

# Integrating Services for Co-occurring Disorders

Final Report  
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By

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The Center can be found on the web at: [csipmh.rfmh.org](http://csipmh.rfmh.org)

# INTEGRATING SERVICES FOR CO-OCCURRING DISORDERS

## EXECUTIVE SUMMARY

### INTRODUCTION

Directors of county mental health systems face persistent and frustrating barriers to providing services to the population with co-occurring mental illness and chemical abuse disorders. Individuals in this group are both difficult to engage and retain in traditional treatments and challenging to support in the community. There is a consensus that services for individuals with varying degrees of co-occurring disorders should be coordinated along a continuum ranging from consultation to collaboration to integration.

This report:

- ❑ provides the research and data context that supports integrating services
- ❑ documents the barriers experienced in New York State
- ❑ describes strategies that have met with some success in integrating services

### IDENTIFICATION AND ASSESSMENT OF CO-OCCURRING DISORDERS

In order to engage clients in available and appropriate treatments, strategies to identify clients' substance use and need for treatment and supports at entry to services are crucial. The following are highlighted in this section:

- ❑ a central assessment unit with cross-trained staff and a single assessment instrument that meets all regulatory requirements
- ❑ a single point of assessment with agencies co-located in a single building
- ❑ a multi-dimensional, holistic assessment process
- ❑ a review of assessment instruments for persons with severe mental illnesses, including: Addiction Severity Index; Dartmouth Assessment of Lifestyle Inventory; Clinician Rating Scales; Substance Abuse Treatment Scale; Readiness to Change Questionnaire.

### ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) has demonstrated effectiveness for clients with co-occurring disorders. Research projects have ranged from enhanced mental health services to intensive integration to harm reduction models. Key components have been identified as:

- ❑ multi-disciplinary team approach
- ❑ long term perspective
- ❑ stagewise treatment based on motivation and readiness to change

Fidelity to the ACT model appears to be important for successful outcomes. Several ACT-like strategies are described addressing issues of housing, high risk populations and rural outreach.

### THE FORENSIC SYSTEM

County Directors reported a substantial amount of direct involvement with local criminal justice systems. After release, inmates are vulnerable to relapse and re-arrest and women in particular are at high risk of pregnancy and contracting sexually transmitted diseases including HIV. The task of engagement in the service system post-release becomes more daunting. Strategies discussed include

- ❑ jail-based assessment and treatment
- ❑ diversion through probation and police training
- ❑ Drug Court expansion to include persons with mental illness
- ❑ post incarceration transition programs and links

## **HOUSING**

County Directors named the lack of safe, stable housing as a critical gap in providing adequate services to the target population. The residential continuum for people with co-occurring disorders described in this section includes:

- ❑ a modified therapeutic community
- ❑ MICA residences
- ❑ supported, scatter site apartments

## **PEER-DRIVEN MODELS OF DUAL RECOVERY**

Peer directed self-help groups are emerging that extend the concept of recovery to severe mental illness co-occurring with drug and alcohol problems, and provide participants with strong support and common bonds. Examples range from social clubs that seek to educate the public about persons with mental illness to mutual-aid groups based on traditional 12-step models that have been modified for persons with co-occurring disorders. Some provide peer counseling and others support consumers as they participate in committees and community boards.

## **STAFF TRAINING**

County Directors have expended much effort on and indicated significant progress in training staff to work with individuals with co-occurring disorders. Most painted complex pictures of diverging treatment philosophies, conflicting staff cultures, and resistance to change. Efforts to expand cross-training opportunities are presented and resources for training are enumerated.

## **CONCLUSION**

This Technical Assistance Project report has described strategies used by local leadership to effect changes in fragmented and complex service systems. System-level integration of provider agencies is important but is not sufficient. While research demonstrations regarding effectiveness are crucial, federal, state and local leadership is required to implement what is known. A framework for initiating and promoting innovations is presented. In order to launch innovation, County Directors in NYS have mobilized willpower, involved key players, identified models, collaborated with the substance abuse and other systems, trained the work force and funded these innovations using the flexibility of demonstration and reinvestment dollars.

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# INTEGRATING SERVICES FOR CO-OCCURRING DISORDERS

## I. INTRODUCTION

Directors of county-level mental hygiene or behavioral health systems face persistent and frustrating barriers to providing services to the population with co-occurring mental illness and chemical abuse disorders. Individuals in this group are both difficult to engage and retain in traditional treatments and challenging to support in the community. There is a consensus among policy leaders, state and local governments, the academic and treatment communities and consumers that services for individuals with varying degrees of co-occurring disorders should be coordinated along a continuum ranging from consultation to collaboration to integration. The Surgeon General's Report on Mental Health (1999) identifies combined services for people with co-occurring disorders as services that are in consistently short supply across the nation, as are assertive community treatment programs, prevention, and early identification programs. This report provides the current research/data context that supports integrating services for co-occurring disorders, documents the local barriers in New York State, and describes local strategies that have met with some success in integrating services. In the face of a host of regulatory, fiscal and treatment culture barriers to these goals, counties have made innovative and far-reaching efforts to deliver services that meet both the mental health and chemical dependency treatment needs of individuals with co-occurring severe mental illness and substance use disorders.

The Nathan Kline Institute was engaged by the New York State Conference of Local Mental Hygiene Directors to provide technical assistance services related to the integration of services for individuals with co-occurring disorders. This Technical Assistance Project has included a phone survey of all county directors and an in depth look at strategies toward integration in six counties. The report is organized conceptually around areas of greatest need identified in the phone survey:

- ❑ successful strategies to identify and assess co-occurring disorders
- ❑ engaging persons with co-occurring disorders in community services
- ❑ minimizing involvement with criminal justice system
- ❑ securing stable housing.
- ❑ developing and supporting peer-driven models for dual recovery and
- ❑ staff cross-training

Finally, a framework is presented to assess progress toward integration and to systematize "next steps" for providing adequate services for this population. Each section contains background material and examples of strategies identified in the six counties. Outlines of these counties and summaries of their key efforts to integrate services are provided in an Appendix, as are additional programs, including some that are consumer focused or driven.

### **Integrated services**

Clinical course and outcome are worse when mental illness and substance use are present. These co-occurring disorders, sometimes referred to as MICA (Mental Illness and Chemical Abuse), are associated with greater likelihood of treatment non-

compliance, symptom exacerbation, violent behavior, family friction, hospitalization, incarceration, homelessness, suicide, higher service use and costs (Surgeon General's Report, 1999). Substantial research shows that treating co-occurring disorders through separate service systems has been ineffective (Mueser, et al., 1997), and supports a shift to combined or integrated treatment (see Mercer-McFadden, et al., 1998 for a summary).

*Integrated clinical services.* Integrated treatment refers to the simultaneous treatment of all disorders by a dually trained clinician or a cross-trained treatment team whose members are competent to treat both the substance abuse and mental health disorders. The critical component of an integrated approach is cooperation and communication between clinicians about the nature and effectiveness of the treatment and about changes in the client's life. The goal is for patients to receive consistent explanation and interventions for their co-occurring disorders. The evidence is that integrated or combined approaches to providing treatment for co-occurring disorders are effective but rarely available in most states. Most frequently, mental health and substance abuse services are provided in parallel, by two or more clinicians who work either in a single agency or in two separate agencies. Cooperation and communication may be hindered by time pressures, by treatment-culture differences between the agencies, or by competing goals in the two agencies. In sequential models, one disorder may be effectively ignored while the other is treated.

Except for a very few MICA specific services, typically as part of Continuing Day Treatment programs, true integration is extremely difficult to accomplish in the current treatment system in New York State. For the most part, agencies stitch together parallel treatment with the advantages of co-located services, to create apparently seamless treatment for clients. They rely on case management or MICA coordinators as well, to provide the linkages across programs.

<p><b>SAMHSA AUTHORIZATION LEGISLATION: CURRENT STATUS</b>  <b>S.976 the Youth Drug and Mental Health Services Act</b></p> <ul style="list-style-type: none"> <li>❑ Passed by Senate in late 1999</li> <li>❑ Currently in House Commerce Committee</li> <li>❑ States are required to develop comprehensive service plans for people with severe mental illness.</li> <li>❑ Mental Health Block Grant (1911):                  \$356 million in FY 2000                  Includes the first appropriation increase in its history</li> <li>❑ Substance Abuse Prevention &amp; Treatment Block Grant (1912):                  \$ 2 billion in FY 2000</li> <li>❑ Advocates recommend language that               <ul style="list-style-type: none"> <li>1) allows states to blend block grant funds for integrated treatment</li> <li>2) requires reporting that does not hinder States' ability to combine funds to provide integrated services to individuals with co-occurring disorders.</li> </ul> </li> </ul>
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Almost half of the nation's Mental Health and Alcohol and/or Drug authorities are entirely separate administrative structures that report to separate state departments. In the federal government, the separate agencies in the Substance Abuse and Mental Health Services Administration

(SAMHSA) administrative structure -- Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) -- both reflect and reinforce the states' administrative, fiscal and political fragmentation. Their philosophical differences, differences in professional credentialing and lack of appreciation of each other's competence have been documented as barriers to provision of integrated services in a survey by NASADAD/CSAT (1998). Despite findings supporting the effectiveness of integrated services, the Federal government has not endorsed this approach to address co-occurring disorders. SAMHSA, in response to Mental Health advocates, has clarified their policy that block grants to the states may be blended, but only if separate accounting procedures continue to be followed. The legislation to reauthorize SAMHSA -- S.976 The Youth and Mental Health Services Act -- which retains this language was passed by the Senate. It is now in the House Commerce Committee where advocates, including NAMI are urging that the language include reporting requirements that do not "hinder states in their ability to combine funds from ...the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant...in order to provide and integrated program of services to individuals with co-occurring disorders. While SAMHSA has expressed a willingness to work with the States to promote effective services for co-occurring disorders, the language of integrated treatment is not yet supported by legislation. The recently released Surgeon General's Report on Mental Health uses the language "combined treatment" to describe what is referred to in the literature, in the field, and in this report as "integrated services".

*Integrated support systems.* A community based service system for people with severe mental illness can only work with affordable, safe housing, especially for people with co-occurring disorders. A critical finding of the Robert Wood Johnson Nine Cities demonstration program to integrate services across systems for people with severe mental illness was that client level improvements appear to require more than service integration and traditional case management alone (Goldman, et al., 1994; Lehman et al., 1994). Rent subsidies and supports, or more intense, higher quality Assertive Community Treatment-like case management services were essential (Ridgely, et al., 1996). Better system integration contributed to movement from homelessness to independent housing for homeless people with co-occurring disorders in the Federally funded Access to Community Care and Effective Service Systems (ACCESS) demonstrations (Rosenheck, et al., 1998).

Finally, the growing presence of people with co-occurring disorders in criminal justice settings requires that mental health services be integrated into arrest and arraignment proceedings, in-jail treatment, and pre-release planning, and the post release window of vulnerability to relapse and recidivism.

The focus of this report is on locally identified barriers to integration and on efforts to move creatively toward integration of clinical treatment and support services within the mental health and substance abuse systems as they are currently configured. New York is a diverse state, encompassing the nation's largest city as well as the 6<sup>th</sup> largest rural population in the country (Hewitt, 1989). Counties range in population from 5,000 to well over 2,000,000. Local governing structures and organization of mental health and substance abuse services vary. Some counties provide all local public mental health and substance use services, some contract all of these services to local agencies, and some

do both. Local fiscal constraints and political processes impact both the nature and the level of resources that will be made available to address particular behavioral health and social services needs. Services, strategies and energy to address co-occurring disorders compete with those to address severe mental illness only, children and families, welfare reform efforts and assisted outpatient treatment. Frustration with providing adequate training and motivation for staff to treat dual disorders and for consumers to participate in their own recovery is pervasive. Finally, the ability to accomplish local innovations depends on relationships among local stakeholders as well as on the formal organization and structures of services.

## SURVEY OF COUNTY DIRECTORS

This technical assistance project included a phone survey of all County Directors of behavioral health services in New York State. Fifty-three counties (93%) participated in the survey which asked for a description of the county and its service system, barriers to coordinating services, significant non-clinical features of the population, characterization of the target population, consumer barriers, and successful strategies.

**Target population.** 55% of the County Directors surveyed indicated that the populations in need of integrated services in their counties were severely impaired due to a psychiatric disability alone or in conjunction with a substance use disorder. Severe mental illness diagnoses were the focus for 35%; broader diagnostic criteria for 25%, and severe functional impairment regardless of psychiatric diagnoses defined the target population for 25% of county directors. Some respondents noted that although they thought it more productive to consider functional limitations in targeting integrated services, billing criteria foster consideration primarily of diagnostic labels.

