6 Traditional Settings and Models

In This Chapter...

Overview

What happens to clients with co-occurring disorders (COD) who enter traditional substance abuse settings? How can programs provide the best possible services to these people?

This chapter adopts a program perspective to examine both outpatient and residential settings, highlighting promising treatment models that have emerged both within the substance abuse field and elsewhere. It also discusses the various treatment approaches and models available to those working in substance abuse settings.

The chapter opens with a review of the seven essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD: (1) screening, assessment, and referral; (2) mental and physical health consultation; (3) the use of a prescribing onsite psychiatrist; (4) medication and medication monitoring; (5) psychoeducational classes; (6) onsite double trouble groups; and (7) offsite dual recovery mutual self-help groups. These elements are applicable in both residential and outpatient programs. This section of the chapter also discusses general considerations in treatment of clients with COD.

Essential background related to outpatient care for this population, including available data on its effectiveness, follows the discussion of essential programming. The chapter then turns to an overview of the critical factors in the successful design, implementation, evaluation, and maintenance of effective outpatient programs for clients with COD. Two examples of successful outpatient programs are highlighted: the Clackamas County Mental Health Center of Oregon City, Oregon, an outpatient substance abuse and mental health treatment center; and the Arapahoe House of Denver, Colorado, which is the State's largest provider of substance abuse treatment services. These are intended to "prime the pump" for readers considering the addition of new program elements to serve clients with COD. The section closes with an exploration of two specialized outpatient models for clients with co-occurring

substance use and serious mental disorders, Assertive Community Treatment and Intensive Case Management.

A discussion of residential substance abuse treatment programs for clients with COD completes the chapter. Like the discussion of outpatient care, this section describes the background and effectiveness of residential care for the COD population, the key issues that arise in program design and implementation, and the challenges of evaluating and sustaining residential programs. Modified therapeutic communities (MTCs)—forms of residential care particularly well suited to clients with COD—are described in detail. The chapter closes with a presentation of two other residential models: Gaudenzia, Inc., located in Norristown, Pennsylvania, which uses an MTC to provide care for its clients, the majority of whom have serious mental illness, and the Na'nizhoozi Center, Inc., located in the rural community of Gallup, New Mexico, a program that uses a range of culturally appropriate interventions to meet the needs of its predominantly American-Indian clients.

Essential Programming for Clients With COD

Individuals with COD are found in all addiction treatment settings, at every level of care. Although some of these individuals have serious mental illness and/or are unstable or disabled, many of them have relatively stable disorders of mild to moderate severity. As substance abuse treatment programs serve the increasing number of clients with COD, the essential program elements required to meet their needs must be defined clearly and set in place.

Program components described in this section should be developed by any substance abuse treatment program seeking to provide integrated substance abuse and mental health services to clients with COD (that is, to attain the level of capacity associated with the "COD capable" classification defined in chapter 2). These elements have been culled from a variety of strategies, approaches, and models described in the TIP and from consensus panel discussion of current clinical programming. The panel believes these elements constitute the best practices currently available for designing COD programs in substance abuse treatment agencies. A detailed discussion of these elements appears in chapter 1. What follows are program considerations for implementing these essential components.

Screening, Assessment, and Referral

All substance abuse treatment programs should have in place appropriate procedures for screening, assessing, and referring clients with COD. It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. For a detailed discussion, see chapter 4. If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD.

Physical and Mental Health Consultation

Any substance abuse treatment program that serves a significant number of clients with COD would do well to expand standard staffing to include mental health specialists and to incorporate consultation (for assessment, diagnosis, and medication) into treatment services. Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen an agency's ability to provide services for these clients. These staff members could function as consultants to the rest of the team on matters related to mental disorders, in addition to

being the liaison for a mental health consultant and provision of direct services.

A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with COD: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. (See the section below on the advantages of having a psychiatrist on staff as part of the treatment team.) If lack of funding prevents the substance abuse treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. A memorandum of agreement formalizes this arrangement and ensures the availability of a comprehensive service package for clients with COD. Such arrangements are used widely in the field, and examples of "best practices" are available (Ridgely et al. 1998; Treatment of Persons 2000).

Prescribing Onsite Psychiatrist

Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al. 2001; Saxon and Calsyn 1995). The onsite psychiatrist brings diagnostic, medication, and psychiatric counseling services directly to the location clients are based for the major part of their treatment. This approach often is the most effective way to overcome barriers presented by offsite referral, including distance and travel limitations, the inconvenience of enrolling in another agency and of the separation of clinical services (more "red tape"), fears of being seen as "mentally ill" (if referred to a mental health agency), cost, and the difficulty of becoming comfortable with different staff.

The consensus panel is aware that the cost of an onsite psychiatrist is a concern for many programs. Many agencies that use the onsite psychiatrist model find that they can afford to hire a psychiatrist part-time, even 4 to 16 hours per week, and that a significant number of clients can be seen that way. A certain amount of that cost can be billed to Medicaid, Medicare, insurance agencies, or other funders. For larger agencies, the psychiatrist may be full time or share a full-time position with a nurse practitioner. The psychiatrist also can be employed concurrently by the local mental health program, an arrangement that helps to facilitate access to such other mental health services as intensive outpatient treatment, psychosocial programs, and even inpatient psychiatric care if needed. Studies describing this model more fully and including outcome data include Saxon and Calsyn (1995) and Charney and colleagues (2001). The approach also has been shown to be cost effective in a large health maintenance organization (Weisner et al. 2001).

An onsite psychiatrist fosters the development of substance abuse treatment staff, enhancing their comfort and skill in assisting clients with COD.

Some substance abuse programs may be reluctant to hire a psychiatrist or to provide psychiatric services. This issue can be resolved through agencywide discussions of the types of clients with COD seen by the agencies, how their services are coordinated, and the barriers clients experience to receiving all the elements of COD treatment. In many cases, the largest and most obviously missing elements of good, integrated, onsite COD treatment are mental disorder diagnosis and treatment. It also should be noted that an onsite psychiatrist fosters the development of substance abuse treatment staff, enhancing their comfort and skill in assisting clients with COD. The psychiatrist may be able upgrade counselors' skills through seminars on medication management and other

pertinent topics. Also, the psychiatrist usually attends the weekly meeting of the clinical team, helping to develop effective treatment plans for active cases of clients with COD. For many psychiatrists, this arrangement also affords a welcome opportunity for further exposure to substance abuse treatment.

Ideally, agencies should hire a psychiatrist with substance abuse treatment expertise to work onsite at the substance abuse treatment agency. Finding psychiatrists with this background may present a challenge. Psychiatrists certified by the American Society of Addiction Medicine (ASAM), the American Academy of Addiction Psychiatry, or the American Osteopathic Association (for osteopathic physicians) are good choices. They can provide leadership, advocacy, development, and consultation for substance abuse staff. Historically, however, substance abuse education in medical schools and residencies has received little attention, though promising efforts on multiple levels are working to ensure that all physicians receive at least a basic knowledge of substance use disorders. Thus, learning usually flows both ways, to the benefit of the client. When recruiting a psychiatrist, the substance abuse treatment program should discuss key issues around this bidirectional flow of clinical information and knowledge. In addition, a discussion of prescribing guidelines (such as those included in appendix F) is in order.

The prescribing onsite psychiatrist model is a useful and recommended step that substance abuse treatment agencies can take to provide integrated COD treatment services. A detailed manual is needed to help agencies install this model and to guide the participating psychiatrists to provide the best services within the model. Further research is needed to document cost offsets for implementing the model and gauge its clinical effectiveness in a variety of substance abuse treatment settings.

Medication and Medication Monitoring

Many clients with COD require medication to control their psychiatric symptoms and to stabilize their psychiatric status. The importance of stabilizing the client with COD on psychiatric medication when indicated is now well established in the substance abuse treatment field. (See appendix F for a comprehensive description of the role of medication and the available medications.) One important role of the psychiatrist working in a substance abuse treatment setting is to provide psychiatric medication based on the assessment and diagnosis of the client, with subsequent regular contact and review of medication. These activities include careful monitoring and review of medication adherence.

Psychoeducational Classes

Substance abuse treatment programs can help their clients with COD by offering psychoeducational classes such as those described below.

Mental and substance use disorders

Psychoeducational classes on mental and substance use disorders are important elements in basic COD programs. These classes typically focus on the signs and symptoms of mental disorders, medication, and the effects of mental disorders on substance abuse problems. Psychoeducational classes of this kind increase client awareness of their specific problems and do so in a safe and positive context. Most important, however, is that education about mental disorders be open and generally available within substance abuse treatment programs. Information should be presented in a factual manner, similar to the presentation of information on sexually transmitted diseases (STDs). Some mental health clinics have prepared synopses of mental illnesses for clients in terms that are factual but unlikely to cause distress. A range of literature written for the layperson also is available through government

agencies and advocacy groups (see appendix I). This material provides useful background information for the substance abuse treatment counselor as well as for the client.

Relapse prevention

Programs also can adopt strategies designed to help clients become aware of cues or "triggers" that make them more likely to abuse substances and help them develop alternative coping responses to those cues. Some providers suggest the use of "mood logs" that clients can use to increase their consciousness of the situational factors that underlie the urge to use or drink. These logs help answer the question, "When I have an urge to drink or use, what is happening?" Similarly, basic treatment agencies can offer clients training on recognizing cues for the return of psychiatric symptoms and for affect or emotion management, including how to identify, contain, and express feelings appropriately.

Double Trouble Groups (Onsite)

Onsite groups such as "Double Trouble" provide a forum for discussion of the interrelated problems of mental disorders and substance abuse, helping participants to identify triggers for relapse. Clients describe their psychiatric symptoms (e.g., hearing voices) and their urges to use drugs. They are encouraged to discuss, rather than to act on, these impulses. Double Trouble groups also can be used to monitor medication adherence, psychiatric symptoms, substance use, and adherence to scheduled activities. Double Trouble provides a constant framework for assessment, analysis, and planning. Through participation, the individual with COD develops perspective on the interrelated nature of mental disorders and substance abuse and becomes better able to view his or her behavior within this framework.

Dual Recovery Mutual Self-Help Groups (Offsite)

Fortunately, a variety of dual recovery mutual self-help groups exist in many communities. Substance abuse treatment programs can refer clients to dual recovery mutual self-help groups, which are tailored to the special needs of a variety of people with COD. These groups provide a safe forum for discussion about medication, mental health, and substance abuse issues in an understanding, supportive environment wherein coping skills can be shared. Chapter 7 contains a comprehensive description of this approach and a listing of organizations that provide such services. See also appendix J, which provides a list of such programs, their characteristics, and contacts.

General Considerations for Treatment

In addition to these seven essential elements of COD programming, all treatment providers would do well to develop specific approaches to working with COD clients in groups and find meaningful ways of including them in program design. Since families can have a powerful

Advice to Administrators: Recommendations for Providing Essential Services for People With COD

Develop a COD Program with the following components:

1. Screening, assessment, and referral for persons with COD
2. Physical and mental health consultation
3. Prescribing onsite psychiatrist
4. Medication and medication monitoring
5. Psychoeducational classes
6. Double trouble groups (onsite)
7. Dual recovery self-help groups (offsite)

influence on a client's recovery, it is especially important to reach out to the families of persons with COD and help them understand more about COD and how they can best support the client and help the person recover.

Working in groups

Group therapy in substance abuse treatment settings is regarded generally as a key feature of substance abuse treatment. However, group therapy should be augmented by individual counseling since individual contact is important in helping the client with COD make maximum use of group interventions.

It is not uncommon for groups tailored to individuals with COD to consist of between two and four individuals in the early stages.

Group therapy should be modified for clients with COD. Generally, it is best to reduce the emotional intensity of interpersonal interaction in COD group sessions; issues that are nonprovocative to clients without COD may lead to reactions in clients with COD. Moreover, because many clients with COD often have difficulty staying focused, their treatment groups usually need stronger direction from staff than those for clients who do not have COD. Typically, some persons with COD have trouble sitting still, while others may have trouble getting moving at all (for instance, some people with depression); therefore, the duration of a group (and other activities) should be shortened to less than an hour, with the typical group or activity running for no more than 40 minutes. Because of the need for stability, the groups should run regularly and without cancellation.

Because many clients with COD have difficulty in social settings, group sizes may need to be smaller than is typical. There is benefit even to allowing a few individuals to be considered a group, so long as sessions are group-oriented and used as a means to introduce the client to a larger group setting. It is not uncommon for groups tailored to individuals with COD to consist of between two and four individuals in the early stages. Co-leaders are especially important in these groups, as one leader may need to leave the group with one member, while the group continues with the co-leader. With appropriate staff guidance, peers who have completed the program or advanced to its latter stages can sometimes be used as group cofacilitators.

