the public domain. View PDF version formatted for ADAI DMC applications at: http://adai.washington.edu/instruments/pdf/TWEAK.pdf

Reference:

- Russell, M.; Martier, S.S.; Sokol, R.J.; Jacobson, S.; Jacobson, J.; and Bottoms, S. (1991). Screening for pregnancy risk drinking: TWEAKING the tests. *Alcoholism Clin Exp Res 15(2):*638.

37. Triage Assessment for Addictive Disorders (TAAD)

The TAAD is a very brief, structured interview covering current alcohol and drug problems related to the DSM-IV criteria for abuse and dependence. As a triage interview it provides more definitive findings than a screen. The TAAD identifies obvious cases and provides substantial support for the diagnosis. In cases where a diagnosis is not indicated, the TAAD provides documentation of negative responses to some of the more prevalent abuse and dependence symptoms. For the remaining cases, where only a few problems are indicated, a comprehensive assessment will be required to make a definitive determination http://www.evinceassessment.com/product_taad.html

Author: Norman G. Hoffmann, Ph.D

Availability: The TAAD is copyrighted. Photocopying or adapting it is illegal and constitutes unethical conduct. TAAD is also available by site license arrangement for large volume users. Site licenses provide a substantial discount. Please call for additional information.

To order, contact: Evince Clinical Assessments, PO Box 17305, Smithfield, RI 02917. Tel: 800-755-6299, 401-231-2993. Fax: 401-231-2055

38. Treatment Entry Questionnaire (TEQ)

The TEQ was developed by Addiction Research Foundation (now the .. Centre for Addiction and Mental Health) to assess the extent to which treatment motivation reflects a client's personal choices and values, guilt, interpersonal conflict and coercive forces pressuring the client into treatment. The scale measures three types of motivation called internal positive, internal negative and external coercion

Reference:

- Wild, T.C. (1997). *Treatment Entry Questionnaire (TEQ): User's Guide*. Toronto, Ontario: Addiction Research Foundation.

39. Treatment Services Review (TSR)

The TSR is an interview used to gather information about specific services provided to patients attending substance abuse and other types of treatment programs. The TSR focuses on services for seven potential problem areas-medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status-that correspond to the seven patient functioning areas assessed by the Addiction Severity Index. Patients are asked about the services that they received in the past week either in a program or outside of a program through referral. [description taken from http://www.niaaa.nih.gov/publications/tsr.htm]

Availability: This instrument is in the public domain. View PDF version formatted for ADAI DMC applications at http://adai.washington.edu/instruments/pdf/TSR.pdf

Ordering: c/o A. Thomas McLellan, Ph.D. ,Building #7 PVAMC ,University Avenue, Philadelphia, PA 19104

References:

- McLellan, A.T.; Alterman, A.I.; Cacciloa, J.; Metzger, D.; and O'Brien, C.P. (1992). A new measure of substance abuse treatment: Initial studies of the Treatment Service Review. J *Nerv Ment Dis 180:*101-110.
- McLellan, A. Thomas ; Zanis, David ; Incmilkoski, Ray ; Parikh, Gargi ; Stevens, George ; Brock, Maureen. (1989). *Administration manual for the Treatment Services Review 'TSR'.* Philadelphia : Philadelphia VA Medical Center, and The University of Pennsylvania. The Center for Studies of Alcoholism, 21 p., appendix.

40. University of Rhode Island Change Assessment (URICA)

This 32 item scale assesses attitudes toward changing problem behaviors (the stages of change construct from the transtheoretical model). Eight items assess each of four stages: precontemplation, contemplation, action and maintenance. Subjects are asked to endorse these statements using a Likert Scale of 1-not at all to 5-extremely in response to how important this statement is to them. Items are summed to give a total score for each stage. [description taken from http://www.niaaa.nih.gov/publications/urica.htm]

Availability: Instrument in the public domain. View PDF version formatted for ADAI DMC applications at: http://adai.washington.edu/instruments/pdf/URICA.pdf. Also available from author at: Carlo C. DiClemente, University of Maryland, Psychology Department, 1000 Hilltop Circle, Baltimore, MD 21250. Tel. 410-455-2415

Reference:

- McConnaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983).Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice, 20,* 368-375,

APPENDIX C: ASA Patient Placement Criteria[39]

The American Society of Addiction Medicine (ASAM) publishes the Second Edition - Revised of its Patient Placement Criteria (ASAM PPC-2R), comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems

Responding to requests for criteria that better meet the needs of patients with co-occurring mental and substance-related disorders ("dual diagnosis"), for revised adolescent criteria and for clarification of the residential levels of care, the A*SAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, (Second Edition -– Revised): (ASAM PPC-2R) was released in April, 2001.

The *ASAM PPC-2R* provides two sets of guidelines, one for adults and one for adolescents, and five broad levels of care for each group. The levels of care are:

- Level 0.5, Early Intervention;
- Level I, Outpatient Treatment;
- Level II, Intensive Outpatient/Partial Hospitalization;
- Level III, Residential/Inpatient Treatment; and
- Level IV, Medically-Managed Intensive Inpatient Treatment.

Within these broad levels of service is a range of specific levels of care. For each level of care, a brief overview of the services available for particular severity of addiction and related problems is presented; as is a structured description of the settings, staff and services, and admission criteria for the following six dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioural or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment.

The diagnostic terminology used in the *ASAM PPC-2R* is consistent with the most recent language of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). The "unbundling" of clinical services is addressed, recognizing that these services can be and often are provided separately from environmental supports. With unbundling, the type and intensity of treatment are based on the patient's needs and not on limitations imposed by the treatment setting. Criteria are also included which attempt to match a patient's severity of illness along Dimension 1 (Acute Intoxication and/or Withdrawal Potential) with five intensities of detoxification service.

The *ASAM PPC-2R* has been totally reformatted and published in a format to facilitate comparisons across levels of service care. There are significant additional criteria and appendices that will assist both the addiction treatment and mental health fields improve services for people with co-occurring mental and substance-related disorders.

[39] Taken from the ASAM web page, April 2004: http://www.asam.org/ppc/ppc2.htm