### *Who receives integrated clinical services in NYS?*

Integrated clinical services ideally means that a client receives one set of interventions

# Counties	% Of Target Population Receiving Integrated Clinical Services
9	HALF
5	ONE THIRD
6	ONE TENTH
12	FEWER THAN ONE TENTH
8	NONE
14	CAN'T ESTIMATE

Source: Phone Survey of County Directors

for both mental and substance abuse problems from one clinician or team with both sets of skills. Clients with co-occurring disorders who receive integrated services in NYS are primarily that small number (one third or fewer of the target population in three quarter of the counties) who could be accommodated in MICA tracks, typically in

Continuing Day Treatment (CDT) Programs. In some instances, co-located, or very closely located, mental health and substance abuse clinics are able to provide MICA

groups co-led by mental health and substance abuse staff. Because Medicaid regulations prohibit billing for two simultaneous services, agencies may alternate billing for the group. Since reimbursement for Alcohol and Other Drug (AOD) services is lower than for Mental Health (MH) services, counties where MH AOD authorities are combined can arrange for one agency to donate staff time for the group

***Non-clinical characteristics of the population/ Barriers to integrating treatment***

**Significant Non-Clinical Characteristics of the Target Population**

- ❑ Corrections system involvement
- ❑ Violence and victimization
- ❑ Residential problems
- ❑ Family issues
- ❑ Culture and language
- ❑ Insurance and entitlements

Source: Phone Survey of County Directors

People with co-occurring disorders live most of their lives in the community outside of formal clinical settings. However, they are at heightened risk to be in crisis, in jail, in and out of housing of varying degrees of safety and habitability, and are frequently in isolation and in need of social support. They negotiate a “de facto” complex of systems - criminal justice; social services for housing, entitlements, child protection; medical care; mental health and chemical

dependency These systems must work together to devise large and small solutions to fragmentation of clinical and support services.

County Directors reported major systemic, situational and personal/familial barriers to providing integrated services in New York State. By combining knowledge of these barriers with the information about the characteristics of the population we have identified six key areas that the remainder of this report will address. They are 1)

**BARRIERS TO INTEGRATING TREATMENT**

**SYSTEMIC**

- Specific services not available
- Services not coordinated
- Staff attitudes and acceptance
- Limited insurance benefits
- Lack of support services

**SITUATIONAL**

- Transportation
- Housing
- Isolation
- Lack of employment opportunities

**PERSONAL/FAMILIAL**

- Stigma
- Resistance/denial
- Inability to pay for services
- Family problems

Source: phone survey of county directors

assessment; 2) assertive community treatment; 3) forensics; 4) housing; 5) peer-driven models; and 6) training. For each of these we present examples from within New York State that may prove informative for other counties.

We have taken in-depth looks at six counties that are representative of New York State and describe here the approaches they have in place to work around these barriers to integrated treatment. The counties are geographically dispersed, include the continuum of rural

and urban populations, and reflect degrees of organizational complexity.

## II. IDENTIFICATION AND ASSESSMENT

**Background.** There is a high probability that an individual seeking mental health treatment in New York State has an alcohol or substance use disorder. Prevalence rates of 29% have been reported in the general population (Regier, et al., 1991), and one third to two thirds of clients in a variety of mental health treatment settings in New York State outside New York City (Alexander & Haugland, 1997) have current substance abuse problems. The NYS Office of Alcoholism and Substance Abuse Services estimates that 13% of individuals in their system have associated mental health problems (OASAS Year 2000 County Resource Book). The 1991 and 1994 National Household Survey on Drug Abuse indicate that current and lifetime use of marijuana, hallucinogens, inhalants and cocaine is converging among adults in rural, and urban areas, with similar demographic and social correlates of use (Robertson and Donnermeyer, 1998).

The phone survey conducted with County Directors reveals that services targeted for individuals with co-occurring disorders most often are provided within the context of Continuing Day Treatment programs. These programs often include discrete and regularly scheduled psycho-education and psychotherapy groups focused on co-occurring disorders. Often identified as comprising a county's "MICA track" the CDT programs utilize cross-trained staff or shared staff resources under the umbrella of the county mental health department. Peer-led mutual support groups and traditional 12-step groups may also be included in the array of services made available at the CDT program location.

But co-occurring disorders must be identified and treatment and support needs assessed at the point of entry to services in order to engage clients in available and appropriate services. This initial step is both crucial and problematic. Skilled clinicians are most often competent in either mental health or substance abuse, bringing with them training, experience and a treatment philosophy that tempers their decisions. Therefore it is critical that procedures be in place to ensure that persons accessing a County Mental Hygiene services are assessed properly and consistently for both mental health and substance abuse disorders and services. Ideally this would be an integrated assessment, but there are barriers to this process.

Because secrecy frequently accompanies alcohol and drug use it is important to make these behaviors explicit issues in assessment and treatment. Self-reporting, combined

### Barriers to integrated assessment

- a problem identified in a record must be addressed
- logistics of dual record keeping
- confidentiality mandates
- lack of standards and instruments
- lack of cross-trained staff

with collateral or clinician input, fairly accurately identifies substance use problems, particularly if a positive response is not associated with negative consequences such as arrest, refusal of treatment, or loss of housing (Wolford et al, 1999). Guidelines recommend

using data from multiple sources incorporated into longitudinal assessments over time (Carey et al, 1996; Drake, Alterman & Rosenberg, 1993). Clear inclusion of questions about alcohol and drug use and their consequences in initial and ongoing assessments, and/or random urine tests are useful in identifying individuals with problems, and in keeping the goals of recovery alive. Urine testing to identify substance use is helpful if use is very recent, and is more costly than self-report. Prior as well as current use should be assessed because clients who are not currently using remain vulnerable to relapse, and continue to need services that explicitly focus on maintaining recovery. Although clients in recovery do not use the intensive services that current users do, they do use more rehabilitative and housing services (Bartels, et al., 1993). It is also likely that vocational services and the support of mutual aid 12 step approaches will be useful for clients in recovery (Vogel, 1998; Clark 1996). Assessment in these dimensions should be included so integration with the appropriate support systems occur as early in the treatment process as possible.

### ***Integrated Assessment***

Several directors cited the need for holistic assessments that would occur over time so that clinical staff would be able to address or at least identify the critical aspects of treatment. Several counties reported some degree of assessment centralization – ranging from a specific assessment unit with cross-trained staff utilizing a single integrated assessment form to relying on co-location of services to facilitate communication between workers from divergent fields.

### ***Rockland County***

Central Assessment Unit. Rockland County's integrated assessment procedure was developed during a reorganization of the county mental health and social service system. Persons with co-occurring disorders were seen as a major target population but admission to any of the 17 programs offered at the County Health complex was a separate process. Core staff from each of these programs helped develop a single assessment procedure and ensured that each program's requirements were incorporated. Furthermore, the distinct data elements required by OMH and OASAS regulations are included. While this leads to some redundancy, it assures a most complete record. The Central Assessment Unit staff members are cross-trained, and do training with the remaining staff. In addition, an Assessment Unit staff member does screenings and assessments at the county jail.

Another feature of Rockland's assessment process is the use of frequent and ongoing urinalysis. Knowledge of active drug and alcohol use was seen as critical to the success of the Chemical Dependency treatment goals as well as necessary to assessing responses to prescribed medications. Monitoring alcohol and drug use through urinalysis takes place at the time of initial assessment and weekly while in treatment. While implementing this procedure required overcoming staff resistance, it is felt to be a cornerstone of their success in coordinating the delivery of a complex array of services. All clients served in the county must sign a contract stipulating that they agree to this procedure.

### **Single point of assessment**

Initial screens may identify a person as needing help with both mental health and chemical dependency. Having a single place to refer the person, especially if it diverts the case from hospitalization or jail is a plus. Chemung County has a single point MICA assessment done at the Family Services Clinic. Referrals can come from many sources including the police and the hospital Emergency Room via the urgent care worker, the rural ACT Team and non-crisis referrals from physicians, schools and families.

An integrated assessment process may be closely approximated by the co-location of service providers in the same building, allowing for consultations and collaborative efforts. The Department of Community Services in Sullivan County is housed in a new building, and the County Mental Health, Chemical Dependency and Social Services Departments are developing a good working relationship. Because transportation to the site is costly in this rural and sparsely populated county, and consumer engagement is always a problem, it is important to do as much as possible while a consumer is there. This includes the assessment process as well as treatment programs. In the past year, the county has brought in a consultant from The Rehabilitation Institute who has developed a comprehensive approach to MICA services. One component of this is an integrated, holistic assessment procedure that the county is considering adopting. In this county, instituting a single point of assessment by cross-trained staff has improved:

- ❑ the likelihood and consistency of identification of co-occurring disorders
- ❑ treatment plan compatibility, since a common assessment form is used
- ❑ access to support services, since several assessments are completed in one visit
- ❑ the ability of consumers to overcome transportation and motivational barriers to complete the assessment process

### ***ASSESSMENT INSTRUMENTS***

A copy of each of the assessments described in detail below is included in Appendix I.

*Dartmouth Assessment of Lifestyle Inventory.* This is an 18 item screen derived from the items on widely used screens for alcohol and drug use problems that best predicted presence of a problem for individuals with severe mental illness (Rosenberg, et al., 1998). Scales used to develop the DALI include the frequently used MAST, DAST, CAGE and TWEAK. The screen can be self administered, or can be administered by a mental health worker. There is a computerized version of the screen as well, in which the items are delivered by voice to the respondent. In the web-based version, the screen is instantly scored and identification is returned to the clinical site. This screen has been validated in a rural, male Caucasian sample with severe mental illness diagnoses. A project to extend the screens validity to a range of mental health treatment settings in NYS and to a Caribbean Hispanic version will occur in the next year.

*Clinician Rating Scale.* This is a set of two five point scales (one for alcohol and one for drug use problems) that can be used to guide and summarize information from multiple sources (family, clinicians, case managers, client) that reflect use and impairment over

time. These types of assessments are most appropriate for clients with ongoing contact with mental health services, in non-acute settings where behavioral disorganization will not interfere. The Clinical Rating Scales (CRS) are anchored with descriptions that correspond to DSM criteria for alcohol and substance abuse and dependence disorders (Drake and Noordsy, 1990). They have very high sensitivity (correctly identify those with an alcohol problem) and specificity (do not incorrectly identify anyone without an alcohol problem as having one) (Carey, et al., 1998). The Clinical Rating Scales are more sensitive than several self-report scales, including the Structured Clinical Interview for Diagnosis (SCID), and the Addiction Severity Index (ASI), primarily because they incorporate information from a clinician, case manager or collateral (Wolford, et al., 1999).

Copies of both CRS scales are included in Appendix I. Because the ASI is frequently used in chemical dependency settings, a copy is included as well in Appendix I. However, it should be noted that to be clinically useful, the ASI requires training, and that the measure has fairly low test retest reliability among individuals with severe mental illness.

*Readiness to Change.* A major finding to come out of federally funded evaluations of integrated services for co-occurring disorders is that clients must be matched to the right treatment. Besides identifying negative consequences of alcohol or substance use, assessments should also include staging of change and recovery. Prochaska et al (1992) developed a 5 stage model that includes pre contemplation, contemplation, preparation, action and maintenance. Osher and Kofoed (1989) developed a similar model that is more focused on the role of the treatment system: engagement, persuasion, active treatment and relapse prevention. Two brief questionnaires that target a client's stage of readiness to change are the URISA (Rollnick, et al, 1992), and the Substance Abuse Treatment Scale (SATS) (McHugo, et al., 1995).

**Multidimensional Assessment.** The Recovery Institute is a for-profit organization

<b>FUNCTIONAL ASSESSMENT DIMENSIONS FOR CO-OCCURRING DISORDERS</b>	
<input type="checkbox"/> Physical/Medical	<input type="checkbox"/> Interpersonal
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Addictions
<input type="checkbox"/> Legal/Moral	<input type="checkbox"/> Leisure
<input type="checkbox"/> Emotions	<input type="checkbox"/> Vocational
<input type="checkbox"/> Thoughts	<input type="checkbox"/> Family
<input type="checkbox"/> Social Network	<input type="checkbox"/> Intelligence
<input type="checkbox"/> Self image	<input type="checkbox"/> Spirituality
<input type="checkbox"/> Coping strategies	<input type="checkbox"/> Sexuality
Source: The Recovery Institute, Inc.	

that runs a well integrated, OASAS licensed rehabilitation program at St. Peter's Addiction and Recovery Center in Albany, New York and provides in-service training and consultation on assessment and service provision for co-occurring disorders (See Appendix VIII). A functional, multi dimensional and holistic approach to assessment is a critical feature of this rehabilitation program. The 50 item assessment is used to key

a client's functional severity to a treatment package which in turn is keyed to a case rate. In this way, intensity of service use can be reimbursed in a managed care environment. Software for the assessment tool is being developed. The model is theoretically driven. Stages of change (pre contemplation through maintenance) are

incorporated into treatment, using the assessment over time to monitor progress and move clients through its continuum of services. The assessment tool also allows the program to continue to key client severity to treatment package and intensity, and case rate. The program looks like a Day Treatment program for clients assessed as severely disabled, and would look like a stable outpatient program for clients assessed as mildly disabled. After some trial and error, the program now successfully manages this critical "step down" in service intensity by keeping the client in the same place with overlapping staff so critical staff-client relationships can be maintained across a continuum of care.

Staff burnout is explicitly addressed in this program model. Team building meetings are held regularly that apply the concept of stages of change and promote the model's orientation toward recovery in order to sustain motivation and minimize burnout. The treatment team consists of a nurse practitioner and psychiatrist who provide primary care interventions as well as monitoring of psychiatric medications; MSWs who are Certified Alcoholism Counselors coordinate all care internally and provide individual treatment for a caseload of 15-20 clients; CASACs run groups and perform case management for a caseload of 30-40 clients, doing outreach and linking clients to external agencies; a master's level vocational counselor is being incorporated into the team.

The model was developed in conjunction with both OMH and OASAS and ran for ten years in Rensselaer County as a Task Force on Integrated Projects (TFIP) grant. The program's major goal is to decrease fragmentation by wrapping services, including primary care, around the client. In its current form this 18-month rehabilitation model, supplemented by county reinvestment dollars for primary care and crisis response, is tailored to provide integrated outreach, clinical, rehabilitation and crisis prevention services to moderately to severely impaired individuals with co-occurring disorders.