Considerable tolerance is needed for varied (and variable) levels of participation depending on the client's level of functioning, stability of symptoms, response to medication, and mental status. Many clients with serious mental illness (e.g., those with a diagnosis of schizophrenia, schizoid and paranoid personality) may not fit well in groups and must be incorporated gradually at their own pace and to the degree they are able to participate. Even minimal or inappropriate participation can be viewed as positive in a given case or circumstance. Verbal communication from group leaders should be brief, simple, concrete, and repetitive. This is especially important to reach clients with cognitive and functional impairments. Affirmation of accomplishments should be emphasized over disapproval or sanctions. Negative behavior should be amended rapidly with a positive learning experience designed to teach the client a correct response to a situation. In general, group leaders will need to be sensitive and responsive to needs of the client with COD and the addition of special training can enhance his or her competency. TIP 41, *Substance Abuse Treatment: Group Therapy* (Center for Substance Abuse Treatment [CSAT] 2005) contains more information on the techniques and types of groups used in substance abuse treatment.

Involving clients in treatment and program design

Because clients can provide important guidance relative to their treatment and valuable feedback on program design and effectiveness, they should be involved in program discussions. Some guidelines for involving client/consumers include:

- Form a Consumer Advisory Group.
- Include both current clients from the program and past clients.
- Elect a client representative to discuss client concerns with staff.
- Provide a staff liaison to help coordinate client meetings and to provide a continuing link to staff.
- Hold regular meetings and phone conferences.
- Provide incentives to clients for participation.
- Solicit input on a variety of matters and in an ongoing way.
- Involve clients in meaningful projects.
- When client input is solicited and received, consider it respectfully, respond appropriately, and give the client feedback on your response.

Family education

It is important that family members and significant others who are close to the client receive information on mental disorders and substance abuse, as well as on how the disorders interact with one another. Particularly in cultures that value interdependence and are community- and/or family-oriented, a family and community education and support group can be helpful. In an effort to build or maintain support for the client and his treatment, family members and significant others need to understand the implications of having COD and the treatment options available to the client. Programs must provide this instruction in an interactive style that allows questions, not in a lecture mode. The essentials of this information include:

- The name of the disorder
- Its symptoms
- Its prevalence
- Its cause
- How it interacts with substance abuse—that is, the implications of having both disorders
- Treatment options and considerations in choosing the best treatment
- The likely course of the illness
- What to expect
- Programs, resources, and individuals who can be helpful

Outpatient Substance Abuse Treatment Programs for Clients With COD

Background and Effectiveness

Treatment for substance abuse occurs most frequently in outpatient settings—a term that subsumes a wide variety of disparate programs (Simpson et al. 1997*b*). Some offer several hours of treatment each week, which can include mental health and other support services as well as individual and group counseling for substance abuse; others provide minimal services, such as only one or two brief sessions to give clients information and refer them elsewhere (Etheridge et al. 1997). Some agencies offer outpatient programs that provide services several hours per day and several days per week, thus meeting ASAM's criteria for Intensive Outpatient Programs. Typically, treatment includes individual and group counseling, with referrals to appropriate community services. Until recently, there were few specialized approaches for people with COD in outpatient substance abuse treatment settings. One of many small exceptions was a methadone maintenance program that also made psychiatrists and mental health services available to its clients (Woody et al. 1983).

Deinstitutionalization and other factors are increasing the prevalence of persons with COD in outpatient programs. Many of these individuals have multiple health and social problems that complicate their treatment. Evidence from prior studies indicates that a mental disorder often makes effective treatment for substance use more difficult (Mueser et al. 2000; National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors 1999). Because outpatient treatment programs are available widely and serve the greatest number of clients (Committee on Opportunities in Drug Abuse Research 1996; Lamb et al. 1998), using current best practices from the substance abuse treatment and mental health services fields is vital. Doing so enables these programs to use the best available treatment models to reach the greatest possible number of persons with COD.

Prevalence

COD is clearly a defining characteristic commonly found in clients who enter substance abuse treatment. A Drug Abuse Treatment Outcome Study (DATOS) of 99 treatment programs in 11 U.S. metropolitan areas between 1991 and 1993 found the following distribution of co-occurring mental disorders: 39.3 percent met DSM-III-R (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised [American Psychiatric Association 1987]) diagnostic criteria for antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and about 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996) (see also Figure 1-2 in chapter 1). DATOS and other data indicate that substance abuse programs can expect a substantial proportion of the clientele to have COD.

Empirical evidence of effectiveness

Evidence suggests that outpatient treatment can lead to positive outcomes for certain clients with COD, even when treatment is not tailored specifically to their needs. Outpatient substance abuse treatment programs can be effective settings for treating substance abuse in clients with less serious mental disorders. This conclusion is supported by evidence from the most current and comprehensive database on substance abuse treatment, the DATOS dataset (Flynn et al. 1997).

Clients who were in outpatient treatment, including individual and group counseling and mutual self-help groups, showed reductions in drug use after treatment. Clients with 3 months or more of outpatient treatment reported even lower rates of drug use compared to their rate of use prior to treatment (Hubbard et al. 1997; Simpson et al. 1997*a*). These data show that substance abuse treatment outpatient programs can help clients, many with COD, who remain in treatment at least 3 months. However, modifications designed to address issues faced even by those with less serious mental disorders can enhance treatment effectiveness and in some instances are essential.

Designing Outpatient Programs for Clients With COD

The population of persons with COD is heterogeneous in terms of motivation for treatment, nature and severity of substance use disorder (e.g., drug of choice, abuse versus dependence, polysubstance abuse), and nature and severity of mental disorder. For the most part, however, clients with COD in outpatient treatment have less serious and more stabilized mental and substance abuse problems compared to those in residential treatment (Simpson et al. 1999).

Outpatient treatment can be the primary treatment or can provide continuing care for clients subsequent to residential treatment, which implies a degree of flexibility in the activities/interventions and the intensity of the treatment approaches. However, reports from clinical administrators indicate that an increasing number of clients with serious mental illness (SMI) and substance abuse problems are entering the outpatient substance abuse treatment system. Treatment failures occur with both people with SMI and those with less serious mental illness for several reasons, but among the most important are that programs lack the resources to provide the time for mental health services and medications that, in all likelihood, significantly would improve recovery rates and recovery time.

If lack of funding prevents the full integration of mental health assessment and medication services within a substance abuse treatment agency that provides outpatient services, establishing a collaborative relationship with a mental health agency (through the mechanism of a memorandum of agreement) would ensure that the services for the clients with COD are adequate and comprehensive. In addition, modifications are needed both to the design of treatment interventions and to the training of staff to ensure implementation of interventions appropriate to the needs of the client with COD.

To meet the needs of specific populations among persons with COD, the consensus panel encourages outpatient treatment programs to develop special services for populations that are represented in significant numbers in their programs. Examples include women, women with dependent children, homeless individuals and families, racial and ethnic minorities, and those with health problems such as HIV/AIDS. Several substance abuse treatment agencies have already developed programs for specialized subpopulations. Two such programs—the Clackamas County Mental Health Center (women, criminal justice, young adults) and Arapahoe House (women with children, homeless persons)—are described later in this chapter. Since the types of co-occurring disorder will vary according to the subpopulation targeted, each of these programs must deal with COD in a somewhat different manner, often by adding other treatment components for COD to existing program models.

Screening and assessment

As chapter 4 provides a full discussion of assessment, this section will address only those screening and assessment issues of concern in outpatient settings or that deserve reiteration in this specific context.

A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients entering treatment.

Screening and assessment are used to make two essential decisions:

1. Is the individual stable enough to remain in an outpatient setting, or is more intense care indicated, warranting rapid referral to an appropriate alternative treatment?
2. What services will the client need?

To answer either question, staff must first determine the scope of the client's problems, including his physical and mental status, living situation, and the support he has available to face these problems. Whereas screening requires basic counseling skills, the consensus panel recommends that only specially trained or highly capable staff should perform assess-

ments—not, as is too often the case, less experienced personnel.

A thorough assessment should establish the client's mental and physical status. The process should determine any preexisting medical conditions or complications, substance use history, level of cognitive functioning, prescription drug needs, current mental status, and mental health history.

Centralized intake

A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients entering treatment. When applied in an agency with multiple programs, centralized intake reduces duplication of referral materials as well as assessment services. At Arapahoe House (a model described later in this chapter), the information and access team manages hundreds of telephone calls weekly, conducts screenings, and sets appointments for admission to any of the programs within the agency, with the exception of three detoxification programs. Where centralized intake serves a multi-modality treatment organization or a community with multiple settings (the latter being especially difficult), the intake process can be used to refer clients to the treatment modality most appropriate to their needs (e.g., residential or outpatient), so long as careful attention is paid to the accurate coordination of intake information.

Reassessment

Once admitted to treatment, clients need regular reassessment as reductions in acute symptoms of mental distress and substance abuse may precipitate other changes. Periodic assessment will provide measures of client change and enable the provider to adjust service plans as the client progresses through treatment.

Referral and placement

Careful assessment will help to identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious substance use disorders who may require a period of abstinence or reduced use before they can engage actively in all treatment components. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998e), contains information on assessing physical and cognitive functioning that is relevant for all populations.

It is important to view the client's placement in outpatient care in the context of continuity of care and the network of available providers and programs. Outpatient treatment programs may serve a variety of functions, including outreach/engagement, primary treatment, and continuing care. Ideally, a full range of outpatient substance abuse treatment programs would include interventions for unmotivated, disaffiliated clients with COD, as well as for those seeking abstinence-based primary treatments and those requiring continuity of supports to sustain recovery.

Likewise, ideal outpatient programs will facilitate access to services through rapid response to all agency and self-referral contacts, imposing few exclusionary criteria, and using some client/treatment matching criteria to ensure that all referrals can be engaged in some level of treatment. In those instances where funding for treatment is controlled by managed care, additional levels of control over admission may be imposed on the treatment agency. The consensus panel has mentioned that treatment providers should be careful not to place clients in a higher level of care (i.e., more intense) than is necessary. A client who might remain engaged in a less intense treatment environment may drop out in response to the demands of a more intense treatment program.

Improving Adherence of Clients With COD in Outpatient Settings

- Use telephone or mail reminders.
- Provide reinforcement for attendance (e.g., snacks, lunch, or reimbursement for transportation).
- Increase the frequency and intensity of the outpatient services offered.
- Develop closer collaboration between referring staff and the outpatient program's staff.
- Reduce waiting times for outpatient appointments.
- Have outpatient programs designed particularly for clients with COD.
- Provide clients with case managers who engage in outreach and provide home visits.
- Coordinate treatment and monitoring with other systems of care providing services to the same client.

Source: Adapted from Daley and Zuckoff 1998.

Engagement

Clients with COD, especially those opposed to traditional treatment approaches and those who do not accept that they have COD, have particular difficulty committing to and maintaining treatment. By providing continuous outreach, engagement, direct assistance with immediate life problems (e.g., housing), advocacy, and close monitoring of individual needs, the Assertive Community Treatment (ACT) and Intensive Case Management (ICM) models (described below) provide techniques that enable clients to access services and foster the development of treatment relationships. In the absence of such supports, those individuals with COD who are not yet ready for abstinence-oriented treatment may not adhere to the treatment plan and may be at high risk for dropout (Drake and Mueser 2000).

Because clients with COD often have poor treatment engagement, it is particularly important that every effort be made to employ methods with the best prospects for increasing engagement. Daley and Zuckoff (1998) note a number of useful strategies for improving engagement and adherence with this population.

Discharge planning

Discharge planning is important to maintain gains achieved through outpatient care. Clients with COD leaving an outpatient substance abuse treatment program have a number of continuing care options. These options include mutual self-help groups, relapse prevention groups, continued individual counseling, mental health services (especially important for clients who will continue to require medication), as well as intensive case management monitoring and supports. A carefully developed discharge plan, produced in collaboration with the client, will identify and match client needs with community resources, providing the supports needed to sustain the progress achieved in outpatient treatment.

Clients with COD often need a range of services besides substance abuse treatment and mental health services. Generally, prominent needs include housing and case management services to establish access to community health and social services. In fact, these two services should not be considered "ancillary," but key ingredients for clients' successful recovery. Without a place to live and some degree of economic stability, clients with COD are likely to return to substance abuse or experience a return of symptoms of mental disorder. Every substance abuse treatment

provider should have, and many do have, the strongest possible linkages with community resources that can help address these and other client needs. Clients with COD often will require a wide variety of services that cannot be provided by a single program.

It is imperative that discharge planning for the client with COD ensures continuity of psychiatric assessment and medication management, without which client stability and recovery will be severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so that the client can recognize symptoms of psychiatric or substance abuse relapse on her own and can call on a learned repertoire of symptom management techniques (e.g., self-monitoring, reporting to a "buddy," and group monitoring). This also includes the ability to access assessment services rapidly, since the return of psychiatric symptoms can often trigger substance abuse relapse.

The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others.

Developing positive peer networks is another important facet of discharge planning for continuing care. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others. Where a client's family of origin is not healthy and supportive, other networks can be accessed or developed that will support him. Programs also should encourage client participation in mutual self-help groups, particularly those that focus on COD (e.g., dual recovery mutual self-help programs). These groups can provide a continuing supportive network for the client, who usually can continue to participate in such programs even if he moves to a different community. Therefore, these groups are an important method of providing continuity of care.

The consensus panel also recommends that programs working with clients with COD try to involve advocacy groups in program activities. These groups can help clients become advocates themselves, furthering the development and responsiveness of the treatment program while enhancing clients' sense of self-esteem and providing a source of affiliation.

Continuing care

Continuing care and relapse prevention are especially important with this population, since people with COD are experiencing two long-term conditions (i.e., mental disorder often is a cyclical, recurring illness; substance abuse is likewise a condition subject to relapse). Clients with COD often require long-term continuity of care that supports their progress, monitors their condition, and can respond to a return to substance use or a return of symptoms of mental disorder. Continuing care is both a process of post-treatment monitoring and a form of treatment itself. (In the present context, the term "continuing care" is used to describe the treatment options available to a client after leaving one program for another, less intense, program.)

The relative seriousness of a client's mental and substance use disorders may be very different at the time she leaves a primary treatment provider; thus, different levels of intervention will be appropriate. After leaving an outpatient program, some clients with COD

may need to continue intensive mental health care but can manage their substance abuse treatment by participation in mutual self-help groups. Others may need minimal mental health care but require some form of continued formal substance abuse treatment. For people with SMI, continued treatment often is warranted; a treatment program can provide these clients with structure and varied services not usually available from mutual self-help groups.

Upon leaving a program, clients with COD always should be encouraged to return if they need assistance with either disorder. Because the status of these individuals can be fragile, they need to be able to receive help or a referral quickly in times of crisis. Regular informal check-ins with clients also can help alleviate potential problems before they become serious enough to threaten recovery. A good continuing care plan will include steps for when and how to reconnect with services. The plan and provision of these services also makes readmission easier for clients with COD who need to come back. The client with COD should maintain contact postdischarge (even if only by telephone or informal gatherings). Increasingly, substance abuse programs are undertaking follow-up contact and periodic groups to monitor client progress and assess the need for further service.

Implementing Outpatient Programs

The challenge of implementing outpatient programs for COD is to incorporate specific interventions for a particular subgroup of outpatient clients into the structure of generic services available for a typically heterogeneous population. Often this is best accomplished by establishing a separate track for COD consisting of the services described in the section on essential programming above. Accomplishing this implies organizational change as substance abuse and mental health service agencies modify their mission to address the special needs of persons with COD. Note that the section on residential treatment contains some additional principles of implementation that are equally applicable to outpatient programs.

Staffing

To accommodate clients with COD, standard outpatient drug treatment staffing should include both mental health specialists and psychiatric consultation and access to onsite or offsite psychopharmacologic consultation. All treatment staff should have sufficient understanding of the substance use and mental disorders to implement the essential elements described above. Ideally, this staffing pattern would include mental health clinicians with master's level education, strong diagnostic skills, and substantial experience with clients with COD. These clinicians could provide a link to psychiatric services as well as to consultation on other clinical activities within the program. It is important that the staff function as an integrated team. Staff cooperation can often be fostered by cross-training, clinical team meetings and, most importantly, a treatment culture that stresses teamwork and collaboration.

Training

An integrated model of treatment for clients with COD requires that each member of the treatment team has substantial competency in both fields. Both mental health and substance abuse treatment staff require training, cross-training, and on-the-job training to meet adequately the needs of clients with COD. Within substance abuse treatment settings, this means training in these areas:

- Recognizing and understanding the symptoms of the various mental disorders
- Understanding the relationships between different mental symptoms, drugs of choice, and treatment history
- Individualizing and modifying approaches to meet the needs of specific clients and achieve treatment goals

- Accessing services from multiple systems and negotiating integrated treatment plans

The addition of mental health staff into a substance abuse treatment setting also raises the need for training. Training should address

- Differing perspectives regarding the characteristics of the person with COD
- The nature of addiction
- The nature of mental disability
- The conduct of treatment and staff roles in the treatment process
- The interactive effects of both conditions on the person and his or her outcomes
- Staff burnout

Staff trained exclusively either in mental health services or in substance abuse treatment models often have difficulty accepting the other's view of the person, the problem, and the approach to treatment. Cross-training and open discussion of differing viewpoints and challenging issues can help staff to reach a common perspective and approach for the treatment of clients with COD within each agency or program setting. Chapter 3 provides a more complete discussion of staff training, while appendix I identifies a number of training resources.

Evaluating Outpatient Programs

Five elements are needed to design an evaluation process for an outpatient program that can provide useful feedback to program staff and administrators on the effectiveness or outcome of treatment for persons with COD. These important data can be used to improve programs.

1. *Define the operational goals of the program in terms of the client behaviors for which change is sought.* Programs may define their goals for client change narrowly in terms of reductions in alcohol and drug use and crime only or more broadly, to include reductions in psychological symptoms, homelessness, unemployment, and so on.
2. *Decide who the study clients will be and devise a plan for selecting or sampling those clients.* Depending on the rate of client entry into a program and the number of clients sought for the outcome study (typically at least 35), a program may select every client presenting to treatment over the course of a designated time period or may sample systematically (e.g., taking every third client) or randomly (e.g., using a coin toss). It is important to use a system that avoids bias (i.e., avoids the selection of clients who, for one reason or another, are believed to be more likely to respond particularly well or particularly poorly to the treatment program).
3. *Locate and/or develop instruments that can be used to assess client functioning in the areas of concern for outcome.* Include areas about which the program staff feels information is needed (e.g., demographic characteristics and background variables such as source of referral, drug use and criminal justice histories, education or employment histories, prior drug treatment, social support, physical and mental health histories, etc.). For studies generally, and for in-treatment studies in particular, it is also important to gather information about client retention. Indeed, a number of studies now suggest that length of retention is a useful proxy measure for understanding posttreatment outcomes, and that retention to 3 months in outpatient programs is critical for clients to achieve meaningful behavior change.
4. *Develop a plan for data collection.* Information on client functioning can be gathered using selected instruments at the time of entry into treatment (baseline) and at intervals of 1 or more months from time of entry while the individual is in treatment. Data gathered may be restricted to self-report or may include biological markers such as urinalysis and/or data gathered from others knowledgeable about the client's functioning (e.g., family or school

personnel). Outcome studies frequently involve continuing assessment after the client leaves treatment, and again at designated intervals; typically, assessments at 6- to 12-month intervals.

5. *Develop a plan for data analysis and reporting.* Data analysis may be comparatively simple, describing client functioning at baseline in the areas of concern (e.g., drug use) and client functioning in those same areas at times of assessment or follow-up; alternatively, it may be complex, comparing client functioning in the areas of concern at multiple points in time and controlling for variables that might affect that functioning (e.g., prior treatment history). The findings obtained through data analysis are communicated through written and oral reporting to interested parties, particularly program staff who can use this information on program effectiveness to its greatest advantage (i.e., to improve the program's capacity to facilitate client change). Both the National Institute on Drug Abuse (NIDA) and CSAT have developed manuals for outcome studies designed to be conducted by treatment program staff. NIDA's document (1993) is titled *How Good Is Your Drug Abuse Treatment Program? A Guide to Evaluation.* CSAT's document (1997*b*) is titled *Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program.*

Sustaining Outpatient Programs

Funding resources for substance abuse treatment remain significantly lower per client than those available for mental health services. Models demonstrating positive results originating in the mental health field often are too expensive to be implemented fully in more fiscally limited substance abuse treatment settings. The consensus panel recommends developing funding for the essential programming described in this chapter and, where possible, for adapting the successful models for the treatment of mental disorders in outpatient settings described below.

Financing integrated treatment

As noted earlier, systemic difficulties related to the organization and financing of integrated treatment models, including funding for enhanced mental health services, have delayed implementation of integrated treatment models in many outpatient substance abuse treatment settings. Resources for funding extended continuity of treatment, which are available generally in mental health settings, are not usually provided in substance abuse treatment systems. Since the majority of substance abuse treatment agencies treat clients with COD, an obvious solution to funding shortfalls is to access funding streams that support mental health services. Such funding may be based on demonstrating the nature, severity, and extent of co-occurring mental disorders among their clients, with documentation of the full range of diagnosed disabilities of clients with COD. This information also helps programs to modify their programs to address current client needs, and to educate and promote an appreciation for the documented efficacy of integrated treatment for those with COD (Drake et al.

Since the majority of substance abuse treatment agencies treat clients with COD, an obvious solution to funding shortfalls is to access funding streams that support mental health services.

1998*b*). Chapter 3 presents additional information on overcoming barriers and for accessing funding for COD in substance abuse treatment settings.

Planning for organizational change

Substance abuse treatment agencies should plan for any organizational changes needed to introduce new or altered approaches into program settings (e.g., adding and integrating mental health staff into the substance abuse setting). Agencies should be aware, however, that changing the processes and approaches in an organization is challenging. Strategies should be grounded in sound organizational change principles and may be effective in helping all parties understand, accept, and adjust to the changes. A recommended sourcebook administrators might find useful is *The Change Book: A Blueprint for Technology Transfer* (Addiction Technology Transfer Center National Office 2000).

Examples of Outpatient Programs

A CSAT initiative, titled *Grants for Evaluation of Outpatient Treatment Models for Persons With Co-Occurring Substance Abuse and Mental Health Disorders* (Substance Abuse and Mental Health Services Administration [SAMHSA] 2000) promotes the development and evaluation of new models for the treatment of COD in outpatient substance abuse treatment settings. A variety of models for treatment of clients with COD in outpatient substance abuse treatment settings are now emerging, some of which are outlined in appendix E.

Recognizing that providers must address these issues within the constraints of particular systems that differ significantly from each other, two providers have been chosen—the Clackamas County Mental Health Center, Oregon, and Arapahoe House, Colorado—to illustrate different approaches to providing outpatient care for clients with COD.

Assertive Community Treatment and Intensive Case Management: Specialized Outpatient Treatment Models for Clients With COD

This section focuses on two existing outpatient models, ACT and ICM (both from the mental health field) and the challenges of employing them in the substance abuse field. The rationale for selecting these specialized models is that the framework, model, and methods of each are articulated clearly, both have been disseminated widely and applied, and each has support from a body of empirical evidence (though the empirical support for ICM is relatively modest compared to ACT). Because service systems are layered and difficult to negotiate, and because people with COD need a wide range of services but often lack the knowledge and ability to access them, the utility of case management is recognized widely for this population. Although ACT and ICM can be thought of as similar in several features (e.g., both emphasize case management, skills training, and individual counseling), they function differently from each other with regard to goals, operational characteristics, and the nature and extent of the activities and interventions they provide. Therefore, each is described separately below.

Assertive Community Treatment

Developed in the 1970s by Stein and Test (Stein and Test 1980; Test 1992) in Madison, Wisconsin, for clients with SMI, the ACT model was designed as an intensive, long-term service for those who were reluctant to engage in traditional treatment approaches and who required significant outreach and engagement activities. ACT has evolved and been modified to address the needs of individuals with serious mental disorders and co-occurring substance use disorders (Drake et al. 1998*a*; Stein and Santos 1998).

The Clackamas County Mental Health Center, Oregon

Overview

Clackamas County is a geographically large county in northwest Oregon that is about the size of the State of Delaware and encompasses urban, suburban, and rural areas. Oregon City, the county seat, is home to 15,000 people. The County provides outpatient substance abuse and mental health treatment services at four major clinics throughout the county. Its substance abuse treatment program has made a concerted and sustained effort to develop working agreements with major sources of referral, reflecting client needs in the community (e.g., corrections, child protective services, adult and family services, and a local community college). In addition, the program continues to consult with other service providers to build further linkages.