### III. ASSERTIVE COMMUNITY TREATMENT

**Background.** The vast majority of people with co-occurring disorders who seek services need treatment to recover. In a long term (7 year) study of the natural history of dual diagnoses, fewer than 5% of individuals with severe mental illness and substance use disorders recovered in a year, while many of those with minor alcohol problems progress to more severe alcoholism (Bartels, et al., 1995).

**Development of interventions.** Treatment is effective in reducing hospitalization and substance abuse for people with co-occurring disorders, but requires a long view of stabilization and recovery and use of motivational techniques to move clients through stages of change (Prochaska, 1992; Mercer-McFadden, et al., 1998). Models of combined treatment that have been found to be effective include case management, group interventions and assertive outreach (Mueser, et al., 1997). Combined treatment should engage people with both disorders in outpatient treatment, maintain continuity and consistency of care with the goals of reducing substance abuse and hospitalization, and improving social functioning (Surgeon General's Report, 1999; Mueser, et al, 1997; Miner, et al., 1997). Research is emerging on promising self-help approaches specifically for people with co-occurring disorders (Vogel, et al., 1998; Laudet et al., in press). But access to truly integrated, simultaneous services for both mental health and substance abuse disorders provided by the same clinician or group of clinicians treatment remains accessible for only a small proportion of the target population (Kosten and Zeidonis, 1997; Surgeon General's Report, 1999 p. 288).

#### EFFECTIVE APPROACHES FOR TREATING PERSONS WITH CO-OCCURRING DISORDERS

- Assertive outreach
- Integration of services
- Flexibility and specialization of clinicians
- Stage wise treatment
  - Engagement
  - Persuasion
  - Active treatment
  - Relapse prevention
- Recognize client preferences
- Close monitoring
- Comprehensive services
- Stable living situations
- Long term perspective

Source: Mercer-McFadden, et al., 1998

The Federal government (Center for Mental Health Services) and private foundations (Robert Wood Johnson) have sponsored several substantial demonstration and research initiatives since the mid eighties that focus on the process and outcomes of integrating fragmented clinical services and community support systems for individuals with co-occurring disorders. These demonstrations collectively show that programmatic and systemic integration must occur if clients are to become and remain engaged in treatment over a long enough time period (18 months or more) for reductions in substance abuse and hospitalization and for substantial rates of remission for substance abuse disorders to be successfully attained (Mercer-McFadden, et al., 1998). There is also some prospective evidence that patients drop out of services by

8 months without extensive efforts at engagement and motivation (Hellerstein, 1995).

The first wave of demonstrations implemented in the late 1980's generally tailored usual mental health programs for patients with co-occurring disorders by adding substance abuse groups and peer and professional counselors for several hours a day over several weeks or months to usual mental health programs with co-occurring disorders. With this level of integration, patients could not be maintained in treatment. Dropout rates of over 60% were common.

A second wave of demonstrations offered more assertive outreach, had a short term intense treatment phase, sometimes in residential settings and focused on more intense integrated community based treatment which included standard mental health treatment and assertive outreach, intensive case management, individual, group and sometimes family substance abuse counseling. Some of these interventions took place in intensive inpatient or residential

RESULTS OF FEDERAL DEMONSTRATION PROJECTS ON INTEGRATED SERVICES	
INTERVENTIONS	OUTCOMES
<p><b>Enhance usual MH services</b> added peer and/or professional counselors and substance abuse groups to usual mental health programs for several hours a day over several weeks or months.</p>	<p>Could not maintain patients in programs.</p>
<p><b>Intensive Integration</b> standard MH Treatment <b>AND</b> Assertive outreach, Intensive Case Management, Individual Group and Family Substance Abuse Counseling. Some intense inpatient or residential environments had several interventions/day over several months.</p>	<p>*High dropout rates *For those remaining: Good outcomes during intensive phase, <b>BUT</b> high relapse after discharge.</p>
<p><b>Add Stagewise &amp; and Harm Reduction Paradigms to Integration</b> CSP demonstrations developed stage wise interventions to include different levels of engagement and to reduce the most immediate damaging effects of substance abuse (Harm Reduction)</p>	<p>*59-87% clients retained *Hospitalizations reduced *Substance Abuse reduced *Substantial rates of *Substance Abuse remission</p>

(e.g. modified therapeutic community) environments that involved multiple interventions daily, for several hours a day over a period of several months. Multidisciplinary case management teams were used to deliver the community based interventions. Dropout rates were lower than in the first set of demonstrations, but were still high (40-50%). Those who remained in treatment did well during the intensive phase, but relapse rates post-discharge were high. There was minimal evidence for sustained improvement.

Results from a third wave of Community Support Program (CSP) demonstrations

identified the need for motivational, stage wise interventions, and for a long-term view of both treatment and successful outcomes. The major modalities used in these studies were dual disorder treatment groups, case management services and family interventions. At one year follow up, 60 - 90% of people were retained in treatment, dual disorder programs were created in a variety of clinical settings, special populations, namely homeless mentally ill individuals, were effectively engaged in services. Over the one year period of follow up, hospitalization and severity of substance abuse was reduced.

The most recent CMHS demonstrations, which ran from 1993-1998, were the Access to Community Care and Effective Services and Supports (ACCESS) programs for individuals who are homeless and mentally ill. These programs fuse state of the art assertive approaches to community services with initiatives to integrate service systems (housing, forensics, employment, mental health and substance abuse). They incorporated motivational interventions, Assertive outreach, ICM, Counseling, Family interventions and Medication management. High rates of client engagement were achieved, and interventions were delivered for 18 months or more. Preliminary analyses of single sites are becoming available with successful outcomes including reductions in substance abuse and hospitalization, and substantial rates of remission for substance abuse disorders. Successful client outcomes are not clearly related to successful integration efforts.

### ***Assertive Community Treatment***

<p><b>Critical Components of ACT</b></p> <ul style="list-style-type: none"> <li>❑ Services provided in community</li> <li>❑ Assertive engagement</li> <li>❑ High intensity (as needed)</li> <li>❑ Small caseloads (10:1)</li> <li>❑ Continuous responsibility for clients (24/7: crises, hospital discharges and admissions)</li> <li>❑ Staff continuity</li> <li>❑ Team approach</li> <li>❑ Multi disciplinary staff</li> </ul> <p>Source: McHugo, et al., 1999)</p>
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Assertive Community Treatment (ACT) was developed in the late 1970's to support people with severe mental illness in communities during deinstitutionalization. ACT is a team approach to engagement and treatment of people with severe mental illness that is delivered 24 hours a day, 7 days a week by an interdisciplinary team, including case managers, a psychiatrist, nurses, social workers, and vocational workers. Substance abuse treatment and peer counselors have been added to the mix.

The model fosters engagement and participation in treatment through delivery of services that are keyed to clients' practical needs outside of an office setting. Caseloads are small, generally 1 staff to 10 clients. ACT is an intense and costly model and is most cost effectively delivered to high intensity service users (Lehmann and Steinwachs, 1998). Successful outcomes for ACT and ACT-like models include reduced need for hospitalization, reduced substance use and maintaining clients in housing (Mueser, et al., 1998). Employment and social supports are not as improved, and substance use does not diminish unless specific interventions targeted to stage of recovery are also offered (Mercer-McFadden, et al., 1998).

<p><b>Effectiveness of ACT and ACT-like models</b></p> <ul style="list-style-type: none"> <li>❑ decrease hospitalization among high use patients</li> <li>❑ increase housing stability among high use patients</li> <li>❑ little effect (alone) on social function, arrests, jail time or vocational function (may need social vocational skills training)</li> <li>❑ when reduced or withdrawn without continuity, deterioration frequently occurs (some evidence that "step down" can be managed well)</li> <li>❑ decreases substance use when stage wise interventions for addiction are included</li> <li>❑ most cost effective when focused on high use patients. <b>BUT</b> as fiscal incentives shift, fewer differences in costs will be seen</li> </ul> <p>Source: Mueser, et al., 1998</p>
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*Is ACT cost effective?* In a 3 year follow up study with random assignment to Assertive Community Treatment (ACT) or a less intensive set of services, Supportive Case Management (SCM), in 7 Community Mental Health Centers across New Hampshire, both programs decreased substance abuse and improved quality of life (Clark, et al., 1998). Both treatment cost and social cost analyses showed the superiority of ACT in the third year. Early on, both ACT and SCM clients were referred to housing and day treatment programs in New Hampshire's relatively richly resourced service environment. But, in the 3<sup>rd</sup> year ACT enrollees' costs for housing, day treatment and arrests diminished. These long-term effects of ACT suggest that premature "step down" may actually increase total costs over time.

*Model Fidelity.* Fidelity to the ACT model appears to be important for successful outcomes, but there is currently a great deal of debate about what elements are

MODIFICATIONS OF PACT		
Rehabilitation Accreditation Commission		
	PACT Model	Modifications
<input type="checkbox"/> Crisis coverage	24/7 by ACT Team	Crisis team covers weekend/holidays
<input type="checkbox"/> Team Psychiatrist	16 hours/week for every 50 clients	No set # of hours
<input type="checkbox"/> Team meetings	daily	Three times per week
<input type="checkbox"/> Staff coverage	1:10 3 nurses	Range - 1:8 to 1:15 1 nurse
<input type="checkbox"/> Duration	2 stable years prior to discharge	1 stable year prior to discharge

Source: W. Kanapaux. A question of standards. Behavioral Healthcare Tomorrow. Feb 2000.

essential; which groups of clients will most benefit and when; and whether and how to "step down" this intensive use of resources (e.g. Quinlivan, 2000; Valencia, et al., 1997). As the ACT approach has been demonstrated to be effective, modifications have been developed, but there is not enough research on which components are critical for good outcomes. In 1998 SAMHSA published standards for the

Program for Assertive Community Treatment. No more than 75 of the 400 or more ACT Teams in the US meet these criteria. The Rehabilitation Accreditation Commission is challenging these standards based on comments from the agencies they accredit.

An intervention that enhances (but does not directly provide) support to homeless men, most with co-occurring disorders, during the critical period of transition from a shelter to stable housing was effective in reducing homelessness during an 18 month follow-up period (Susser, et al., 1997). This "critical time intervention" (CTI) was designed for use by jails and hospitals as well as shelters, and has been demonstrated to be cost effective (Jones, et al., submitted for publication). Further, as fiscal incentives shift away from inpatient services toward prevention and maintenance it will be more difficult to demonstrate cost effectiveness for a model, like ACT, that reallocates costs from Inpatient cost centers to community treatments.

## ***ACT AND ACT-LIKE STRATEGIES***

### ***Monroe County***

Several in Monroe County possess either a traditional ACT or ICM team. Others have indicated successful variations on these models.

**Project Link** (Criminal Justice Advocacy Program), established in 1995, is a consortium of 5 community organizations and is designed to prevent repeat incarceration and hospitalization of homeless persons with severe mental illness as well as to promote integration within the community. The services are geared to multicultural populations who are involved with, or at risk of becoming involved with, the criminal justice system. There are approximately 100 clients enrolled in the program. The program is a multidisciplinary team that includes a forensic psychiatrist, a nurse practitioner and five case advocates, operating out of the Department of Psychiatry at University of Rochester.

High-risk clients, primarily identified as having co-occurring disorders, can be recruited to the program in a number of ways. The Project Link mobile crisis and treatment team may identify individuals in the community; program staff may intervene in the courts to provide an alternative to incarceration, and may also recruit individuals at risk of homelessness and recidivism who are ready for jail release.

Staff members in the program assess the client for service needs and make appropriate referrals. Both the forensic psychiatrist and nurse practitioner can provide services to those clients who refuse to accept the referrals. The 5 paraprofessional case advocates on staff are each assigned a caseload of 20 clients. The team, which incorporates principals of both ACT and ICM, is also considered a mobile treatment team since they are on call 24 hours/day, 7 days/week. There is also a treatment residence for clients with chemical dependence only. The program utilizes an existing ten bed residential facility managed by DePaul Community Services for this purpose. The success of this program is indicated by reductions in incarceration and monthly hospitalization costs, and the self-reported decrease in drug and alcohol consumption. The program has been successful in creating links between health care, social service and the criminal justice system through its referrals.

**MICANet** provides community based outreach and case management services to clients with co-occurring disorders in the VIAHealthcare system. There are 5 staff members consisting of 1 MSW, 1 BSW/CASAC, 1 RN, 1 rehabilitation counselor and a contracted psychiatrist who work comprehensively with each client. They go out into the community as a team, to do outreach (monitor substance use and build relationships with the client) in order to link him or her with other services/programs within the community. MICANet enrolls the client at the pre-engagement stage with the goal of assisting the client in reaching the next step.

**The Homeless MICA Project** was established approximately 4 years ago with reinvestment dollars. Specialized caseworkers located at two mental health sites

(Rochester General Hospital and University of Rochester Department of Psychiatry at Strong Memorial Hospital) identify the homeless mentally ill and link them with Shelter-Plus Care, outpatient services and assist them in obtaining entitlements. There are approximately 15 cases for the two workers to be handled at any given time. The ICM workers are encouraged to remain in contact with the clients after discharge in order to provide additional support.

In addition to these programs, critical collaborations include the substance and alcohol abuse treatment team in prison, other programs within the parent agency, Operation Friendship (community social club), Genesee Alcohol Treatment Program and Averill Court Continuing Day treatment (CDT). Unity Health System houses Recovery Case Management (RCM). This is a grant-funded 3<sup>rd</sup> year pilot ICM program that provides referrals for clients with co-occurring disorders who are Medicaid-eligible, have had some history with the criminal justice system and a history of 3 inpatient admissions within the past year due to chemical dependence. Approximately 75% of the clients have co-occurring disorders. Staff members provide services through the weekends as well as support services that are not usually provided by ICM teams (car rides, etc.). Two staff members are currently preparing to take the CASAC certification. Cross-training to enhance competence with mental health issues has been identified.