All staff members who provide initial assessment and treatment have at least master's level training and substance abuse certification (or its equivalent), which has facilitated the awareness of potential co-occurring interactions beginning at intake. It is recognized that this level of staffing is unusual within substance abuse treatment programs.

Clients Served

The county provides treatment for clients with substance abuse and COD. The Clackamas County Mental Health Center has a number of programs that target specific populations, including a women's program; a program for clients involved in the criminal justice system who are on electronic surveillance or who were referred by juvenile and adult Drug Courts; clients with serious and persistent mental illness; and through the Passport Program, young adult men and women ages 17 to 23 who have co-occurring substance use disorders and significant mental disorders.

Services

Each clinic offers both Level 1 and 2 services (as defined by ASAM) (2001) and has working agreements with residential treatment programs for those who need that level of care. Outpatient services include treatment for individuals, families, and groups; case management; and consultation. More specialized treatment has been developed for some subpopulations within the program (e.g., clients with serious and persistent mental illness, clients on electronic surveillance, women).

Program model

ACT programs typically employ intensive outreach activities, active and continued engagement with clients, and a high intensity of services. ACT emphasizes shared decisionmaking with the client as essential to the client's engagement process (Mueser et al. 1998). Multidisciplinary teams including specialists in key areas of treatment provide a range of services to clients. Members typically include mental health and substance abuse treatment counselors, case managers, nursing staff, and psychiatric consultants. The ACT team provides the client with practical assistance in life management as well as direct treatment, often within the client's home environment, and remains responsible and available 24 hours a day (Test 1992). The team has the capacity to intensify services as needed and may make several visits each week (or even per day) to a client. Caseloads are kept smaller than other community-based treatment models to accommodate the intensity of service provision (a 1:12 staff-to-client ratio is typical).

ACT treatment activities and interventions

Examples of ACT interventions include

- *Outreach/engagement.* To involve and sustain clients in treatment, counselors and administrators must develop multiple means of attracting, engaging, and re-engaging clients. Often the expectations placed on

Arapahoe House, Colorado

Overview

Arapahoe House, a nonprofit corporation located near Denver, Colorado, is the State's largest provider of substance abuse treatment services. In addition, Arapahoe House is a licensed mental health clinic and strives to provide fully integrated services for clients with COD in all of its treatment programs. Because all Arapahoe House programs are designed to provide integrated treatment for clients with COD, the agency employs several psychiatrists on contract in both the residential and outpatient settings.

Clients Served

The Arapahoe House Adult Outpatient Programs admit clients with substance use disorders who do not require 24-hour medical monitoring or detoxification and do not have symptoms of mental illness that place them at high risk of harming themselves or others. Adult clients who do not meet these criteria are referred to Arapahoe House's detoxification services or its inpatient treatment program where they can receive comprehensive assessment and stabilization. Arapahoe House also has a number of programs for specific populations. There is a residential treatment program for women with dependent children and specialized services for homeless persons.

Services

Arapahoe House provides a full continuum of treatment services, including residential and outpatient treatment for adults and adolescents of multiple levels of intensity; case management services for specific target populations; nonmedical detoxification services; housing and vocational services; and, for adolescents, school-based counseling. The organization offers outpatient services at six locations in the metropolitan Denver area. These outpatient programs provide individual and group therapy, education, family counseling, sobriety monitoring, and mental health evaluation.

Arapahoe House also provides a wide array of services devoted to the needs of homeless persons, including intensive case management services and a housing program. Specific services for persons with COD include the 20-bed adult short-term intensive residential treatment program, the six adult outpatient clinics, and the New Directions for Families program, which is a comprehensive residential treatment program for women and their dependent children. New Directions has a capacity of sixteen families, with an expected length of stay of 4 months, followed by 4 months of outpatient continuing care.

Finally, with respect to adult services, The Wright Center, which is a 22-bed transitional residential program for men and women, has been modified to serve clients with COD. In addition to these programs for adults, Arapahoe House offers an array of programs designed to meet the needs of adolescents, and all of these programs target young persons with COD. This continuum of adolescent services includes counselors who work onsite in 16 high schools across the metropolitan Denver area; outpatient services at two sites, including day treatment; and two intensive residential treatment centers: one comprising 20 beds for male and female adolescents and the other a center for 15 adolescent females. These residential treatment centers offer comprehensive substance abuse and mental health treatment using an integrated model, and both sites contain an accredited school.

clients are minimal to nonexistent, especially in those programs serving very resistant or hard-to-reach clients.

- *Practical assistance in life management.* This feature incorporates case management activities that facilitate linkages with support services in the community. While the role of a counselor in the ACT approach includes standard counseling, in many instances substantial time also is spent on life management and behavioral management matters.

Making ACT Work

Team cohesion and smooth functioning are critical to success. The ACT multidisciplinary team has shared responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical issues. While team members may play different roles, all are familiar with every client on the caseload. Additionally, the ACT model includes the clients' family and friends within treatment services.

Source: Wingerson and Ries 1999.

- *Close monitoring.* For some clients, especially those with SMI, close monitoring is required.

  This can include (Drake et al. 1993):

  – Medication supervision and/or management

  – Protective (representative) payeeships

  – Urine drug screens
- *Counseling.* The nature of the counseling activity is matched to the client's motivation and readiness for treatment.
- *Crisis intervention.* This is provided during extended service hours (24 hours a day, ideally through a system of on-call rotation).

Key modifications for integrating COD

When working with a client who has COD, the goals of the ACT model are to engage the client in a helping relationship, to assist in meeting basic needs (e.g., housing), to stabilize the client in the community, and to provide direct and integrated substance abuse treatment and mental health services. The standard ACT model as developed by Test (1992) has been modified to include treatment for persons who have substance use disorders as well as mental disorders (Stein and Santos 1998). The key elements in this evolution have been

- The use of direct substance abuse treatment interventions for clients with COD (often through the inclusion of a substance abuse treatment counselor on the multidisciplinary team)
- A team focus on clients with COD (Drake et al. 1998*a*)
- COD treatment groups (Drake et al. 1998*a*)
- Modifications of traditional mental health interventions, including a strong focus on the relationships between mental health and substance use issues (e.g., providing skills training that focuses on social situations involving substance use [Drake and Mueser 2000])

Substance abuse treatment strategies are related to the client's motivation and readiness for treatment and include

- Enhancing motivation (for example, through use of motivational interviewing)
- Cognitive–behavioral skills for relapse prevention
- 12-Step programming, including use of the peer recovery community to strengthen supports for recovery
- Psychoeducational instruction about addictive disorders

For clients who are not motivated to achieve abstinence, motivational approaches are structured to help them recognize the impact of substance use on their lives and on the lives of those around them. Therapeutic interventions are modified to meet the client's current stage of change and receptivity.

Populations served

When modified as described above to serve clients with COD, the ACT model is capable of including clients with greater mental and functional disabilities who do not fit well into many traditional treatment approaches. The characteristics of those served by ACT programs for

Nine Essential Features of ACT

1. Services provided in the community, most frequently in the client's living environment
2. Assertive engagement with active outreach
3. High intensity of services
4. Small caseloads
5. Continuous 24-hour responsibility
6. Team approach (the full team takes responsibility for all clients on the caseload)
7. Multidisciplinary team, reflecting integration of services
8. Close work with support systems
9. Continuity of staffing

Source: Drake et al. 1998*a*.

COD include those with a substance use disorder and

- Significant mental disorders
- Serious and persistent mental illness
- Serious functional impairments
- Who avoided or did not respond well to traditional outpatient mental health services and substance abuse treatment
- Co-occurring homelessness
- Co-occurring criminal justice involvement (National Alliance for the Mentally Ill [NAMI] 1999)

In addition to, and perhaps as a consequence of, the characteristics cited above, clients targeted for ACT often are high utilizers of expensive service delivery systems (emergency rooms and hospitals) as immediate resources for mental health and substance abuse services.

Empirical evidence for ACT

The ACT model has been researched widely as a program for providing services to people who are chronically mentally ill. The general consensus of research to date is that the ACT model for mental disorders is effective in reducing hospital recidivism and, less consistently, in improving other client outcomes (Drake et al. 1998*a*; Wingerson and Ries 1999).

Randomized trials comparing clients with COD assigned to ACT programs with similar clients assigned to standard case management programs have demonstrated better outcomes for ACT. ACT resulted in reductions in hospital use, improvement on clinician ratings of alcohol and substance abuse, lower 3-year posttreatment relapse rates for substance use, and improvements on measures of quality of life (Drake et al. 1998*a*; Morse et al. 1997; Wingerson and Ries 1999). It is important to note that ACT has not been effective in reducing substance use when the substance use services were brokered to other providers and not provided directly by the ACT team (Morse et al. 1997). Researchers also considered the cost-effectiveness of these interventions, concluding that ACT has better client outcomes at no greater cost and is, therefore, more cost-effective than brokered case management (Wolff et al. 1997).

Other studies of ACT were less consistent in demonstrating improvement of ACT over other interventions (e.g., Lehman et al. 1998). In addition, the 1998 study cited previously (Drake et al. 1998*b*) did not show differential improvement on several measures important for establishing the effectiveness of

ACT with COD—that is, retention in treatment, self-report measures of substance abuse, and stable housing (although both groups improved). Drake notes that "drift" occurred in the comparison group; that is, elements of ACT were incorporated gradually into the standard case management model, which made it difficult to determine the differential effectiveness of ACT. Further analyses indicated that clients in high-fidelity ACT programs showed greater reductions in alcohol and drug use and attained higher rates of remissions in substance use disorders than clients in low-fidelity programs (McHugo et al. 1999). Nevertheless, ACT is a recommended treatment model for clients with COD, especially those with serious mental disorders, based on the weight of evidence.

Intensive case management

The earliest model of case management was primarily a brokerage model, in which linkages to services were forged based on the individual needs of each client, but the case manager did not provide formal clinical services. Over time, it became apparent that clinicians could provide more effective case management services; consequently, clinical case management largely supplanted the brokerage model. ICM emerged as a strategy in the late 1980s and early 1990s. It was designed as a thorough, long-term service to assist clients with SMI (particularly those with mental and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers.

ICM is not a precisely defined term, but rather is used in the literature to describe an alternative to both traditional case management and ACT. The goals of the ICM model are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*b*), contains more information on the history of case management, both how it has developed to meet the needs of clients in substance abuse treatment (including clients with COD) and specific guidelines about how to implement case management services.

Program model

ICM programs typically involve outreach and engagement activities, brokering of community-based services, direct provision of some support/counseling services, and a higher intensity of services than standard case management. The intensive case manager assists the client in selecting services, facilitates access to these ser-

Advice to Administrators: Treatment Principles From ACT

- Provide intensive outreach activities.
- Use active and continued engagement techniques with clients.
- Employ a multidisciplinary team with expertise in substance abuse treatment and mental health.
- Provide practical assistance in life management (e.g., housing), as well as direct treatment.
- Emphasize shared decisionmaking with the client.
- Provide close monitoring (e.g., medication management).
- Maintain the capacity to intensify services as needed (including 24-hour on-call, multiple visits per week).
- Foster team cohesion and communication; ensure that all members of the team are familiar with all clients on the caseload.
- Use treatment strategies that are related to the client's motivation and readiness for treatment, and provide motivational enhancements as needed.

vices, and monitors the client's progress through services provided by others (inside or outside the program structure and/or by a team). Client roles in this model include serving as a partner in selecting treatment components.

In some instances, the ICM model uses multidisciplinary teams similar to ACT. The composition of the ICM team is determined by the resources available in the agency implementing the programs. The team often includes a cluster-set of case managers rather than the specialists prescribed as standard components of the treatment model. The ICM team may offer services provided by ACT teams, including practical assistance in life management (e.g., housing) and some direct counseling or other forms of treatment. Caseloads are kept smaller than those in other community-based treatment models (typically, the client-to-counselor ratio ranges from 15:1 to 25:1), but larger than those in the ACT model. Because the case management responsibilities are so wide ranging and require a broad knowledge of local treatment services and systems, a typically trained counselor may require some retraining and/or close, instructive supervision in order to serve effectively as a case manager.