### ***Chemung County***

**Modified Rural ACT Team**. While Elmira is an urban center, the population of Chemung County is not large enough to support a permanent, full-time ACT team. The county's solution is a modified rural ACT team which functions as a 24 hour/7 day mobile crisis and outreach team that relies on consultants who are on call and county staff who coordinate the team members. A county Mental Health Department crisis care worker is assigned to each shift to insure full-time coverage. This person decides which members of the team will be needed for a particular call. The County contracts with a psychiatrist, nurse, certified social worker and other professionals to be on call to serve as needed as part of the ACT Team. Each ACT Team member is paid on retainer and is reimbursed when their service is used at a rate that varies according to where the intervention takes place – office, hospital or community. The psychiatrist and Ph.D. consultant can bill for telephone consultations as well.

In this modified ACT model, team members are not expected to deal immediately with all situations, but are available to ensure that a person will be seen by appropriate clinicians that same day. This model also differs from the PACT model in that the team does not retain clients in its caseload but rather makes referrals to the existing county treatment and support system and case managers to ensure continued engagement in treatment. In emergency cases, the person may be taken to a hospital or jail where the ACT team will intervene on site.

## IV. THE FORENSIC SYSTEM

### *Background*

People with co-occurring disorders are more likely than people with severe mental illness and no substance use problem to have high rates of assaultiveness, arrest and legal difficulties (Drake, et al, 1993). The National GAINS Center reported that 33% of detainees nationally met criteria for substance use disorders, that 7% have an acute and serious mental illness at booking, that over 50% have other mental illness diagnoses, and that more than 50% test positive for illicit drug use. In New York City a quarter of the 130,000 inmates jailed each year require some mental health intervention; 10-15% are thought to have severe mental illness. Most are charged with non-violent offenses and could be treated or detained elsewhere; however, poor coordination, short stays, strong philosophical differences and non-existent organizational incentives present barriers to integration between jails and community services (CMHS, 1994). The law mandates that persons with severe mental illness in the criminal justice system receive necessary and appropriate mental health evaluation and services (Brakel, et al., 1985), but it defines neither the conditions under which evaluation and services are necessary nor what constitutes appropriate services. There have been virtually no efforts to systematically study the interactions among key players in the two systems and the consequences of the decisions they make for persons with co-occurring disorders, though it has become clear that persons with severe mental illness “fall between the cracks” (Wolff, 1998).

### *Local Strategies to Address Criminal Justice Issues*

Consistent with their concern about forensics, violence and co-occurring disorders, county

LOCAL FORENSIC STRATEGIES	
Strategy/Program	County
❑ Forensic Task Force: Diversion; Jail based treatment; Post discharge links to Social Services and emergency housing	Rensselaer
❑ Diversion; Jail-based treatment; Post discharge programs	Monroe
❑ Behavioral Science Court	Genesee
❑ Pre arrest Assessments; Diversion; Assessment; Police training	Chemung
❑ Assessment at arraignments; Links to services	Rockland
❑ Diversion through police/probation	Sullivan

<sup>1</sup>See text and appendices for program descriptions

directors reported a substantial amount of direct involvement with local criminal justice systems in the phone survey. This includes jail, parole and probation for diversion, treatment, discharge planning and post incarceration

programs. In some cases, mental health caseworkers are situated in the jails and provide group therapy, counseling and medication monitoring to persons with mental illness. It is more difficult to provide substance abuse services in jails because shorter jail stays preclude OASAS certification and reimbursement of effective programs. Jail based substance abuse treatment, therefore, often falls to mental health staff, underscoring

again how key it is to provide cross training for mental health workers, especially in forensic settings.

There are many other reasons for County Directors to be interested in diverting persons with co-occurring disorders from jails. The cost of incarceration is high and increases fiscal burdens. During incarceration, inmates lose residences, jobs, Medicaid and other entitlements. They often experience violence and other harm at the hands of other prisoners, or decompensate from the stress of incarceration. Post release, inmates are vulnerable to relapse and re-arrest, but re- engagement with community based systems of care is difficult. Reapplication for benefits and entitlements is lengthy and uncertain; housing for people with co-occurring disorders is scarce; women, especially, are at high risk for pregnancy and for contracting sexually transmitted diseases, including HIV.

### ***Rensselaer County***

**The Rensselaer County Forensic Task Force.** The Rensselaer County Forensic Task Force engages players from across multiple systems: mental health, substance abuse, forensics, social services, health and education. The Task Force meets once a month to identify gaps and devise solutions across service systems where the jail is the hub. In this forum of partnership and collaboration both large and small solutions have been developed to better integrate services for those inmates with co-occurring disorders who

- |  |
|--|
| <p style="text-align: center;"><b>Forensic Task Force<br/>- Expected Outcomes -</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Easier Jail Management</li><li><input type="checkbox"/> Decrease Jail Overcrowding</li><li><input type="checkbox"/> Improve client's ability to cope throughout incarceration</li><li><input type="checkbox"/> Better treatment for clients in jail</li><li><input type="checkbox"/> Estimated jail savings through diversion and management of about \$7,000 per day</li><li><input type="checkbox"/> Better post release linkages with community based services</li><li><input type="checkbox"/> Lower recidivism</li></ul> |
|--|

are at the highest risk of repeated offending, arrest and incarceration. This is the population that most needs planned links with community agencies. While males make up the vast majority of inmates in the county's jail (93%), the number of female detainees rose by 9% in 1996. Since there are few if any services that address the particular needs of women in jail or post release, the Task Force agreed to address the needs of these women specifically.

The County initiated the Task Force in 1996 based on a model of collaboration that was demonstrated at a National GAINS Center Forum. Initially the Task Force included

representatives who could make policy decisions and who would follow through in a timely fashion. Agencies were invited to join based on reputation, engagement with people with co-occurring disorders, and services provided. The Task Force consciously worked at their monthly meetings and in between to create an atmosphere where members could grapple as a group and individually with their agencies' histories, competition for scarce resources, survival and independence before they could begin joint ventures across agencies. They focused on their long-term ability to attract more resources for the target population based on the increased effectiveness and efficiency they would be able to demonstrate through their joint ventures. Although they established their initial links without substantial new funding, the Task Force has drawn funds from private, county, state and federal sources to develop and support programs (See program summary in Appendix V).

***Jail Treatment.*** The Rensselaer County Correctional Facility has a 20-bed MICA Housing Unit that was established in 1992. It is under the direct supervision of the County Forensic Mental Health Coordinator and since July 1999 has included a discharge planner. Following assessment, this unit provides medication management, individual psycho-educational therapy, Alcoholics Anonymous and Narcotics Anonymous groups and discharge planning to MICA-identified male inmates. The average stay for a dually diagnosed inmate can range from 24 hours to 6 months. Individuals are often brought in directly from the streets or from the psychiatric Emergency Room if an assessment there indicates that the person does not need hospitalization. The unit is available to house inmates with other than mental illness and/or chemical abuse problems, as it is a medical and mental health unit.

The County MICA coordinator provides added assessment, group therapy and individual therapy on an as needed basis for MICA-identified female inmates. Given the high risk for women to contract sexually transmitted disease (STD) post discharge, a Health Department nurse provides education and consultation on STD's and pregnancy to inmates during incarceration and provides follow up care.

***Post Release Links - DSS.*** The Task Force has enlisted DSS support and is currently trying to implement a plan to facilitate inmates' applications for SSDI, DSS and Medicaid benefits while incarcerated so they will be eligible more quickly following release. These agreements include facilitating the application process during incarceration, providing a single DSS worker to understand the procedure for handling all applications for inmates with mental health problems, provision of transportation on the day of release to DSS by a voluntary agency to further facilitate application and eligibility for benefits.

***Post Release Links - Housing.*** Little housing is available in the county for the target population, and there are fewer options for rehabilitation programs. The Task Force has developed beds in a crisis shelter to provide "bridge" housing on release from jail in shelter and crisis centers for clients waiting for admission to chemical dependency rehabilitation programs. The Task Force has also worked with the local YWCA to develop substantial support from HUD, TANF and OMH to provide housing and treatment support for women with co-occurring disorders and their children.

***Post release housing for women and their children.*** A post release residential program with 5 OMH supported beds for women with co-occurring disorders and their children, was established at the YWCA in June, 1999. It is staffed by 3 peer counselors from COPES (peer-run drop-in center – See Section VI of this report) who receive training from the YWCA staff and the COPES director. The peer counselors support residents to meet their daily needs, and refer clients to other programs and agencies (but only with the request and written consent of the client) as needs are identified. Other funding for this program comes from:

- A TANF grant to provide outreach and coordination to parents in welfare to work
- Reinvestment dollars from the Psychosocial club, COPES, to support one full time and two part time peer counselors
- The YWCA for a (HUD) capital improvement grant and Section 8 subsidies to expand their ability to house this population

- the YWCA to support a full time social worker to provide assessment, treatment and referrals for women at the residence
- County reinvestment dollars to support the MICA coordinator who provides consultation and training on women and co-occurring disorders to YWCA staff

**Post release bridge housing.** Providing post release housing for inmates with co-occurring disorders in Rensselaer County requires diligent planning efforts. Inmates referred on discharge to a chemical dependency residential rehabilitation program in a neighboring county frequently wait, post release, for an available bed. In the interim they need bridge housing. Through the collaborations forged in the Task Force, this type of short term, emergency housing is available at Joseph's House, a short term. Emergency shelter. The full range of support services for co-occurring disorders, however, are not available in a shelter environment.

**Current issues.** The Forensic Task Force is currently addressing

- Jail treatment issues related to Post-Traumatic Stress Disorder
- Increased DSS involvement in the Forensic Task Force
- Impact of local DSS law on people with co-occurring disorders
- Case management needs of discharged inmates

### ***Monroe County***

Two forensic programs that provide services for individuals with co-occurring disorders were identified in Monroe County: The High Impact Incarceration Program and Project Link.

**High Impact Incarceration Program** (HIIP) provides services, in general, to inmates with chemical dependence. The program is embedded within the Department of Corrections and is housed in the smaller of the two correctional facilities in Monroe County. Approximately 20% of clients currently occupying beds in this program have co-occurring disorders. Mental health needs are met via educational group therapy, anger management groups and some experiential groups geared specifically to the female inmates. The program is, however, rooted in the chemical dependence aspect of the work, housed as it is in an environment that favors this perspective on intervention. The program's goals are to achieve a reduction in crime rate, reduction of recidivism, and client abstinence. There are at present 10 staff members on site, but none of them have been identified as cross-trained. A MICA-track might enable this level of training to take place. This program works with the entire criminal justice system and interfaces with outside mental health providers in order to provide integrated services.

**Project Link** (Criminal Justice Advocacy Program), established in 1995, is a consortium of 5 community organizations and is designed to prevent repeat incarceration and hospitalization of homeless persons with severe mental illness as well as to promote integration within the community. The services are geared to multicultural populations who are involved with, or at risk of becoming involved with, the criminal justice system. There are approximately 100 clients enrolled in the program. The program is a multidisciplinary team that includes a forensic psychiatrist, a nurse practitioner and five case advocates, operating out of the Department of Psychiatry at University of Rochester.

High-risk clients, primarily identified as having co-occurring disorders, can be recruited to the program in a number of ways. The Project Link mobile crisis and treatment team identifies high risk individuals in the community; program staff intervene in the courts to provide an alternative to incarceration; and staff engage inmates at risk for homelessness and recidivism just prior to release from jail.

Staff members in the program assess the client for service needs and make appropriate referrals. Both the forensic psychiatrist and nurse practitioner can provide services to those clients who refuse to accept the referrals. The 5 paraprofessional case advocates on staff are each assigned a caseload of 20 clients. The team, which incorporates principals of both ACT and ICM, is also considered a mobile treatment team since they are on call 24 hours/day, 7 days/week. The program links clients with chemical dependency only to an existing ten bed treatment residence managed by DePaul Community Services. The success of this program is indicated by reductions in incarceration and monthly hospitalization costs, and the self-reported decrease in drug and alcohol consumption. The program has been successful in creating links between health care, social service and the criminal justice system through its referrals.

***Genesee County***  
**Batavia City Drug Treatment Court**

Genesee County is a small county (population 60,000) in Western New York State with substantial networking within the county and with counties to its north and south. The

Criteria for acceptance into Drug Court Program
<input type="checkbox"/> history of substance abuse/dependence
<input type="checkbox"/> other need areas (mental health, employment, financial, housing problems)
<input type="checkbox"/> an expressed desire to make positive life changes

county's MICA Task Force coordinates communication about co-occurring disorders among its members who have grown to include Mental Health and Chemical Dependency programs, the Mental Health Association, Probation and Jail leadership. The Task Force also retains the clinical function of

coordinating treatment planning for the many clients who receive conjoint treatment in the county's two parallel programs.

The county's Drug Treatment Court in Batavia is based on the nationwide Drug Court model and seeks to divert people with chemical dependence disorders from incarceration. In February of 1999, the County Public Defender's Office added a "behavioral science" component, in order to incorporate more effective mental health referrals for offenders with co-occurring disorders. The Behavioral Science Court currently has no funding, and relies on the Public Defender's Office to donate 2 hours of the Drug Court Coordinator's time on a daily basis. Referrals are made to the Drug Court Coordinator by criminal justice staff. The Court Coordinator screens applicants to ensure that they meet the criteria for acceptance into the program; treatment and mental health evaluations are performed by outside providers. Offenders remain in the program no less than one year and no longer than two years and required to maintain complete sobriety. Seven out of 26 clients enrolled in this program last year had co-occurring

disorders in which their mental illness was severe. The Court has not been operational long enough to evaluate its success for people with co-occurring disorders.