Treatment activities and interventions

Examples of ICM activities and interventions include

- **Engaging** the client in an alliance to facilitate the process and connecting the client with community-based treatment programs
- **Assessing** needs, identifying barriers to treatment, and facilitating access to treatment
- **Offering practical assistance** in life management and facilitating linkages with support services in the community
- **Making referrals** to treatment programs and services provided by others in the community (see TIP 27 [CSAT 1998*b*] for guidance on establishing linkages for service provision and interagency cooperation)
- **Advocating for the client** with treatment providers and service delivery systems
- **Monitoring progress**
- **Providing counseling and support** to help the client maintain stability in the community
- **Crisis intervention**
- **Assisting** in integrating treatment services by facilitating communication between service providers

Key modifications of ICM for co-occurring disorders

Key ICM modifications from basic case management for clients with COD include

- Using direct interventions for clients with COD, such as enhancing motivation for treatment and discussing the interactive effects of mental and substance use disorders
- Making referrals to providers of integrated substance abuse and mental health services or, if integrated services are not available or accessible, facilitating communication between separate brokered mental health and substance abuse service providers
- Coordinating with community-based services to support the client's involvement in mutual self-help groups and outpatient treatment activities

Empirical evidence

The empirical study of ICM for COD is not as extensive or as clarifying as the research on ACT; however, some studies do provide empirical support. ICM has been shown to be effective in engaging and retaining clients with COD in outpatient services and to reduce rates of hospitalization (Morse et al. 1992). Further, treatments combining substance abuse counseling with intensive case management services have been found to reduce substance use behaviors for this population in terms of days of drug use, remission from alcohol use, and reduced consequences of substance use (Bartels et al. 1995; Drake et al. 1993, 1997; Godley et al. 1994). The con-

tinued use and further development of ICM for COD is indicated based on its overall utility and modest empirical base.

Comparison of ACT and ICM

Similarities between ACT and ICM

Both ACT and ICM share the following key activities and interventions:

- Focus on increased treatment participation
- Client management
- Abstinence as a long-term goal, with short-term supports
- Stagewise motivational interventions
- Psychoeducational instruction
- Cognitive–behavioral relapse prevention
- Encouraging participation in 12-Step programs
- Supportive services
- Skills training
- Crisis intervention
- Individual counseling

Differences between ACT and ICM

ACT is more intensive than most ICM approaches. The ACT emphasis is on developing a therapeutic alliance with the client and delivery of service components in the client's home, on the street, or in program offices (based on the client's preference). ACT services, as described by NAMI (1999), are provided predominantly by the multidisciplinary staff of the ACT team (typically, 75 percent of services are team provided), and the program often is located in the community. Most ACT programs provide services 16 hours a day on weekdays, 8 hours a day on weekends, plus on-call crisis intervention, including visits to the client's home at any time, day or night, with the capacity to make multiple visits to a client on any given day. Caseloads usually are 12:1. ICM programs typically include fewer hours of direct treatment, though they may include 24-hour crisis intervention; the focus of ICM is on brokering community-based services for the client. ICM caseloads range up to 25:1.

The ACT multidisciplinary team has shared responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical issues. While team members may play different roles, all are familiar with every client on the caseload. The nature of ICM team functioning is not as defined, and cohesion is not necessarily a focus of team functioning; the ICM team can operate as a loose federation of independent case managers or as a cohesive unit in a manner similar to ACT. Also, the ACT model has been developed to include the clients' family and friends within treatment services (Wingerson and Ries 1999), which is not necessarily true for ICM models.

ICM most frequently involves the coordination of services across different systems and/or over extended periods of time, while ACT integrates and provides treatment for COD within the team. As a consequence, while advocacy with other providers is a major component of ICM, advocacy in ACT focuses on ancillary services. Additionally,

Advice to Administrators: Treatment Principles From ICM

- Select clients with greater mental and functional disabilities who are resistant to traditional outpatient treatment approaches.
- Employ low caseload per case manager to accommodate more intensive services.
- Assist in meeting basic needs (e.g., housing).
- Facilitate access to and utilization of brokered community-based services.
- Provide long-term support, such as counseling services.
- Monitor the client's progress through services provided by others.
- Use multidisciplinary teams.

the ACT multidisciplinary team approach to treatment places greater emphasis on providing integrated treatment for clients with COD directly, assuming that the team members include both mental health and substance abuse treatment counselors and are fully trained in both approaches.

Recommendations for extending ACT and ICM in substance abuse treatment settings

It is not self-evident that ACT and ICM models translate easily to substance abuse settings. The consensus panel offers the following six key recommendations for successful use of ACT and ICM in substance abuse settings with clients who have COD:

1. *Use ACT and ICM for clients who require considerable supervision and support.* ACT is a treatment alternative for those clients with COD who have a history of sporadic adherence with continuing care or outpatient services and who require extended monitoring and supervision (e.g., medication monitoring or dispensing) and intensive onsite treatment supports to sustain their tenure in the community (e.g., criminal justice clients). For this subset of the COD population, ACT provides accessible treatment supports without requiring return to a residential setting. The typical ICM program is capable of providing less intense levels of monitoring and supports, but can still provide these services in the client's home on a more limited basis.
2. *Develop ACT and/or ICM programs selectively to address the needs of clients with SMI who have difficulty adhering to treatment regimens most effectively.* ACT, which is a more complex and expensive treatment model to implement compared with ICM, has been used for clients with SMI who have difficulty adhering to a treatment regimen. Typically, these are among the highest users of expensive (e.g., emergency room, hospital) services. ICM programs can be used with treatment-resistant clients who are clinically and functionally capable of progressing with much less intensive onsite counseling and less extensive monitoring.
3. *Extend and modify ACT and ICM for other clients with COD in substance abuse treatment.* With their strong tradition in the mental health field, particularly for clients with SMI, ACT and ICM are attractive, accessible, and flexible treatment approaches that can be adapted for individuals with COD. Components of these programs can be integrated into substance abuse treatment programs.
4. *Add substance abuse treatment components to existing ACT and ICM programs.* Incorporating methods from the substance abuse treatment field, such as substance abuse education, peer mutual self-help, and greater personal responsibility, can continue to strengthen the ACT approach as applied to clients with COD. The degree of integration of substance abuse and mental health components within ACT and ICM is dependent upon the ability of the individual case manager/counselor or the team to provide both services directly or with coordination.
5. *Extend the empirical base of ACT and ICM to further establish their effectiveness for clients with COD in substance abuse treatment settings.* The empirical base for ACT derives largely from its application among people with SMI and needs to be extended to establish firm support for the use of ACT across the entire COD population. In particular, adding an evaluation component to new ACT programs in substance abuse settings can provide documentation currently lacking in the field concerning the effectiveness and cost benefit of ACT in treating the person who abuses substances with co-occurring men-

tal disorders in substance abuse treatment settings. The limitations of ICM have been listed above. The use of ACT or ICM should turn on the assessed needs of the client.

Residential Substance Abuse Treatment Programs for Clients With COD

Background and Effectiveness

Residential treatment for substance abuse comes in a variety of forms, including long-term (12 months or more) residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. The long-term residential substance abuse treatment facility is the primary treatment site and the focus of this section of the TIP. Historically, residential substance abuse treatment facilities have provided treatment to clients with more serious and active substance use disorders but with less SMI. Most providers now agree that the prevalence of people with SMI entering residential substance abuse treatment facilities has risen.

Prevalence

As noted, mental disorders have been observed in an increasing proportion of clients in many substance abuse treatment settings (De Leon 1989; Rounsaville et al. 1982*a*). Compared to the rates found in clients in the outpatient programs of DATOS, slightly higher rates of antisocial personality disorder, and roughly similar rates of major depressive episode and generalized anxiety disorder, were found among adult clients admitted to the long-term residential programs that were part of DATOS (Flynn et al. 1996; see also Figure 1-2 in chapter 1 of this TIP). Of course, those admitted to long-term residential care tended to have more severe substance abuse problems. Additionally, in the year prior to admission to treatment, clients in long-term residential care reported the highest rate of past suicidal thoughts or attempts (23.6 percent) as compared to outpatient drug-free (19.3 percent) and outpatient methadone treatment (16.6 percent). Only the suicide thoughts and attempts rate for clients admitted to short-term inpatient treatment was higher (31.0 percent) (Hubbard et al. 1997, Table 2). This evidence points to the need for a programmatic response to the problems posed by those with COD who enter residential treatment settings.

Empirical evidence of effectiveness

Evidence from a number of large-scale, longitudinal, national, multisite treatment studies has established the effectiveness of residential substance abuse treatment (Fletcher et al. 1997; Hubbard et al. 1989). In general, these studies have shown that residential substance abuse treatment results in significant improvement in drug use, crime, and employment.

The most recent of these national efforts is NIDA's DATOS (Fletcher et al. 1997). The DATOS study involved a total of 10,010 adult clients, including many minorities, admitted between 1991 and 1993 to short-term inpatient substance abuse treatment programs, residential TCs, outpatient drug-free programs, or outpatient methadone maintenance programs across 11 cities (Chicago, Houston, Miami, Minneapolis,

Historically, residential substance abuse treatment facilities have provided treatment to clients with more serious and active substance use disorders but with less SMI.

Newark, New Orleans, New York, Phoenix, Pittsburgh, Portland, and San Jose). Of the 4,229 clients eligible for follow-up and interviewed at intake, 2,966 were re-interviewed successfully after treatment (Hubbard et al. 1997).

Encouragingly, even with this high prevalence of clients with COD, DATOS study participants displayed positive outcomes for substance use and other maladaptive behaviors in the first year after treatment. Because studies of populations that abuse substances have shown that those who remain in treatment for at least 3 months have more favorable outcomes, a critical retention threshold of at least 90 days has been established for residential programs (Condelli and Hubbard 1994; Simpson et al. 1997*b*, 1999). Persons admitted to residential programs likely have the most severe problems, and those remaining beyond the 90-day threshold have the most favorable outcomes (Simpson et al. 1999).

Legal pressure and internal motivation among clients in residential programs have been associated with retention beyond the 90-day threshold (Knight et al. 2000). This relationship between legal pressure and retention supports practices that encourage court referrals to residential treatment for drug-involved persons (Hiller et al. 1998). Broome and colleagues (1999) found that hostility was related to a lower likelihood of staying in residential treatment beyond the 90-day threshold, but depression was associated with a greater likelihood of retention beyond the threshold.

Designing Residential Programs for Clients With COD

To design and develop services for clients with COD, a series of interrelated program activities must be undertaken, as discussed below. While the MTC described in detail later in this chapter is used frequently as a frame of reference throughout this discussion, these observations are applicable both to such TCs and to other residential programs that might be developed for COD.

Intake

Chapter 4 provides a full discussion of screening and assessment. This section will address intake procedures relevant to persons with COD in residential substance abuse treatment settings. The four interrelated steps of the relevant intake process include:

1. *Written referral.* Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, STDs, and hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. *Intake interview.* An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance abuse problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Finally, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in chapter 4, can be used in conjunction with this intake interview.
3. *Program review.* Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and

an introduction to some of the clients who are already enrolled in the program.

4. *Team meeting.* At the end of the intake interview and program review, the team meets with the client to arrive at a decision concerning whether the referred client should be admitted to the program. The client's receptivity to the program is considered and additional information (e.g., involvement with the justice system, suicide attempts) is obtained as needed. It should be noted that the decisionmaking process is inclusive; that is, a program accepts referrals as long as they meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Assessment

Once accepted into the program, the client goes through an assessment process that should include five areas:

1. *Substance abuse evaluation.* The substance abuse evaluation consists of assessing age at first use, primary drugs used, patterns of drug and alcohol use, and treatment episodes. This information can be augmented by some basic standard data collection method such as the Addiction Severity Index (ASI).
2. *Mental health evaluation.* Upon placement in a residential facility, it is desirable to have a psychiatrist, psychologist, or other qualified mental health professional evaluate each client's mental status, cognitive functioning, diagnosis, medication requirements, and the need for individual mental health services. If individual treatment is indicated, it is integrated with residential treatment via contact among the client, the case manager, and the therapist.
3. *Health and medical evaluation.* Referral information contains the results of recent medical examinations required for placement. All outstanding medical, dental, and other health issues, including infectious diseases, especially HIV and hepatitis, should be addressed early in the program through affiliation agreements with licensed medical facilities. Each client should receive a complete medical evaluation within 30 days of entry into the program.
4. *Entitlements.* The counselor should assess the status of each client's entitlements (e.g., Supplemental Security Income [SSI], Medicaid, etc.) and assist clients in completing all necessary paperwork to ensure maximum benefits. However, care must be taken not to jeopardize a client's eligibility for SSI by inadvertently mischaracterizing the client's disability as substance abuse primary.
5. *Client status.* Staff members assess clients' status as they enter treatment, including personal strengths, goals, family, and social supports. A key assessment weighs the client's readiness and motivation for change.

A successful engagement program helps clients to view the treatment facility as an important resource.

Engagement

The critical issue for clients with COD is engaging them in treatment so that they can make use of the available services. A successful engagement program helps clients to view the treatment facility as an important resource. To accomplish this, the program must meet essential needs and ensure psychiatric stabilization. Residential treatment programs can accomplish this by offering a wide

range of services that include both targeted services for mental disorders and substance abuse and a variety of other "wraparound" services including medical, social, and work-related activities. The extensiveness of residential services has been well documented (Etheridge et al. 1997; McLellan et al. 1993; Simpson et al. 1997*a*).

The interventions to promote engagement described in Figure 6-1 incorporate therapeutic community-oriented methods described in other studies (Items 1, 3, 5–7) (De Leon 1995), as well as strategies employed and found clinically useful in non-TC programs (Items 2 and 4). This approach holds promise for expanding treatment protocols for TC and many non-TC programs to permit wider treatment applicability.

Continuing care

Returning to life in the community after residential placement is a major undertaking for clients with COD, with relapse an ever-present danger. The long-term nature of mental disorders and substance abuse requires continuity of care for a considerable duration of time—at least 24 months (see, e.g., Drake et al. 1996*b*, 1998*b*). The goals of continuing care programming are sustaining abstinence, continuing recovery, mastering community living, developing vocational skills, obtaining gainful employment, deepening psychological understanding, increasing assumption of responsibility, resolving family difficulties, and consolidating changes in values and identity. The key services are life skills education, relapse prevention, 12-Step or double trouble groups, case management (especially for housing) and vocational training and employment. A recent study (Sacks et al. 2003*a*) provided preliminary evidence that a continuing care strategy using TC-oriented supported housing stabilizes gains in drug use and crime prevention, and is associated with incremental improvement in psychological functioning and employment.

Discharge planning

Discharge planning follows many of the same procedures discussed in the section on outpatient treatment. However, there are several other important points for residential programs:

- Discharge planning begins upon entry into the program.
- The latter phases of residential placement should be devoted to developing with the client a specific discharge plan and beginning to follow some of its features.
- Discharge planning often involves continuing in treatment as part of continuity of care.
- Obtaining housing, where needed, is an integral part of discharge planning.

Implementing Residential Programs

The literature contains many descriptions of programs that are employed in the various agencies but far fewer descriptions of how to design and implement these programs. Figure 6-2 (p. 166) identifies some principles found effective in designing and implementing residential programs.

Staffing

Developing a new treatment model places unique demands on staff. Staff for clients with COD should contain a substantial proportion of both mental health and substance abuse treatment providers, include both recovering and nonrecovering staff, and be culturally competent with regard to the population in treatment. A typical 25-bed residential program should consist of about 15 staff, as follows:

- Program director (preferably with an advanced degree in the human service field or with at least 5 years' experience in substance abuse treatment, including at least 3 years of supervisory experience), a secretary, a program supervisor (preferably with a

Figure 6-1
Engagement Interventions

Item	Element	Description
1	Client Assistance Counseling	• Emphasizes client responsibility, coaching and guiding the client, and using the client's senior peers to provide assistance
2	Medication	• Begins with mental health assessment and medication prescription, then monitors for medication adherence, side effects, and effectiveness
3	Active Outreach and Continuous Orientation	• Builds relationships and enhances program compliance and acceptance through multiple staff contacts
4	Token Economy	• Awards points (redeemable for tangible rewards such as phone cards, candy, toiletries) for positive behaviors including medication adherence, abstinence, attendance at program activities, follow-through on referrals, completing assignments, and various other activities essential to the development of commitment
5	Pioneers—Creating a Positive Peer Culture	• Facilitates program launch by forming a seedling group of selected residents (pioneers) to transmit the peer mutual self-help culture and to encourage newly admitted clients to make full use of the program
6	Client Action Plan	• Formulated by clients and staff to specify, monitor, and document client short-term goals under the premise that substantial accomplishments are achieved by attaining smaller objectives
7	Preparation for Housing	• Entitlements are obtained—a Section 8 application for housing is filed, available treatment and housing options are explored, work readiness skills are developed, and household management skills are taught

Source: Adapted from Sacks et al. 2002.

Figure 6-2
Principles of Implementation

How to organize

- Identify the key person responsible for the successful implementation of the program.
- Use a field demonstration framework in which there is cross-fertilization between program design and empirical data.

How to integrate with a system

- Follow system policy, guidelines, and constraints.
- Involve system stakeholders.

How to integrate in an agency

- Select an agency that displays organizational readiness and encourages program change.
- Form collaborative relationships at all levels of the organization, including both program and executive staff.

How to design, launch, and implement

- Develop a planning group of key stakeholders that meets regularly.
- Ensure client and staff orientation to all program elements.
- Provide training and technical assistance in the context of implementation.

Source: Adapted from Sacks et al. 1997*b*.

bachelor's degree), and 10 line staff (with high school diplomas or associate's degrees)

- A clinical coordinator, a nurse practitioner (half-time), an entitlements counselor (half-time), and a vocational rehabilitation counselor (half-time)
- Consultive and/or collaborative arrangements for medical, psychiatric, and psychological input or care

The optimal staffing ratio for morning, afternoon, and night shifts is 3:1, 3:1, and 8:1, respectively. The critical position is the clinical coordinator who will direct program implementation.

Training

Initial training

To implement a new initiative such as the multicomponent MTC requires both initial training and continuing technical assistance. Learning should be both a didactic and experiential activity. The initial training for an MTC, conducted at the program site for 5 days before program launch, provides a model of structure and process that can be applied in other TC and non-TC settings. The training includes 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 a review of treatment process, including a description of the stages and phases of treatment. This curriculum also includes special training in the assessment and treatment of clients with COD and in the key modifications of the TC for clients with COD (see Figure 6-3). Once established, the flagship program becomes the model for subsequent experiential training.

Figure 6-3
Sample Training and Technical Assistance Curriculum

What is a TC?	• Describes the theory, principles, and methods of the TC • Presents the TC perspective of four views: person, disorder, recovery, and "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 people with COD?	• Reviews the literature on the increased prevalence of clients with COD in the mental health services, substance abuse 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 MTCs for clients with COD
What is an MTC?	• Describes the seven main modifications of the TC for clients with COD • Elaborates key changes in structure, process, and interventions of MTCs for clients with COD
How do we assess/diagnose the client with COD?	• Describes the main signs and symptoms of SMI for schizophrenia, major depression, and mania • Presents critical differences between Axis I and Axis II disorders (see the DSM-IV-TR) and their implications for program design • Describes the 10 main characteristics of populations of people with substance use disorders • Presents a classification of criminal behavior and criminal thinking • Presents three clinical instruments for assessing mental disorders, substance abuse, and danger profile • Presents empirical data on profiles of clients with COD
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 establish the TC culture • Describes six techniques for engaging the client in treatment • Presents empirical data from staff studies on the process of change • Develops a sequence for implementing the core TC elements

Figure 6-3 (continued)
Sample Training and Technical Assistance Curriculum

What are the main interventions and 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, medication/medication monitoring), community/clinical management (e.g., learning experiences), and work/other (e.g., peer work hierarchy) • Delineates the interventions for both the residential and continuing care 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 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 criminal justice 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 resident • Demonstrates a typical schedule for a TC day/week • Addresses the concerns and issues of non-TC trained staff

Ongoing training and technical assistance

Training and technical assistance take place in the field; both are 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 debriefing sessions before and after each group activity, a process that continues for several months. As staff members begin to lead new activities, technical assistance staff members provide guidance for a period of several weeks. Monitoring continues until staff demonstrate competency (which takes 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. Training in the MTC model and its implementation has been conducted nationally by National Development and Research Institutes as a part of grant supported activities on NIDA- and SAMHSA-funded projects at no cost to the provider agencies. Other TC agencies (e.g., Gaudenzia, Odyssey House in New York) have also developed this model and either provide training or have the capacity to provide training. SAMHSA's Co-Occurring Center for Excellence affords a unique opportunity for training and the further dissemination of the MTC and other evidence- and consensus-based practices recommended by the consensus panel. See also appendix I for a list of training resources.

Evaluating Residential Programs

The model outlined in the section on outpatient services can be applied here. Program evaluation for use by administrators to improve their programs also can consist of assessing performance standards such as bed or occupancy rates, program retention, average duration of stay, existence of service plans, and referral rates to continuing care. These will be evaluated by comparing standards (to be established by each program) to actual data. Such measures are available in almost all programs and require very little in the way of additional resources. In addition, client satisfaction surveys and focus groups are useful in providing feedback from the perspective of the client and his or her family.

The efficacy of programs can be evaluated by determining change from pre- to post-treatment on basic measures of substance abuse and psychological functioning. Chapter 4 outlines a variety of measures that are available for this purpose including the ASI (McLellan et al. 1985), the Global Appraisal of Individual Needs (Dennis 2000), the Symptom Checklist-90 (Derogatis and Spencer 1982; Derogatis et al. 1973) and the Beck Depression Inventory (Beck and Steer 1987). These measures are relatively easy to use and can be employed even in substance abuse treatment programs with limited resources. The highest level of evaluation involves systematic research study; such efforts

Special Issue: The Use of Confrontation in Residential Substance Abuse Treatment

Confrontation is used commonly in residential substance abuse treatment. De Leon (2000*b*) presents a full description of confrontation that serves as the basis of this discussion. De Leon defines confrontation as a form of interpersonal exchange in which individuals present to each other their observations of, and reactions to, behaviors and attitudes that are matters of concern and that should change. In TC-oriented programs, confrontation is used informally in peer interactions, and formally in the encounter group process. The primary objective of confrontational communication simply is to raise the individual's awareness of how his or her behavior and attitudes affect others. Compassionate conversation, mutual sharing, and other supportive communications and interactions balance properly implemented confrontational exchanges.

Confrontation presents "reality" to individuals. Reality in this sense consists of peer reactions to each other's behavior and attitudes: teaching clients to say it as they see it and to say it honestly. Peer reactions include thoughts as well as the expression of honest feelings that enhance the credibility of the observations. These emotional expressions may be uncomfortable (e.g., hurt, anger, disappointment, fear, sadness) or comfortable (e.g., love, hope, happiness, encouragement, optimism). Appropriate intensity of emotions always is delivered with responsible concern. Thus, the observations and reactions of a confrontation may address negative "reality" and also affirm the "reality" of positive changes in behaviors and attitudes in individuals as they are perceived by others.

Confrontation skills and their application in encounter group are learned through staff training. There are tools and rules that enhance the therapeutic utility of confrontation in particular and the encounter group process in general. Thus, clients and staff must be trained in the proper use of confrontation.

The consensus panel notes that in working with individuals who have COD, the conflict resolution group replaces the encounter group, and the conflict resolution group is described below in the section on MTCs. In brief, the conflict resolution group has many of the same goals as the encounter group but modifies some of the features (especially the degree of emotional intensity) that characterize the confrontation employed in standard encounter groups as described by De Leon above.

usually require partnerships with research investigators.

Sustaining Residential Programs

One important vehicle for sustaining the residential program is through the development of a Continuous Quality Improvement (CQI) plan. The goal of CQI is to assess and ensure that the program meets established standards. It is a participatory process led by internal program staff with consultation from experts who use both quantitative and qualitative information to monitor and review program status and to develop action plans for program improvements and refinements. For quality control, the CQI staff uses observation, key informant interviews, resident focus groups, standardized instruments, and staff review. CQI is a management plan for sustaining program quality, for ensuring that programs are responsive to client needs, and for maintaining performance standards.

The goals of the TC are to promote abstinence from alcohol and illicit drug use, to decrease antisocial behavior, and to effect a global change in lifestyle, including attitudes and values.

A sample CQI plan for an MTC in residential facilities, applicable with modified instruments to other residential programs, is as follows:

- *Fidelity of program implementation to program design and TC standards.* Program fidelity (i.e., assurance that the key elements/interventions of the TC are present) may be tested by administration of the TC Scale of Essential Elements Questionnaire (SEEQ) (Melnick and De Leon 1999). Any scores that fall below the level of "meets the standard" will trigger discussion and appropriate adjustments.
- *Delivery of actual program activities/elements.* Appropriate measures for success include (1) the delivery of an established number of program hours per day or week, as measured by a review of staff schedules and information systems report; (2) the delivery of an established level of specific groups and activities, as assessed by program schedules and program management information system activity reports; and (3) satisfactory concordance rate between program activities as designed and as delivered. This rate may be assessed using the Program Monitoring Form and the TC Scale of Essential Elements Questionnaire (Melnick and De Leon 1999).
- *Presence of a therapeutic environment.* The use of community as the healing agent, the existence of trust in interpersonal relationships, and the perception of the TC program as a place to facilitate recovery and change, together constitute a therapeutic environment. The extent to which these elements exist may be established by participant observation, interviews, and focus groups.