#### SERVICES ACCESSED BY THE DRUG COURT

##### For co-occurring disorders:

- ❑ Counseling, case management, and intensive case management
- ❑ Immediate placement for homeless people, persons in need of detoxification and MICA services including inpatient and halfway house placement
- ❑ Residential and supportive housing

##### For chemical dependency alone

- ❑ Outpatient CD treatment, halfway house and supportive apartments (each for 6-12 months)
- ❑ Inpatient CD treatment
- ❑ Emergency medical treatment, CD & MH treatment, hospitalization and detoxification

### Other County Strategies for Forensic Integration

#### *Chemung County*

*Education.* The county mental health department provides education and training on identifying and handling emotionally disturbed persons to cadets, police, corrections officers and probation department workers at a police academy in Elmira and at two correctional facilities. The emphasis is on timely identification of persons with mental illness with/or without substance abuse problems before they are incarcerated. Local consumers also participate in this training program and support it directly through the mini-grant program they run out of their psychosocial club. This is a crucial component of reducing stigma among persons with mental illness and gaining acceptance in the community.

*Diversion.* Police who receive 911 calls are directed to contact the county crisis coordinator when they identify a person with a mental illness and/or substance abuse problem. The modified ACT Team then may assess the individual in crisis at the local jail or court and make a referral from there. They work with the judge and with probation department to prevent the person from an unnecessary incarceration. A forensic case worker regularly visits the county jail, courts and probation department to screen inmates.

#### *Rockland County*

Rockland County situates a forensic caseworker in the local jail to assess clients according to the County's assessment protocol (see Appendix VI). Clients remanded to Probation attend groups co-led by the caseworker for the duration of their probation. The staff recognizes that mandated clients have different motivations (usually avoiding jail time) than voluntary clients. A behavioral health team, including a psychiatrist, screens inmates and provides and therapy in the jail. The County mental health

department actively educates justices about co-occurring Mental Illness and Chemical Dependency.

***Sullivan County***

Sullivan County has no formal jail or court interventions, but has developed informal working relationships with state troopers, local police and probation officers that are seen as critical to diverting persons with mental illness from incarceration. The police and probation departments have been active in the county-wide multi-agency work group that plans improved services to clients with co-occurring disorders.

## V. HOUSING

### BACKGROUND

Affordable housing and supports—employment, income assistance and health benefits-- are integral to a de-institutionalized, community based mental health system (Surgeon General's Report, 1999). County directors, in responding to the Technical Assistance Project phone survey, named the lack of safe, stable housing as a critical gap in providing adequate services to the target population. Individuals with severe mental illness and their families also name housing as a priority concern (Lynch and Kruzich, 1986; Hatfield, 1992).

#### **BARRIERS TO HOUSING FOR PEOPLE WITH CO-OCCURRING DISORDERS**

- Limited housing stock
- Limited resources for clinical support
- No model/provider identified
- Variable relationships with local DSS
- Residents using alcohol or drugs evicted from Supported Housing
- AOD housing excludes people on psychiatric medications
- History of jail, arrest or contact with the criminal justice system limits options
- In rural areas, clients burn their bridges with only a few landlords
- Limited duration of housing support for substance related disabilities
- Stressed families cannot house individual using alcohol or drugs
- Responsibility for housing provision varies based on locality

Research consistently shows that substance abuse is a major risk factor for homelessness among people with co-occurring disorders. Most recently, in a randomized study comparing outcomes in staffed group homes with independent apartments (both with specialized case managers) for NYC shelter residents, the single most predictor of days homeless among participants with severe mental illness was substance abuse co-morbidity (Goldfinger, et al., 1999). In a cohort of patients with schizophrenia, discharged from inpatient services, the major predictors of homelessness within 3 months of

discharge were substance use disorder, persistent psychiatric symptoms and impaired global functioning at discharge (Olfson, et al., 1999). Individuals with these profiles may need intense supports like ACT or a Critical Time Intervention (CTI) as they transition into housing. Effective transitional supports include treatment for substance use disorder, maintaining cooperation with medication, money management, preventing housing related crises and providing symptom control (Susser, et al., 1997; Jones, et al., under review)

Housing needs for people with co-occurring disorders can only be addressed by cross system integration. The Robert Wood Johnson Foundation addressed cross system

integration in their first mental health research program, a nine city demonstration in partnership with the Department of Housing and Urban Development (HUD) to integrate all services, including housing, by local mental health authorities (Shore and Cohen, 1994). Evaluations of these demonstrations showed that better continuity of care (through case management) decreased service fragmentation (Morrissey, et al., 1994),

#### **PREDICTORS OF HOMELESSNESS FOR PEOPLE WITH SEVERE MENTAL ILLNESS**

- Co-occurring substance abuse
- Persistent psychiatric symptoms
- Impaired global functioning at discharge

(Olfson, et al., 1999; Goldfinger, et al., 1999)

decreased family burden, and improved clients' quality of life and social functioning (Lehman, et al., 1994; Shern, et al., 1994). A critical finding was that client level

**CONSEQUENCES OF HOUSING INSTABILITY**

For 25% of the target population:

- ❑ Housing instability exacerbates both disorders
- ❑ Substance use mediates homelessness
- ❑ "Institutional circuit" (hospital, jail) disrupts stable housing
- ❑ Intensified support during transition from "institutional circuit" is cost effective in decreasing days homeless
- ❑ Staff accurately assess level of housing support needed

improvements could not be directly linked to systems integration.

Evaluators concluded that service integration and traditional case management alone were not sufficient to produce optimal outcomes (Goldman, et al., 1994; Lehman, et al., 1994) and that rent subsidies and

supports, or more intense, higher quality ACT-like case management services were essential (Ridgely, et al., 1996).

This set of findings prompted the development by SAMHSA of another demonstration program to specify the supports needed to obtain good client level outcomes in terms of housing stability, substance use reduction, decreased hospitalization and quality of life. Preliminary findings from the evaluations of these Access to Community Care and Effective Service Systems (ACCESS) demonstrations support the utility of assertive community treatment in obtaining good clinical and social outcomes. With better system integration, more participants moved from being homeless to independent housing, (Rosenheck, et al., 1998).

*A Housing continuum.* The residential continuum for people with co-occurring disorders ranges from intensely serviced modified therapeutic communities to supportive housing, and supported, scatter site apartments where the housing is not licensed.

**HOUSING OPTIONS**

- ❑ Intensive - modified therapeutic communities
- ❑ Supportive -staffed group homes, SRO community residences
- ❑ Supported - scatter sites with services available but not required; ACT/ICM support
- ❑ Independent living, often Adult Homes

***Modified therapeutic communities.*** Modified, drug-free, therapeutic communities offer an intense residential approach that has been adapted from the substance abuse community for individuals with co-occurring disorders. This approach offers specific behavioral guidelines that can be understood by people with cognitive limitations; incorporates peer leadership

(Galanter, et al., 1993); and offers features that should be effective for people with severe mental illness—engagement, care and nurturing, structure, limit setting, development of responsibility, positive reinforcement and self esteem (Blankertz and Cnaan, 1993). Studies show diminished substance use for about one third of participants (Westreich, et al., 1997) even for those with extensive criminal histories (Taylor, et al., 1997). However, in one study, over half of screened treatment candidates never started the program, and about one fifth of those who started, completed the program (Nuttbrock, et al., 1998). Post-intense period substance use outcomes are variable (Mercer-McFadden, et al., 1998). Still, this modality has been

successful in the substance abuse community and continues to be actively promoted as a possibility for individuals with co-occurring disorders, especially when a personality disorder co-occurs as well.

**Supportive Housing.** Supportive housing, which includes Single Room Occupancy

HOUSING CONTINUUM	
<b>Supportive housing</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Licensed</li> <li><input type="checkbox"/> On-site 24 hour staffing</li> <li><input type="checkbox"/> SRO or supervised community residences</li> <li><input type="checkbox"/> Program attendance and sobriety required</li> <li><input type="checkbox"/> Lengths of stay 18-24 months and more</li> </ul>
<b>Supported housing</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> No license for housing</li> <li><input type="checkbox"/> Independent apartments</li> <li><input type="checkbox"/> Relapse is a clinical, not a residential issue</li> <li><input type="checkbox"/> ACT Team provides mental health and substance use interventions</li> <li><input type="checkbox"/> Housing is permanent</li> </ul>
<b>Efficacy</b>	Research not yet available

Community Residences and Supervised Community Residences is licensed by NYS OMH and has on-site, 24-hour staffing. MICA community residences have clear requirements for program attendance and sobriety. While intended as transitional (18 – 24 months), lengths of stay frequently exceed this projection. Residents who transition from MICA residences directly to independent living have difficulty maintaining sobriety if they decide to share housing or expenses with someone using drugs or alcohol. A continuum of residential options would allow a more gradual, supported transition to independent living. Sullivan County supports a MICA residence that requires residents to demonstrate successful movement

along a staged transition to independent living. In this stage wise approach, the motivational aspect of readiness to progress to next step is crucial. Residents who move on to the agency's supported apartments return to the residence to share their experience of the transition.

**Supported Housing.** Supported, scatter site housing offers a less structured residential option. This housing model incorporates clients' preferences for more control over how decisions are made and with whom they live (Schutt and Goldfinger, 1996). It minimizes the housing disruptions built in to models where clients must change residences as they progress along the housing continuum, and is less costly than intensely supportive residences. Supported housing is integrated socially, is self-chosen, and encourages empowerment and skills development. The Pathways to Housing program, with sites in NYC and Westchester County, provides a scatter site supported housing program in which an Assertive Community Treatment (ACT) Team visits the houses on average once a week and provides the case management services. The program uses representative payees to ensure that rent is paid on time. Residents can also utilize services provided by the agency at their program sites, or other agencies, but this is not a condition of continued tenancy. This strategy provides immediate access to housing for the homeless mentally ill, most of whom also have substance abuse and/or histories of criminal behavior.

## LOCAL STRATEGIES

### *Monroe County*

#### Homeless MICA Project

The Homeless MICA Project provides housing referrals as well as referrals to other service agencies. This program was established 3-4 years ago via reinvestment dollars and is licensed by OMH and DSS. The County Mental Health Department contracts with DSS to provide Shelter-Plus Care. Specialized and Intensive Case Management is provided. The specialized case workers operate out of the Rochester General Hospital and University of Rochester Department of Psychiatry at Strong Memorial and assist with entitlements, mental health and chemical dependence treatment referrals. Additional staff are assigned to the Shelter-Plus Care residence.

#### Shelter-Plus Care

The Shelter-Plus Care program is composed of 5 different programs: mentally ill persons, people with AIDS, chronic substance abusers, youth with educational disabilities and people with MICA. This program is established with the goal of providing supportive housing to the previously described populations. This program is funded by HUD, while the staff is paid by OMH dollars. A DSS worker does a quick assessment and makes referrals to an appropriate agency. The agency sets the guidelines that the client must adhere to and the client is in turn monitored at the supported housing site. The client must comply fully and is at risk of losing housing if he or she is not able to do so.

The MICA population is the largest subgroup within the Shelter-Plus Care program in Monroe County. Three staff members are working specifically with the MICA population and are identified as paraprofessionals. While they do not directly provide case management, they ensure that the basic living needs of the clients are met and refer clients to available programs in the county.

### *Chemung County*

#### Next Step MICA Residence

Gateways Community Living, part of Catholic Charities of the Southern Tier, provides an array of residential services for about 200 people with mental illness in Chemung County. This includes the Next Step Program, 3 shared occupancy apartments for five 16-21 year-olds with co-occurring disorders. Initially the expectation was that young men would use these apartments, but current occupants are young mothers with co-occurring disorders who need enriched services for themselves and their children. While there, they use other programs so that they can regain custody of their children, which may require a period of documented sobriety. A resident case manager provides referrals to Family Services and other county agencies.

Gateways, in addition, serves 200 individuals from the region in supported and supervised shared and independent living apartments. Funding comes from HUD, OMH, Medicaid and county subsidies to provide housing for people with severe mental illness. The Shelter + Care program additionally addresses needs of homeless persons with severe mental illness, HIV or chemical dependency. Most referrals come from Elmira Psychiatric Center and the Urgent Care worker at Family Services; there is little involvement with the Alcohol and Drug Abuse Council.

**Sullivan County: MICA Residence**

**Revonah Hill MICA Residence** is operated by Rehabilitation Support Services, Inc. (RSS). RSS provides a continuum of residential services for persons with severe mental illness diagnoses in several counties. In Sullivan County, RSS operates 5 Community residences, 5 supervised apartments and 3 supported apartments, some specifically for

<b>Revonah Hill MICA Residence PHASED PROGRAM</b>	
<b>Phase</b>	<b>Goals</b>
Orientation	Adjust to living in the Community Residence
I identify Barriers to Recovery	Begin to identify and manage impulses of both psychiatric and addictive symptoms
I mplement Skills for Dual Recovery	I identify prior relapse patterns and practice using skills needed for dual recovery
Continue to Develop I ndependent Living Skills	Develop external interests and supports that will support successful independent living
Re-entry	Prepare for supportive apartment living: to follow through on attainment of goals, residents access and use supports and resources to maintain dual recovery

Source: Rehabilitation Support Services, Inc.

people with co-occurring disorders. In 1995, reinvestment funds were used to convert a community residence into a specialized MICA residence.