Therapeutic Communities

The goals of the TC are to promote abstinence from alcohol and illicit drug use, to decrease antisocial behavior, and to effect a global change in lifestyle, including attitudes and values. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort, involving intensive mutual self-help typically in a residential set-

ting. At the time of this writing, the duration of residential TC treatment typically is about 12 months, although treatment duration has been decreasing under the influence of managed care and other factors. In a definitive book titled *The Therapeutic Community: Theory, Model, and Method*, De Leon (2000*b*) has provided a full description of the TC for substance abuse treatment to advance research and guide training, practice, and program development.

The effectiveness of TCs in reducing drug use and criminality has been well documented in a number of program-based and multisite evaluations. In general, positive outcomes are related directly to increased length of stay in treatment (De Leon 1984; Hubbard et al. 1984; Simpson and Sells 1982). Short- and long-term follow-up studies show significant decreases in alcohol and illicit drug use, reduced criminality, improved psychological functioning, and increased employment (Condelli and Hubbard 1994; De Leon 1984; Hubbard et al. 1997; Simpson and Sells 1982).

In terms of psychological functioning, clients demonstrate improvement in psychological well-being after treatment (Brook and Whitehead 1980; Carroll and McGinley 1998; De Leon 1984, 1989; De Leon and Jainchill 1982; Kennard and Wilson 1979). Research findings indicate that psychological status improves during treatment, with larger changes in self-esteem, ego strength, socialization, and depression, and smaller changes in long-standing characteristics such as personality disorders (De Leon and Jainchill 1982).

Modified therapeutic communities for clients with COD

The MTC approach adapts the principles and methods of the TC to the circumstances of the COD client. The illustrative work in this area has been done with people with COD, both men and women, providing treatment based on community-as-method—that is, the community is the healing agent. This section focuses on the MTC as the potent residential model developed within the substance abuse treatment field; most of this section applies to both TC and other residential substance abuse treatment programs. A complete description of the MTC for clients with COD, including treatment manuals and guides to implementation, can be found in other writings (e.g., De Leon 1993*a*; Sacks et al. 1997*a*, *b*, 1999).

Treatment activities/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 Figure 6-4 (p. 172) establishes the TC community. Although each intervention has specific individual functions, all share community, therapeutic, and educational purposes.

Key modifications

The MTC alters the traditional TC approach in response to the client's psychiatric symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge control. A noteworthy alteration is the change from encounter group to conflict resolution group. Conflict resolution groups have the following features:

- They are staff led and guided throughout.
- They have three highly structured and often formalized phases—(1) feedback on behavior from one participant to another, (2) opportunity for both participants to explain their position, and (3) resolution between participants with plans for behavior change.
- There is substantially reduced emotional intensity and an emphasis on instruction and the learning of new behaviors.

Figure 6-4
Residential Interventions

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, HIV 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, and monitor the emotional tone of the house.
General Meetings	Provide public review of critical events.
Therapeutic/Educative	
Individual Counseling	Incorporates both traditional mental health and unique M TC goals and methods.
Psychoeducational Classes	Are predominant, using a format to facilitate learning among clients with COD; address 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 clients with COD.
Medication/Medication Monitoring	Begins with mental health assessment and medication prescription; continues with psychoeducation classes concerning the use and value of medication; and then monitors, using counselor observation, the peer community, and group reporting for medication adherence, side effects, and effectiveness. (See chapter 1, subsection titled "Pharmacological advances," and chapter 5, subsection titled "Monitor Psychiatric Symptoms" for more details on the role of the counselor and the peer-community in monitoring mental disorder symptoms and medication.)
Gender-Specific Groups	Combine features of "rap groups" and therapy groups focusing on gender-based issues.

Figure 6-4 (continued) Residential Interventions	
Community and Clinical Management Policies	A system of rules and regulations to maintain the physical and psychological safety of the environment, ensuring that resident life is orderly and 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 and World of Work	A psychoeducational class that addresses issues of mental disorders, substance abuse, and so on, 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 and Placement	Individual counseling after 6 months to establish direction and to determine future employment.
Source: Sacks et al. 1999.	

- There is a persuasive appeal for personal honesty, truthfulness in dealing with others, and responsible behavior to self and others.

In general, to create the MTC program for clients with COD, three fundamental alterations were applied within the TC structure:

- Increased flexibility
- Decreased intensity
- Greater individualization

Nevertheless, the central TC feature remains; the MTC, like all TC programs, seeks to develop a culture in which clients learn through mutual self-help and affiliation with the community to foster change in themselves and others. Respect for ethnic, racial, and gender differences is a basic tenet of all TC programs and is part of teaching the general lesson of respect for self and others.

Figure 6-5 (p. 174) summarizes the key modifications necessary to address the unique needs of clients with COD.

Role of the family

While many MTC clients come from highly impaired and disrupted family situations and find in the MTC program a new reference and support group, some clients do have available

Figure 6-5
TC Modifications for Persons With COD

Modifications to Structure	Modifications to Process	Modifications to Elements (Interventions)
There is increased flexibility in program activities.	Sanctions are fewer with greater opportunity for corrective learning experiences.	Orientation and instruction are emphasized in programming and planning.
Meetings and activities are shorter.		Individual counseling is provided more frequently to enable clients to absorb the TC experience.
There is greatly reduced intensity of interpersonal interaction.	Engagement and stabilization receive more time and effort.	Task assignments are individualized.
More explicit affirmation is given for achievements.		Breaks are offered frequently during work tasks.
Greater sensitivity is shown to individual differences.	Progression through the program is paced individually, according to the client's rate of learning.	Individual counseling and instruction are more immediately provided in work-related activities.
There is greater responsiveness to the special developmental needs of the individual.		Engagement is emphasized throughout treatment.
More staff guidance is given in the implementation of activities; many activities remain staff assisted for a considerable period of time.	Criteria for moving to the next phase are flexible to allow lower-functioning clients to move through the program phase system.	Activities are designed to overlap.
There is greater staff responsibility to act as role models and guides.		Activities proceed at a slower pace.
Smaller units of information are presented gradually and are fully discussed.	Live-out re-entry (continuing care) is an essential component of the treatment process.	Individual counseling is used to assist in the effective use of the community.
Greater emphasis is placed on assisting individuals.		The conflict resolution group replaces the encounter group.
Increased emphasis is placed on providing instruction, practice, and assistance.	Clients can return to earlier phases to solidify gains as necessary.	

Source: Sacks et al. 1999.

intact families or family members who can be highly supportive. In those cases, MTC programs offer a variety of family-centered activities that include special family weekend visiting, family education and counseling sessions, and, where children are involved, classes focused on prevention. All these activities are designed in the latter part of treatment to facilitate the client's reintegration into the family and to mainstream living.

Empirical evidence

A series of studies has established that

- Homeless persons with COD have multiple impairments requiring multifaceted treatment (Sacks et al. 1997*b*, 1998*a*), and the homeless population with COD contains distinctive subgroups (De Leon et al. 1999).
- Residential MTCs for people with COD, including women, produce significantly greater positive outcomes for substance use and employment than treatment as customarily provided (De Leon et al. 2000*c*). A parallel study (Rahav et al. 1995) also demonstrated significantly improved psychological functioning (e.g., lower depression) for an MTC group as compared to a "low demand" community residence program.
- Preliminary evidence shows that TC-oriented supported housing stabilizes the gains from the residential program (Sacks et al. 2003*a*).
- The cost of providing effective treatment through the MTC is no more than the cost of providing less effective treatment delivered through customarily available services (French et al. 1999; McGeary et al. 2000).
- MTC treatment produces $6 in benefit for every dollar spent (French et al. 2002).
- Initial evidence indicates that those with both a mental and substance use disorder in an MTC group show significantly lower reincarceration rates than a group receiving regular mental health services (Sacks et al. 2004).

Current applications

The MTC model has been adopted successfully in community residence programs for serious and persistent mental illness (Sacks et al. 1998*a*), general hospitals (Galanter et al. 1993), and substance abuse treatment programs, both nationally (Caroll 1990) and internationally. It has spread particularly within TC agencies such as Phoenix House, Walden House (Guydish et al. 1994), Odyssey House, Gaudenzia, and Second Genesis.

Manuals have been developed that describe the MTC programs (Sacks et al. 1998*b*, 2002) and principles of implementation (Sacks et al. 1999). In addition, there are procedures that ensure the quality control of new applications (see section on "Continuous Quality Improvement" above). This information is useful to providers planning to develop MTC programs. A representative example of such MTC programs from Gaudenzia is provided on pages 176–178.

Advice to Administrators: Recommended Treatment and Services From the MTC Model

In addition to all the guidelines for treatment cited in chapter 1, the following treatment recommendations are derived from MTC work and are applicable across all models.

- Treat the whole person.
- Provide a highly structured daily regimen.
- Use peers to help one another.
- Rely on a network or community for both support and healing.
- Regard all interactions as opportunities for change.
- Foster positive growth and development.
- Promote change in behavior, attitudes, values, and lifestyle.
- Teach, honor, and respect cultural values, beliefs, and differences.

Gaudenzia, Inc., Pennsylvania

Overview

Gaudenzia, Inc. is a substance abuse treatment organization that provides a range of services at a number of different facilities. It is the largest nonprofit provider of substance abuse treatment services in the State of Pennsylvania, and it has more than 30 different facilities located across the State. Most programs are based on TC or MTC principles and methods. The entire agency has about 550 staff consisting of administrative management, clinical management, front line clinical, administrative, operational support, and nursing personnel. Most of the funding for these programs comes from municipal and State Offices of Mental Health.

While Gaudenzia has facilities in a variety of different areas (urban, suburban, rural), all of the programs described below are in urban areas. Urban locations can support more specialized programs because they serve a larger population, with substantial concentrations of particular subgroups. Six of its facilities were developed as MTC programs to exclusively or primarily serve clients with COD, and a seventh has become a facility for people with HIV/AIDS and COD. They share a common perspective, principles, and methods, which are described below.

Gaudenzia House Broad Street

Gaudenzia House Broad Street is a 30-bed residential treatment program for adult men and women, 18 years or older, who have been diagnosed with both substance use disorders and co-occurring chronic and persistent mental disorders. This facility was opened as a response to the closure of Byberry, Philadelphia's State Hospital, to provide community-based treatment for people with COD. Broad Street is a drug and alcohol and mental health residential program dually licensed by the Commonwealth of Pennsylvania Bureau of Drug and Alcohol Programs as a residential treatment program and by the Office of Mental Health as a residential treatment facility. The program also is accredited by the Joint Commission on Accreditation of Healthcare Organizations. The program uses an MTC approach to treat substance abuse, provides onsite mental health services for co-occurring mental disorders, and integrates substance abuse treatment and mental health services. Program services include individual counseling, work therapy, life skills training, group therapy, educational seminars on substance abuse and mental health, 12-Step and Double Trouble meetings, family counseling, and mental health treatment.

Focus House

Focus House is a long-term (9 months to 2 years) residential substance abuse treatment and mental health services program for men ages 18 and over who have chronic COD. This 12-bed facility provides substance abuse counseling, community residential rehabilitation, and transitional living arrangements for clients with severe and persistent mental illness. Focus House teaches clients the essential life skills they will need to live independent and productive lives in the community, to cease the substance abuse that complicates their mental illness, and to promote self-motivated involvement in the mental health service system. This program is used as a step-down from a more intensive residential inpatient program. All of the clients attend day programs at the local mental health center. In-house program services include group therapy, relapse prevention, individual counseling, socialization skill training, and life skills training.

New Beginnings

Gaudenzia's New Beginnings is an 18-bed residential program that provides long-term residential care for homeless men and women who are chronically mentally ill and have co-occurring substance use disorders. The program initially is a "low-demand" environment that first addresses essential needs and then helps residents change the dysfunctional patterns that contribute to chronic homelessness and aggravate their mental disorders. It is called a "progressive demand facility," which recognizes the need to meet clients where they are, but expects individuals to reach their potential through layering services and expectations in a logical building block manner.