A phased motivational approach guides residents in moving actively through the residential continuum from the MICA residence into the supervised and supported apartments. Each phase has specific criteria which the client must complete before self-advocating to begin

the next phase. A CASAC is available at the MICA residence 20 hrs/wk. Random urine samples are collected to insure compliance with abstinence requirements since documented sobriety is important for obtaining other benefits. No one loses housing because of a slip, but the clear expectation of no drinking or drugs is part of the program. There is a trial period in the apartments overseen by another MICA caseworker. Graduates of the MICA community residence are required to attend 4 meetings back at the residence to help others bridge the transition to independent living.

**Bronx County, New York City**

**Rosebud/Pibly Supported Housing, Modified Therapeutic Community.** This program has adopted a very modified Therapeutic Community (TC) approach to provide housing for clients with co-occurring disorders. The program promotes sobriety and a transition to more mainstream supported housing over a 12 to 18 month period. Rosebud opened its doors in October, 1999 with funding from OMH and a 3-year HUD contract.

Maintenance of sobriety is a key component of this program. After the clinical director conducts an initial assessment, clients begin the steps toward recovery. After a minimum of 4 months of sobriety and successful integration into the TC, clients progress to Step II. After 5-6 months of sobriety, clients progress to Step II with the goal of reintegration into the larger community. The final level is post residential aftercare.

Fifteen paraprofessional counselors, who are themselves in recovery, staff the program, providing drug and alcohol counseling as well as referrals to outside mental health providers. The culture of substance abuse treatment and recovery gives the program a confrontational approach that will be modified to meet the needs of clients with severe mental illness. Rosebud accepts client referrals from a number of sources, which include jail, emergency rooms, shelters and treatment agencies. Clients, however, are not mandated to this program.

### ***Westchester County***

**Cluster.** This OMH certified MICA Community Residence was established in 1993 to provide transitional housing for individuals with co-occurring disorders. This residence is able to accommodate clients with co-occurring disorders who also have life-threatening illnesses such as HIV+/AIDS and cancer. Cluster employs a harm reduction model and aspires to assist the client in meeting his daily living needs. The following services are provided: substance abuse counseling provided by a CASAC, 4 restorative services per month, skills training, NA meetings, service linkages and service coordination. The staff is comprised of a Program Coordinator, 2 "awake" staff and 10 paraprofessional mental health aides.

### ***Columbia County***

**Columbia County Mental Health Center Homeless MICA Residence.** This program which was funded in 1999 via reinvestment dollars provides 4 supportive apartments specifically for people with co-occurring disorders. All residents have severe mental illness diagnoses. This is a collaborative effort between the Columbia County Mental Health Center and the Columbia County Mental Health Association.

The program provides residents with apartments supervised by a psychiatric social worker. The worker links residents with services that will allow them to maintain daily living in the community. A stage-wise model is followed. Pre-engagement clients are introduced to the program. As they progress toward the next level of recovery, clients may choose to remain in the apartment, or to be referred to mainstream supportive housing. Should the client choose to remain, the apartment is re categorized as supportive housing and is subsidized differently. The Homeless MICA Program then becomes free to search for another apartment. This program works closely with both Corrections and DSS. The social worker identifies possible candidates during incarceration and assists them in the transition to the Homeless MICA Program. Recruiting and maintaining landlords has been identified as a challenge to this program.

## VI. PEER-DRIVEN MODELS OF DUAL RECOVERY

### **Background**

Abstinence, substitute dependencies, behavioral and medical consequences, enhanced hope and self esteem and social support that is not ambivalent have been identified as necessary components for recovery (Vaillant, 1983). Research has shown that participation in self-help facilitates recovery for people with alcohol problems. More than 6 million people are estimated to participate in self-help groups at any one time in the United States including 1.6 million in Alcoholics Anonymous (Moos, et al., 1993). The intersection of recovery and self-help is particularly relevant for people with co-occurring disorders, but singly focused self-help groups appear to have limited utility for people with co-occurring disorders.

In some studies, mental health clients' who participate in single focus self-help experienced an increase in sense of security and self esteem, a decrease in existential anxiety, improvement in their alcohol use dependence symptoms, and diminished days intoxicated and levels of depression over a short time period (Galanter, 1988; Kyrouz and Humphreys, 1997).

However, in a treatment program for co-occurring disorders in New Hampshire where clients were required to attend substance abuse self help, only a minority of clients became engaged in the groups. They described the groups as "alienating and unempathic", and reported that case managers' use of "AA talk" ran counter to their own experiences of the problems in their lives. Researchers suggested that emphasis on concepts such as denial or "stinking thinking" can overshadow staff recognition of the roles of stigma, poverty and disenfranchisement for people with severe mental illness (Noordsy, et al., 1993). Single focus self-help may not be as effective for clients with psychiatric disabilities because they often suffer from more isolation and stigma, have fewer social supports, lower self esteem and poorer social skills than people recovering from a single problem.

Peer directed self-help groups for co-occurring disorders are emerging that extend the concept of recovery to psychiatric diagnoses as well as drug and alcohol problems, and provide participants with strong support and common bonds. In these models, individuals with co-occurring disorders can access the strength of self help which allows clients to validate each others' experiences, provides a structure for a new sense of self and helps a person move toward connection with ordinary life (Baxter and Diehl, 1998).

Some models of self-help among individuals with severe mental illness diagnoses rely on indigenous leadership; others may incorporate the presence of a professional (Caldwell and White, 1991). We spoke to consumer-providers in New York State who support and participate in Double Trouble in Recovery and in Change Unlimited, both of which are peer directed dual recovery approaches.

### ***New York City***

**Double Trouble in Recovery** (DTR) was started in 1989 in NYC by Howie Vogel, a dually recovering person. Each DTR group is led by consumers who have been trained as

facilitators. A description of DTR and of the not for profit institute that supports it are included in Appendix VIII.

A 3.5-year effectiveness study of DTR funded by the National Institute of Drug Abuse is currently underway. This study follows 310 members of 25 peer led DTR groups in New York City for one year. Preliminary data suggest that participating in DTR is associated directly with decreased substance use, and with fewer psychiatric symptoms, primarily by increasing the sources and extent of perceived social support.

Dually diagnosed clients view spirituality as critical to their recovery, and clinical staff typically underestimate clients' level of spirituality and the importance they place on it (McDowell, et al., 1996). Early analyses of a DTR evaluation supports high levels of perceived spiritual support among individuals attending (Laudet et al, in press)

A majority of the participants in the DTR evaluation report that dealing with feelings is very difficult. Affect regulation is extremely important in dealing with a psychiatric disability, and may be minimized when a person is actively using. They also report that they attend single focus recovery meetings when they especially need to focus on their alcohol or drug use, but that attendance in more traditional 12-step groups (usually due to relapse or "picking up") is associated with diminished well being (Laudet et al., in press). (NOTE: the 12-step Book for Double Trouble in Recovery is available. Contact The Mental Health Empowerment Project, 1-800-643-7462).

These findings also suggest that a supportive therapeutic environment in addition to attendance at self-help is critical to recovery. People with co-occurring disorders achieve remission through substance abuse treatment that is integrated into their mental health treatment, that is flexible and staged in intensity and that offers addiction treatment options in addition to self-help (Noordsy, et al., 1993).

### ***Erie County***

**Change Unlimited** is a self-help initiative that operates in Buffalo, Erie County. Michael Bricker first developed the model out of Milwaukee in 1988 under the name of STEMMS. The initiative has been renamed Change Unlimited in Buffalo. A steering committee of ten consumers meets regularly to review the progress of Change Limited and to identify new directions.

Groups are designed specifically to meet the needs of individuals with co-occurring disorders, although anyone interested in participating is welcome. The groups follow a 6-step program with a focus on self-awareness of mental health and chemical dependence issues, encouragement and acceptance of knowledge, and self-empowerment. Change Unlimited believes that 12-steps are too difficult for people with a dual-diagnosis. The 6-step approach is a gentler and more inviting intervention, and opens the door for a 12-step group for those who eventually choose that route. Many of the members, however, have been attending Change Unlimited for several years.

The 20 groups held each week are led by a peer counselor who has been running them for 5 years. She has been identified as one of the most significant factors in the success of Change Unlimited. Approximately 150 people per week attend the groups, which

include open discussion, educational groups, literacy groups, support groups for people who have returned to school, self-help book reading groups and a childhood issues group that focuses on trauma. The groups encourage on-going dialogue and unlike other self-help groups do not ban cross-talk.

There are as yet no plans to bring this initiative outside of Erie County, although groups that rely on both professionals and peers to facilitate the STEMMS 6-step approach exist in a number of counties in New York State.

### **Inclusion of Peer Support in Clinical Programs**

Besides self-help or mutual aid groups, consumers can be actively engaged in their own recovery through their work in psychosocial clubs, through peer case management and peer advocacy. Studies support the effectiveness of peer support in combination with mental health services like intensive case management in decreasing crisis events and hospitalizations, improving perceived quality of life and physical and emotional well being (Klein, 1998).

#### ***Chemung County***

**The Social Connection Psychosocial Club.** Chemung has a very active consumer run clubhouse, the Social Connection. The President and Board are all consumers and are elected by the membership. The club provides a drop-in center that is open six days a week and offers a variety of recreational and educational programs for its 300 members. There are 2 computers available at the clubhouse and a peer case manager has an office on the premises.

This Club uses Reinvestment dollars for its own activities (budgeted at \$5000/year) and to administer a \$10,000 mini-grant program for other community organizations. The club solicits applications for grants – up to \$1000 – from local groups, and meets on a monthly basis to decide whether to fund these proposals. The County Mental Health Department administers the Reinvestment funds and its staff is involved in an advisory capacity. As stigma reduction is a main goal of the club, the grant program provides positive visibility for persons with mental illness and gains them respect within the larger community. The club also brings in speakers and sends its members as representatives to regional meetings. They hold an annual luncheon for members of the police academy,

#### **Effective Consumer participation**

- ❑ Pay consumers for their time
- ❑ Educate and support consumers to be active and constructive committee members
- ❑ Support consumers to manage their organizations' budgets

which provides an opportunity for police to be educated directly by consumers in their community. Since information about diagnoses is not collected or disclosed at group meetings, no estimate of the extent of co-occurring disorders among clubhouse members could be made. No clubhouse activities focus specifically on this population.

Chemung County actively supports the three consumers who sit on its Community Services Board to be effective members of their committees. Consumers are paid \$12/hour for the time they spend, and are coached in being active participants. In addition, the Mental Health Subcommittee is 50% consumers and the Substance Abuse Subcommittee is comprised almost exclusively of individuals in recovery.

### ***Rensselaer County***

**COPES.** COPES, Challenging Our Problems with Emotional Support, is a peer-run drop-in center that provides services and support to individuals with mental health disabilities, recovery issues or co-occurring disorders. Eight peer counselors staff COPES. Last year, COPES provided 8,600 units of service (can be a one-shot deal or repeat customers). Approximately 70% of the clients have been identified as MICA. An estimated 10% have a severe mental illness. COPES was established in 1992 and is funded primarily via state OMH and Rensselaer County DMH dollars.

The staff is currently undergoing extensive on-site training to improve competence. Training sites include paid respite work at Joseph's House, which is a shelter and 9-bed permanent residence, nighttime coverage at the YWCA, respite counseling at Unity House and work at Good Samaritan Hospital. Three of the staff members have begun the training. The counselors are also trained to facilitate groups that blend the principles of Double Trouble in Recovery (DTR) and Rational Recovery to support relapse prevention. COPES runs three DTR - like groups once a week: two at the psychosocial club and one at St. Peter's residence. One of these is a new group focusing specifically on young adults (ages 16-23). About 50 people in total attend these DTR-like groups.

### ***Lewis County***

**Parkside House.** The psychosocial club in Lewis County employs four case manager aides who are also peer participants. They are available to assist consumers at the club in attending to their daily needs. This may run the gamut from the balancing of schedules to car rides to the Community Mental Health Services (CMHS) center. The aides also assist the ICM worker employed at CMHS. The services of the aides are not specific to individuals with co-occurring disorders, although approximately 30% of the clients who attend the psychosocial club do, in fact have both severe mental illness and substance use problems. These same clients also receive MICA services at CMHS. There are 3 case manager aides and one Sr. case manager aide who is the person running the club. The 3 case manager aides also work out of CMHS. In addition, Parkside House employs a part-time van driver who is available for use at CMHS.

**Community Human Resources.** Community Human Resources is an advocacy group that was established in 1993. It is funded via Reinvestment dollars and provides services to people with mental health disabilities as well as people with developmental disabilities. People with co-occurring disorders are also seen. The team consists of 4 staff members: 2 focus on mental illness, 1 on developmental disabilities, and there is an office manager. A Double Trouble group was begun in January 2000, modeled on Double Trouble in Recovery (described previously in this report). Community Human Resources is pursuing formal DTR training sessions to foster active peer leadership for this group in Lewis County.

## VII. STAFF TRAINING

### **Background**

Lack of adequately cross-trained mental health and chemical dependence staff was cited by County Directors as a critical barrier to provision of integrated services. Substantial effort is expended to prepare and support staff to work with individuals with co-occurring disorders. Although several County Directors felt that their staff members were adequately cross-trained, most painted complex pictures of diverging treatment philosophies, conflicting cultures and resistance to change.

Nonetheless, training approaches and resources are available for both individuals and counties that address the need for these treatment cultures to come together in order to better provide services to persons with co-occurring disorders.

### ***Suffolk County***

**Dual Recovery Training and Advisory Group.** This OMH funded program, begun in 1999, annually provides 2 trainings to members of the professional community who serve the population with co-occurring disorders. The trainings focus on a broad range of issues including assessments, referrals and case management and offer an opportunity for skills development and follow-up support groups. Focus groups, held early in the process, include consumers and family members in addition to service providers and identify key concerns about hard-to-treat populations, many of whom are dually diagnosed.

In addition to the training sessions, the newly formed Division of Community Mental Hygiene Services – the result of a merger of the Division of Community Mental Health Services and the Division of Alcohol and Substance Abuse Services – publishes a newsletter that is widely disseminated to the provider community. A television program – “Something of Substance” – which highlights the need for focused system of care for dual recovery, was also produced by the county.

### ***Sullivan County***

**The Recovery Institute (TRI) Training Seminars.** For two years TRI has consulted with Sullivan County Department of Community Services to lay the groundwork for providing integrated services to persons with co-occurring disorders. TRI ran a series of training seminars that have included all agencies in the county that have served this population. These ranged from the county's mental health and substance abuse providers to hospitals, community residences, adult homes, jail and probation, the vocational committee, school districts, and consumer advocates. These trainings encompassed holistic approaches to assessment and treatment of the target population driven by a harm-reduction model. In the initial training, providers defined the systems issues in the county, and established work groups for future sessions.

Each agency's roles and responsibilities with respect to integrating services for persons with co-occurring disorders were specified. Additional trainings addressed issues of intra-agency intake, assessment, placement and referral procedures, and the design of vocational preparation and placement programs. While the value of such opportunities for agencies to get together is undeniable, the ultimate success is often dependent on

factors out of the control of the organizers. So far, only the assessment piece of the TRI approach is being implemented and the Department of Community Services is finding that the harm reduction approach is a hard sell at all levels and across all agencies in the county.

**Resources**

**NYS Office of Mental Health Training Bureau.** Training material for working with clients with co-occurring disorders may be obtained at the Office of Mental Health (OMH) Training Bureau. Each spring the Bureau produces a series of video conferences on co-occurring disorders. A list of this spring's offerings is included in Appendix VIII. County and local staff are invited to attend all teleconference trainings. Contact Janet Chassman (518) 474-2578 for information on the sites receiving the teleconference broadcasts or on how agencies with teleconferencing equipment can obtain access to the broadcasts. Prior teleconferences are available on videotape and may be obtained. The Bureau of Medical Education, operating out of OMH, also conducts presentations that often include MICA-related topics. Further information may be obtained by contacting Lynn Wechler at (518) 474-2578.

MICA REGIONAL TRAINING COORDINATORS			
Roger Stone	MHA Erie County	716-886-1242	
Fred DuFour	SUNY (Syracuse) Health Sciences Center	315-464-3105	
Janet Caruso	MHA Dutchess	914-473-2500	
Giselle Stolper	MHA NYC	212-254-0333	Ext. 207
Shelley Steiger	MHA Nassau	516-489-2322	

Six agencies in New York State receive funding to conduct regional MICA-specific training. Training is organized differently in the regions, ranging from scattered, on site training to larger conferences.

**OMH Web Site.** "Dual recovery in focus: Substance use and psychiatric disorders" will be available through the OMH server starting in April 2000.

**NYS OASAS Sponsored Courses.** OASAS publishes a semi-annual Education and Training Provider Calendar in Upstate and Downstate Editions that lists numerous courses available through colleges and private agencies, many of which meet CAC/CASAC certification requirements. Contact: OASAS Division of Standards and Quality Assurance. 1450 Western Avenue, Albany NY 12213-3526.

Dual Recovery in Focus: Substance Use and Psychiatric Disorders [OMH web site for co-occurring disorders]	
<input type="checkbox"/> Mission statement	<input type="checkbox"/> Consumer issues
<input type="checkbox"/> Basic information about MICA	<input type="checkbox"/> Course modules
<input type="checkbox"/> Current and past research	<input type="checkbox"/> Physician training
<input type="checkbox"/> Information on sub-target populations	<input type="checkbox"/> Psychosocial issues
<input type="checkbox"/> Inventory of all MICA-related services	
Contact person: Fred Dufour (315) 464-3105	
<a href="http://www.omh.state.ny.us">http:// www.omh.state.ny.us</a>	

**Northeast States Addiction Technology Transfer Center.** This is a federal program funded by the Center for Substance Abuse Treatment (CSAT) to disseminate the latest research-based information on best practices and treatment techniques to addiction

treatment professionals. In addition, ATTC seeks to foster regional and national alliances among researchers, practitioners, policy makers, funders and consumers. They offer training materials in the form of manuals and diskettes, several of which address co-occurring disorders. In addition, their website offers links to many sources of information and training schedules in New York State. Northeastern States ATTC, Professional Development Program, Rockefeller College, SUNY Albany, 135 Western Ave. – Drawer 314. Albany, NY12222. (<http://www.albany.edu/pdp/attc>)

## VIII. CONCLUSION

Fragmented and inadequate systems of support for people with severe mental illness have consistently been part of the service landscape during this post de-institutionalization era. This report has summarized models for co-occurring disorders for which there is empirical evidence of effectiveness, as well as strategies developed locally and deemed to have some success in addressing the service needs of individuals with co-occurring disorders.

Local initiatives, more than funded research demonstrations, struggle to have an impact on combining mental health and substance abuse services within funding and regulatory constraints. The local strategies and programs described here reflect the key concerns reported by county directors regarding the target population in the Technical Assistance Project survey (Alexander and Haugland, 1999) violence and forensic system involvement, lack of residential options and community supports. In addition, peer driven models of support for co-occurring disorders are explored.

Locally developed strategies in NYS for combining services occur where the leadership is committed to changing services for this population. This has resulted in targeted reinvestment financing to coordinate services and has worked to create additional, sometimes substantial, grant funding for priority areas such as people who are homeless and/or who are involved with the criminal justice system. There is concern, repeatedly expressed by County Directors, that resources for public mental health are diminishing as the needs of individuals with co-occurring disorders grow more complex.

Successful strategies have evolved in localities where substance abuse and mental health service agencies are co-located and where leadership has fostered significant and sustained cross-talk between mental health and substance abuse staff. Counties where a single administrative authority takes the lead for mental health and substance use services appear to be better able to launch and sustain successful innovations, although they, too, must untangle the local, state and federal regulations for separately licensed programs. Such counties have also been able to bring disparate systems such as social services and criminal justice together and have made inroads to integrating their management information systems.

### **FURTHER DIRECTIONS FOR CO-OCCURRING DISORDERS**

Residential Models  
Services for young adults  
Support for families  
Treatment for families  
Peer-driven dual recovery  
Trauma-addiction connection  
Case management and consultation for complex clients

Source: Phone survey – County Directors

Still needed are demonstrations of effective residential models; approaches that address co-occurring disorders in young people between 18 and 25 who are in transition between youth and adult service systems and who are at high risk for the adverse consequences of substance use; service structures that allow clinicians to address the impact of co-occurring disorders on family systems through the provision of support to some families and the provision of direct substance abuse services to others; support for peer driven recovery approaches; recognition of the trauma-addiction connection and provision for case management and consultation for

complex clients.

A helpful framework, based on the dual diagnosis literature, conceptualizes the strategies needed to initiate and promote innovative policy and programs for individuals with co-occurring disorders as cyclic and recurrent (Mercer-McFadden, et al., 1998 – see box on left).

<b>INNOVATIONS ACROSS SYSTEMS TO DEVELOP INTEGRATED SERVICES FOR CO-OCCURRING DISORDERS</b>	
<b>CYCLES</b>	<b>STRATEGIES</b>
<b>Launch innovations</b>	Mobilize willpower Involve key players Identify models Collaborate with SA system Training of work force Demonstrate models Evaluate programs
<b>Promote development</b>	Training of work force Develop finance packages Document and replicate models Invest in technology transfer Disseminate Manage innovations

Source: Mercer-McFadden et al., 1998, p. 135

County Directors in New York State consistently have relied on these strategies to launch the innovations described in this report using the flexibility of demonstration and reinvestment funds. To promote the development of promising approaches they will need the commitment of and active participation by the Office of Mental Health and Office of Alcohol and Substance Abuse Services to overcome the regulatory and cultural barriers to integration of services and service systems.

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# Integrating Services for Co-occurring Disorders: APPENDICES

Final Report

Prepared for  
The New York State  
Conference of Local Mental Hygiene Directors

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March, 2000

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# APPENDIX I ASSESSMENTS

The following references/contacts have been included for the assessments discussed in the text to enable users to access procedure and protocol descriptions required for accurate use of the assessments.

### **Addiction Severity Index (ASI)**

**Contact:** [www.nida.nih.gov/PubCat/PubsIndex.html](http://www.nida.nih.gov/PubCat/PubsIndex.html)

Addiction Severity Index (ASI) Package (1993)  
NCADI # AVA19615VNB2KUS \$52.35

Provides a structured clinical interview designed to collect information about substance use and functioning in life areas from adult clients seeking substance abuse treatment. Includes an introductory brochure, a handbook for program administrators, a resource manual, two videotapes, and a training manual. Materials in the package are described below.

- **Introducing the ASI to Program Staff (1993) - Brochure**  
Describes the Addiction Severity Index(ASI) clinical interview, its benefits as a screening/assessment tool for treatment planning, and materials in the package.
- **Assessing Client Needs Using the ASI: Handbook for Program Administrators (1993)**  
Describes the ASI, and reviews the benefits of using it in program settings for assessment, treatment planning, and monitoring client progress. Discusses various implementation issues from a program administrator's perspective.
- **Assessing Client Needs Using the ASI: Resource Manual (1993)**  
Serves as a practical resource for service providers who will be conducting ASI interviews. Provides a detailed explanation of the purpose of each ASI question, and suggests ways to probe or clarify client responses to obtain complete, accurate answers. Gives guidelines for obtaining severity scores for the client life functioning areas. Gives ASI scores for various types of adult substance abusers.
- **Assessing Client Needs Using the ASI: Training Facilitator's Manual (1993)**  
Provides training instructions, exercises, and handouts/overheads. Includes a completed interview form based on the videotaped segments. Used with ASI videotapes and resource manual, curriculum is designed to train counselors and other practitioners who will administer the ASI.
- **Using the ASI To Assess Client Needs and Treatment Planning: A Training Videotape (1993) - Part I, 65 min - Part II, 64 min**  
Shows actual interviews conducted by experienced interviewers to demonstrate problems and interview techniques. Used in conjunction with the Training Facilitator's Manual, an excellent tool for training intake workers and other service providers in the administration of the ASI.

**Reference:** McLellan, A.T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom,G., Pettinati, H., and Argeriou,M. (1992). The fifth edition of the Addiction Severity Index. Journal of Substance Abuse Treatment, 9, 1999-2013.

National Institute on Drug Abuse. Assessing client needs using the ASI: A handbook for program administrators. National Institute on Drug Abuse. NIH Publication No. 95-3619.

### **Clinician Rating Scales (CRS)**

**Reference:** Drake, R.E., Mueser, K.T. and McHugo, G.J. (1998). Using Clinician Rating Scales to Assess Substance Abuse Among Persons with Severe Mental Illness. In Sederer, L.I. and Dickey, B. Outcomes Assessments in Clinical Practice. Baltimore: Williams & Wilkins.

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Contact: New Hampshire Dartmouth Psychiatric Research Center - (603) 271-5747

### **Substance Abuse Treatment Scale (SATS)**

**Reference:** McHugo, D., Drake, R.E., Burton, H.L. and Ackerson, T.H. (1996). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. Journal of Nervous and Mental Disease, 183, 762-767.

Mueser, K.T., Drake, R.E., Clark, R.E., McHugo, G.J., Mercer-McFadden, C. and Ackerson, T.H. (1995). Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness. The Evaluation Center@HSRI.

Contact: New Hampshire Dartmouth Psychiatric Research Center - (603) 271-5747

### **Dartmouth Assessment of Lifestyle Instrument (DALI)**

**Reference:** Rosenberg, S.D., Drake, R.E., Wolford, G.L., Mueser, K.T., Oxman, T.E., Vidaver, R.M., Carrieri, K.L. and Luckoor, R. (1998). Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. American Journal of Psychiatry, 155, (2) 232-238.

Contact: [www.dartmouth.edu/dms/psychrc/dali.html](http://www.dartmouth.edu/dms/psychrc/dali.html)

### **Readiness to Change Questionnaire**

**Reference:** Rollnick, S., Heather, N., Gold, R. and Hall, W. (1992). Development of a "readiness to change" questionnaire for use in brief, opportunistic interventions among excessive drinkers. British Journal of Addictions, 87, 743-754.