Joy of Living

Gaudenzia's Joy of Living is a 14-bed program that provides long-term (9 to 18 months) residential services for homeless men and women who have COD. The facility provides residents with shelter, support for recovery from substance abuse, and assistance in stabilizing the symptoms of chronic mental disorders. Clients at both the Joy of Living and New Beginnings programs (see above) arrive typically from a hospital or through interventions by city outreach workers or as a next step residence for those who have completed longer-term treatment but are not able to sustain themselves. They generally are not motivated for treatment and have many pressing needs that must be met before they are capable of engaging in a treatment program. Mental health treatment services are not provided onsite because the majority of the clients are in partial-hospital day programs off-site. Case management services are provided to help coordinate services based on clients' abilities to engage in these services.

The facility is considered a specialized progressive demand residence that engages people into formal treatment services by intervention and referral to outside services as needed, such as mental health care, medical services, and vocational/educational programs. Onsite substance abuse treatment includes individual and group counseling, treatment planning, life skills training, medication management, and 12-Step programs.

Progress House

Gaudenzia's Progress House is a 14-bed moderate care community residential rehabilitation program for clients with COD. The facility has six apartments; one is an office and the other five are residences shared by the clients. The program provides semi-independent living for clients who have completed treatment at one of Gaudenzia's other programs. Staff is onsite 16 hours a day, and residents are provided with counseling for mental health and substance abuse issues. All clients go to mental health service programs, vocational programs, or sheltered workshops during the day. Program services include life skills training, vocational guidance, 12-Step meetings, and transitional living services.

New View

Gaudenzia's New View was established to provide community residential rehabilitation services to adult residents (both men and women) of Dauphin County who have SMI and a history of drug and alcohol problems. The program can last up to 2 years depending on a client's clinical progress. The eight-bed program has the features of an MTC, with a strong emphasis on community reintegration. The goal for the majority of the clients is to obtain employment in the community during the later stages of treatment. There also is a strong family component and a weekly continuing care group for clients who have completed inpatient care and are making the transition to independent living.

People With Hope

This program is an MTC 23-bed facility for adult men and women who have AIDS (and are symptomatic) with a variable length of treatment (3 to 9 months); the majority of these clients have co-occurring substance abuse and mental disorders. The goal is to provide substance abuse treatment, shelter, medical care, seminars on HIV disease, and educational services that are designed to enhance the quality of life for the individual. The services during the intensive phase of treatment include individual and group therapy, work therapy, GED/literacy classes, and daily seminars that focus on life skills, AIDS-related issues, parenting, sexual orientation, nutrition, relapse prevention, budgeting, and socialization. The re-entry and continuing care phases of the program include a transitional living component and a strong emphasis on 12-Step participation. For those clients who have a co-occurring disorder, ongoing mental health services such as medication evaluation and monitoring are arranged through the nearby community mental health center. People With Hope has a nursing staff onsite providing medication management and health care case management.

Together House

Together House consists of three distinct programs in the same building licensed by the Commonwealth of Pennsylvania under one umbrella to provide residential treatment for three distinct populations. Among the three tracks, a total of 57 clients are served. The three programs are (1) Men's Forensic Intensive Recovery pro-

gram (MFIR), (2) Women's Forensic Intensive Recovery program (WFIR), and (3) Short-Term Program (STP). MFIR and WFIR each provide residential treatment for 24 adults with COD who have been referred through the City of Philadelphia Forensic network. The majority of these clients come directly to Together House from the city prison system where they have been incarcerated for drug- or alcohol-related offenses.

This program represents a major effort by the city of Philadelphia to provide treatment instead of incarceration to individuals with substance use disorders, recognizing the special needs of the person with COD. The STP serves nine men and women who have HIV, are homeless, and have COD. They must have issues of addiction and also have a co-existing mental disorder. The purpose of STP is engagement, stabilization, thorough assessment, and referral for longer-term treatment. Maximum length of stay is 4 to 6 weeks. In each track, all services are provided onsite, including a full nursing staff, medical management, mental health services, individual and group counseling, life skills education, health and mental health education, vocational planning, onsite 12-Step meetings, and recreational programming.

FIRst Program

The Department of Corrections FIRst (Forensic Intensive Recovery state) is located in the Together House complex and provides a community corrections transitional living program for men coming from incarceration in the State penal system with SMI and substance abuse issues. Started in the summer of 1999, this program was a response to a gaping lack of support for men who were returning to their communities after serving lengthy sentences for what was often a drug- or alcohol-related offense. Their SMI presented a particular problem for early release, hence the FIRst program was indeed a first effort to aid in transition from incarceration to community living.

There are 24 men in residence for 9 to 12 months, with a thorough initial evaluation and stabilization period, followed by increasing reliance on services in the community, decreasing dependence on the program, and gradual re-introduction to the world of work, if possible. Onsite counseling (group and individual), nursing support, mental health services, vocational assessment and referral, recreation, and resocialization classes are all provided. However, after initial engagement, community services are utilized to aid in practicing accessing outside supports in planning a return to outside life. 12-Step meetings are provided onsite and through outside groups.

Recommendations

A considerable research base exists for the MTC approach, and the consensus panel recommends the MTC as an effective model for treating persons with COD, including those with SMI. Recently, the MTC has been rated as one of a few promising practices for COD by the National Registry of Effective Programs and Practices (NREPP), as part of NREPP's ongoing evaluation of COD strategies and models. However, although improved psychological functioning has been reported, differential improvement in mental health functioning using the MTC approach in comparison to more standard treatment has yet to be demonstrated. The TC and MTC approach, although demonstrably effective with various populations of people who use drugs, including those with COD, encounters difficulty in achieving more widespread acceptance. To accomplish greater receptivity to TC and application of its methods, several developments are necessary:

- The principles, methods, and empirical data on MTC approaches need better articulation and broader dissemination to the mental health and other treatment fields. The development of MTCs in mainstream mental health programs is one useful approach (Galanter et al. 1993).
- The application of MTC methods for COD in non-TC medical and mental health settings needs to be established more firmly. It is especially important to ascertain whether, and to what extent, these methods can be separated from their TC framework and made "portable" as services to be used by other systems and approaches.
- As MTC programs continue to adapt for specific populations (e.g., adolescents, prison

inmates, people with COD, women and children), their longer term effectiveness after treatment needs to be evaluated.

- Quality assurance of MTC programs is essential. The theory-based work of De Leon and his colleagues for standard TCs provides the necessary tools for this effort. Specifically, the development of an instrument for measuring the essential elements of TC programs (Melnick and De Leon 1999) and the development of standards for TC prison programs (with Therapeutic Communities of America 1999) enable the service and research communities to assess to what extent TC programs contain the essential elements and meet applicable standards. Further work is needed in adapting these instruments for MTC programs.

Additional Residential Models

A variety of other residential models have been adapted for COD. Two representative models are the Na'nizhoozi model in the Southwest, designed for American Indians with alcohol problems, with the recent incorporation of services for COD (p. 180); and the Foundations Associates model that integrates short-term residential treatment with outpatient services (pp. 181–182).

The Na'nizhoozi Center, Inc. (NCI)

Overview

The NCI has facilities in the town of Gallup, New Mexico (population 20,000), and serves clients throughout a largely rural region of some 450,000 square miles, spanning two States and multiple counties within those States. (In fact, because of the unique nature of the services it offers, the program has accepted clients from across the United States.) The population in the area served by the program predominantly is American Indian.

In 1992, the Navajo Nation, the City of Gallup, the Zuni Pueblo, and McKinley County created NCI to address a significant public intoxication problem in Gallup and in McKinley County, New Mexico. In the 1980s, Gallup alone had more than 34,000 people placed into protective custody for public drunkenness; in 1999, this number had decreased to 14,600.

Clients

The client population is 95 percent American Indian with the great majority (approximately 93 percent) being members of the Navajo Nation. The program has a 150-bed residential facility built to provide service primarily to clients in protective custody (a form of criminal justice sanction that does not involve felony or misdemeanor or other criminal charge in a minimum-security setting, meaning that all doors are locked and the units are segregated).

The primary substance abused by clients entering NCI is alcohol, and the majority of clients (70 percent) is male. Clients exhibit an array of psychological problems and mental disorders. The incidence of COD with the protective custody population is 20 percent. Posttraumatic stress disorder, major affective disorders, and personality disorders are seen most commonly at NCI.

NCI also has a 3-week short-term residential program that is based on American-Indian philosophy. The NCI averages 12 clients per day, of whom 25 percent are admitted from the protective custody residential unit.

Services

NCI's 28-day residential program consists of 150 beds and provides services that are based largely on practices from both Dine' (Navajo) and intertribal traditions. Treatment literature emphasizes culturally appropriate interventions and NCI has made a major effort toward accomplishing this with the American-Indian population it serves. Sweat lodge ceremonies, Talking Circles, language, appropriate individual and group counseling, and culture-based treatment curricula are a few of the initiatives used. Sweat lodge ceremonies are nondenominational group activities with a strong spiritual component. Participants discuss problems or successes in life and receive feedback from other participants. Talking Circles often have a greater number of participants than the sweat lodge ceremonies with less interaction between the speaker and others in the circle. An important factor associated with both activities is that they often are conducted in the native language with Navajo values emphasized in the dialog. Because more than one tribe is served at NCI, the services are designed to meet the needs of different tribal cultures in the southwestern region.

The program has been increasing its services for clients with COD, which include referral to psychiatric assessment, medication, and case management. NCI provides residential and shelter services to support psychiatric interventions by monitoring medication use and providing crisis intervention services within the context of the facility.

Foundations Associates

Foundations Associates in Nashville, Tennessee offers a residential program and a fully integrated continuum of care for clients with COD. Foundations' residential model employs a TC-like structure modified to incorporate best practice concepts for COD. Foundations' program has been recognized as a national leader in serving clients with co-occurring substance abuse and SMI, such as schizophrenia.

Clients

Foundations typically serves clients diagnosed with substance dependence and SMI. Approximately 70 percent of Foundations' residents are diagnosed with schizophrenia, schizo-affective, or mood disorders with psychotic features. Typical substance abuse problems include crack/cocaine, alcohol, and cannabis. Fifty percent of Foundations' consumers are women, and 80 percent are referred from primary substance abuse or mental health treatment programs, typically after referring staff recognize the presence of a second (co-occurring) disorder.

Assessment

Substance abuse, mental health, physical health, vocational/educational, financial, housing/life skills, spiritual, and recreational/social needs are assessed prior to program enrollment. Individualized therapy and case management plans are developed and service matching is determined through the assessment (using ASAM Patient Placement Criteria, Second Edition, Revised). Based on the assessment, clients are assigned to appropriate services.

Services

Core residential services include Dual Diagnosis Enhanced Therapeutic Community, Halfway House, and Independent Living levels of care. Clients progress through the residential program in a series of five stages, based on clinical progress and earned privilege. All clinical activities, including treatment team staffing, are fully integrated to blend treatment for substance use and mental disorders. Program services are comprehensive to meet the complex needs of clients, and frequently include case management, vocational rehabilitation, individual/family/group therapy, and skills training.

Evaluation

Initial findings from a 3-year CSAT-funded evaluation of Foundations' residential program indicated abstinence in 70 to 80 percent of Foundations' clients up to 1 year following treatment. Severity of psychiatric symptoms was reduced by 60 percent, with corresponding improvements in quality of life. Perhaps most notably, high-cost service utilization dropped substantially following integrated treatment, with 80 to 90 percent reductions in inpatient and emergency room (ER) visits related to substance use or mental health problems. Likewise, inpatient and ER visits for general health care declined by 50 to 60 percent. Service profiles showed an increase in appropriate, cost-effective utilization of community supports and services. These results suggest that the program model of integrated and continuous treatment breaks the repetitive cycle of traditional substance abuse and mental health treatment for consumers with COD.

Best Practices

Best practice integrated treatment concepts serve as the basis for all program activities, including

- Continuous cross-training of professional and nonprofessional staff
- Empowerment of clients to engage fully in their own treatment
- Reliance upon motivational enhancement concepts
- Culturally appropriate services
- A long-term, stagewise perspective addressing all phases of recovery and relapse
- Strong therapeutic alliance to facilitate initial engagement and retention

Foundations Associates (continued)

- Group-based interventions as a forum for peer support, psychoeducation, and mutual self-help activities
- A side-by-side approach to life skills training, education, and support
- Community-based services to attend to clinical, housing, social, or other needs
- Fundamental optimism regarding "hope in recovery" by all staff

These principles reflect best practice concepts for COD, but the challenge lies in day-to-day program implementation. To facilitate broader adoption of integrated practices, Foundations Associates will make available upon request implementation guides, program manuals, and clinical curricula for programs interested in adapting this model to their community.

Contact information, detailed program materials, and research findings may be obtained via Foundations' Web site at http://www.dualdiagnosis.org.