## **Rockland County Department of Mental Health Intake and Assessment**

### **See Appendix VI a: Assessment Unit**

Contact: Marge Davott      Assessment Center Director      914-364-2212

**APPENDIX II**  
**CHEMUNG COUNTY**

## **CHEMUNG COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Semi-urban population 95,000 Pop center: Elmira (50,000+)  
Charter county (Executive works with legislature)

### **COUNTY LEVEL SYSTEM COORDINATION**

Community Services Board has MH and SA subcommittees (with consumer representatives)  
Training for police/court/jail

### **MICA FOCUSED SERVICES**

Rural Mobile Crisis Team/Modified non-urban ACT Team (Contract with individuals from different agencies)  
Family Services has MICA track  
Urgent care worker to divert cases from hospital ER  
Next Step/MICA residence (Catholic Charities)

### **OTHER AVAILABLE SERVICES**

Family Services provides array of MH services  
Home Based Crisis Intervention worker  
ADRC (Alcohol and Drug Rehab)  
Forensic Caseworker (assessments, diversion, services in jail)  
Community minority outreach worker (re-engagement)  
Bridger program

### **CONSUMER PARTICIPATION**

Social Connection (psycho-social club)  
Consumers sit on all committees

### **APPROACHES TO OVERCOMING BARRIERS**

Contracting all services allows county to build in provisions for MICA  
Cross-agency meetings (include consumers)  
Contract with multi-county agencies (Catholic Charities)  
Use peer specialists, case managers  
Reinvestment dollars to divert from hospitals  
Educating police as part of academic curriculum

### **BARRIERS REMAINING**

Sharing data (HIPA restrictions)  
Weak family movement  
Educating clinicians

## Chemung County: Next Step MICA Residence

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**Program Name:** Next Step MICA Residence

**Location:** Chemung County (Elmira)

**Contact person:** Jeffrey Eaton, Director Gateways Community Living (607) 734-9784 ext. 110

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**Program objective:**

MICA residence for 16-21 year olds. Provide temporary housing for adolescents with dual disorders at risk of homelessness

**Program history:**

Originally conceived to address housing needs for kids aging out of youth programs but not yet engaged in adult mh system. Currently young mothers are served in this setting some of whom are trying to achieve documented sobriety in order to regain custody of their children.

**Services offered:**

3 supported living apartments with total of 5 beds. There is a resident Case Manager.

**Services linked:**

Family Services of Chemung County provides structured programming specifically for persons identified as MICA. Catholic Charities of the Southern Tier provides support services.

**Funding:**

OMH, Chemung County, Medicaid

**Staffing:**

Case Manager in same building

**Program benefits / Performance measurements:**

Document sobriety in order to obtain social services and other entitlements, regain custody of children

## Chemung County: Modified Rural ACT Team

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**Program name:** Modified Rural Act Team

**Location:** Elmira

**Contact person:** Tom Wallace, Director Chemung County Community Mental Health Services  
(607) 737-5501

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**Program objective:** The population of Chemung County is not large enough to support a permanent full-time ACT team, therefore, a modified rural ACT team has been conceived. This is an on-call mobile outreach team. Although a crisis may not be dealt with immediately, the team ensures that the client will obtain an appropriate referral for services on that same day.

**Program history:** Program was started 1998.

**Services offered:** The ACT team relies upon on-call consultants to provide services. County staff is charged with coordinating the team members. The team that is contracted by the county includes a psychiatrist, nurse, certified social worker and various other mental health professionals. In addition, a County Mental Hygiene Department crisis worker is assigned to each shift to insure complete coverage.

Clients are not retained as a caseload; rather they are referred to the existing county treatment and support team.

**Services linked:** Referrals are made to county treatment and support systems.

**Funding:**

OMH Reinvestment dollars, County funds

**Staffing:** The service providers are contracted, with the exception of the County Mental Hygiene Contract crisis worker.

**Program benefits/Performance measurements:** Individuals are seen on the same day receiving an appropriate level of treatment.

## **Chemung County: Social Connection/Psycho-Social Club**

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**Program Name:** Social Connection

**Location:** Chemung

**Contact Person:** Rob Ameigh, President (607) 732-4855

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### **Program objective:**

Consumer-directed clubhouse provides a mutually supportive environment for persons with mental illness living in the community. The club addresses issues of stigma by being actively involved in the community.

### **Program history:**

### **Services offered:**

The club offers the following: mutual-help groups; training with computers; socialization and recreational activities. The club administers a Mini-grant program to benefit other community groups. Vocational, rehabilitative and social services are also offered.

### **Services linked:**

Catholic Charities of the Southern Tier and the Chemung County Mental Health Department are actively involved in the clubhouse and can provide referrals for mental health services.

### **Funding:**

The psycho-social club is funded through reinvestment dollars administered by the County Mental Health Department. Catholic Charities provides custodial services for the building.

### **Staffing:**

The clubhouse is member-directed by a board comprised of consumers, with Mental Health professionals serving as advisors. Associate board members learn the duties of officers from active board members.

### **Program benefits / Performance measurements:**

The club provides a central meeting place for consumers living in the community and addresses issues of stigma and financial responsibility.

**APPENDIX III**  
**LEWIS COUNTY**

## **LEWIS COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Rural pop. 27,000

Widely dispersed population

**One of the poorest counties in NYS (9% unemployment)**

### **COUNTY-LEVEL SYSTEM COORDINATION**

MICA Services Coordinator

MICA Advisory Group

Single agency provider/single licensure (OMH)

Integrated assessment process

### **MICA-FOCUSED SERVICES**

Community Mental Health Services MICA Program

Staff are cross-trained and are also trainers

### **OTHER AVAILABLE SERVICES**

ICM

Transportation through reinvestment

2 county Trauma Survivors Resource Center with large MICA impact

Alcoholism Treatment Center coordinates with MH services

### **CONSUMER PARTICIPATION**

Psychosocial Club

Double trouble group

Case Manager Aides

Transportation

### **APPROACHES TO OVERCOMING BARRIERS**

Strong ties with corrections, DSS

Focus on staff training and staff competence

Consumer driven focus on trauma as critical component of addiction

Tri-County Trauma Coordinator initiative in 2000

Single licensure facilitates computerized record keeping

Consumers as drivers

### **BARRIERS REMAINING**

Consumer resistance to sobriety

Funding for community residences

Seeking Residential Model for co-occurring disorders

No public transportation

## Lewis County: Community Human Resources

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**Program name:** Community Human Resources

**Location:** Lewis County

**Contact person:** Nancy Lee Closner (315) 376-4648

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**Program objective:** This not-for-profit agency provides advocacy for people with mental health disabilities and developmental disabilities, including people with co-occurring disorders.

**Program history:** Community Human Resources was started in 1993 with the understanding that an advocacy group was needed to support individuals with co-occurring disorders.

**Services offered:** The agency provides a wide array of advocacy, which includes assisting the individual in navigating systems.

A Double Trouble in Recovery (DTR) group started running January 2000. Its aim is to follow Vogel's model. At present they have no peer counselors in Lewis County, thus the groups are chaired by a group member. The chairperson is an individual who had previously attended the Empowerment Council. Plans are in the making to have an official DTR training session. All DTR participants are members of the Lewis County Psycho-Social Club.

**Services linked:**

**Funding:** Reinvestment dollars.

**Staffing:** 4 staff – 1 office manager, 1 works with persons who are mentally retarded/developmentally disabled, and 2 work with persons who are mentally ill.

**Program benefits/Performance measurements:** Individuals participating in a mutual aide group are afforded a sense of self-empowerment, which naturally leads on to a fostering of control and independence.

## Lewis County: MICA Services/Community Mental Health Services

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**Program name:** MICA Services/Community Mental Health Services

**Location:** Lewis County

**Contact person:** Bill Burkhart, MICA Services Coordinator (315) 376-5450

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**Program objective:** This program aims to provide “one-stop shopping” outpatient services to clients identified with co-occurring disorders. The treatment objective is for clients to achieve abstinence, although the difficulty in achieving this goal is acknowledged.

**Program history:** This OMH licensed outpatient program was established in 1993.

**Services offered:** The following services are offered: assessments (psychiatric, psychological and psychosocial); psychotherapy (individual, couples, family) and Double Trouble-like self-help groups; Intensive Case Management and Respite (“big-brother/sister” type of program with no overnights). There are 150 clients with co-occurring disorders enrolled in the program and three Certified Alcoholism Counselors who provide ongoing therapy.

**Services linked:** Many referrals come from Corrections. Case managers also work with DSS to provide housing for the client when needed.

**Funding:** OMH; Medicaid reimbursements; Reinvestment for transportation for clients with dual disorders.

**Staffing:** Although the MICA Services Coordinator is technically the only staff member in this program, Community Mental Health Services staff members (11) are available to provide services for individuals with co-occurring disorders. All 3 counselors have CASAC certification (1 PhD candidate; 1 Master’s level and 1 CSW). Staff also include 1 Intensive Case Manager, 3 case managers and 3 case manager aides. The case manager aides are consumer/providers from Parkside House/Psychosocial Club.

Most of the staff members have at least 10 years of experience at CMHS. The low turn-around rate has been attributed to solid, focused leadership and the compatibility of the team. Staff members have attended OMH trainings, pharmaceutical company trainings, mental health trainings and various other trainings that are drug and alcohol specific.

**Program benefits/Performance measurements:** A large number of clients with co occurring disorders receive “seamless” services by a dually competent team at one central location.

## Lewis County: Parkside House/Psychosocial Club

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**Program:** Parkside House/Psychosocial Club

**Location:** Lewis County

**Contact person:** Pat Farney, Senior Case Manager Aide (315) 376-5450

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**Program objective:** The psychosocial club functions as a drop-in center for consumers with mental health, chemical dependence or co-occurring disorders. The goal is to provide a safe meeting space for consumers and to assist them in meeting their daily living needs.

**Program history:** The Parkside House originally functioned as a Continuing Day Treatment center which evolved into a psychosocial club through reinvestment dollars.

**Services offered:** The Psychosocial Club is the source of consumer/provider case management aides. They also work out of the Community Mental Health Services (CMHS) and serve as links between CMHS and the client. They assist the client in meeting his/her needs and promoting client independence. Approximately 30% attending the club are identified as MICA. Some of the MICA individuals recently began a DTR group, which is operating out of the CMHS for practical reasons.

**Services linked:** All consumers who use The Parkside House and who have co occurring disorders are also CMHS clients. Case manager aides assist consumers in accessing the services they need from CMHS and other agencies.

**Funding:** Currently, partial funding is provided through reinvestment monies.

**Staffing:** The club employs 3 full-time case manager aides as well as a senior case manager aide who functions as the supervisor. The case manager aides are peers and are salaried for their services. There is also a part-time driver on the premises.

**Program benefits/Performance measurements:** The club fosters consumer independence and successful reintegration into the community.

**APPENDIX IV**  
**MONROE COUNTY**

## **MONROE COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Urban/suburban population 714,000; 16% non-white; Pop center: Rochester  
Long standing experience with county-wide hospital-based case register

### **COUNTY-LEVEL SYSTEM COORDINATION**

Coordinated Care Service Inc. (CCSI) provides oversight of all services and data co-ordination  
Monroe Plan – Medicaid Managed Care Organization for Mental Health and Chemical Dependence  
Three hospitals form core of treatment system

### **MICA-FOCUSED SERVICES**

High Impact Incarceration Program (HIIP)

Homeless MICA Project

MICANet

Project Link

Recovery Case Management

Shelter-Plus Care

Averill Court CDT Program

- Chemical Dependence treatment for jail inmates
- MH/DSS collaboration. Housing and service access for homeless individuals with co occurring disorders
- Clinician Case Management
- Criminal Justice Case Advocacy. 5 agencies collaborate to provide culturally sensitive ACT-like services
- Case management for individuals with chemical dependency or co occurring disorders
- MH/DSS collaboration to provide housing
- OMH licensed Continuing Day Treatment Program with dually competent staff (Behavioral Health Network /Genesee

### **OTHER AVAILABLE SERVICES**

Mobile Crisis (CPEP at University Hospital)

### **CONSUMER PARTICIPATION**

Memberships on committees/representative at meetings

Operation Friendship (social club)

County-run Consumer Coalition (funded by NAMI)

### **APPROACHES TO OVERCOMING BARRIERS**

Integrated Assessment Process (Unity Systems)

Pilot project for multi-licensed agency

Demonstration project for jail diversion program

Central intake for all Case Management (ICM, SCM)

### **BARRIERS REMAINING**

Lack of will to resolve regulatory issues at State/Federal levels

Differential resistance to change from treatment philosophies/"cultures"

Inadequate short/long term housing

Anticipated impact of Kendra's Law

## Monroe County: High Impact Incarceration Program (HIIP) Dept. of Justice

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**Program name:** High Impact Incarceration Program (HIIP)

**Location:** Monroe

**Contact person:** Craig Johnson, Director of Inmate Drug and Alcohol Services (716) 274-8555

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**Program objectives:** HIIP is a nationwide program that provides services, in general, to inmates with chemical dependence. It is imbedded in the Correctional Department and is housed in the smaller of two correctional facilities in Monroe County. This location has 150 beds for the sentenced population and 10 beds for parole violators.

**Program history:** This program has been in existence since July 1994. The Justice Department works closely with OMH to provide services.

**Services offered:** There are 30 MICA-identified people currently occupying beds in this program. The mental health interventions include educational group therapy, anger management groups and some experiential groups available only to female inmates. The correctional environment is chemical dependence-oriented and is not considered a mental health treatment environment; therefore outside sources deliver these interventions.

**Services linked:** This program works with the entire criminal justice system and with outside mental health providers.

**Funding:** There are multiple state and county funding sources, including Parole and State Department of Education.

**Staffing:** All staff members are not cross-trained. There are 10 staff members with the following credentials: 6 Masters prepared staff in Community Counseling and CASACs; 2 with a Masters in Public Administration and 2 case managers at the BA level. The staff follows the chemical dependence perspective and the non-clinical academic programs reinforce this perspective. There is no dual-competency training within the program.

**Program benefits / Performance Measurements:** This program fosters cooperation between agencies in the Criminal Justice and Mental Health systems. It measures performance by reduction of recidivism (2 studies have been conducted that look at the re-arrest rate six months post-release). HIIP also focuses on continued abstinence and the reduction of crime rate.

## Monroe County: Homeless MICA Project

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**Program name:** Homeless MICA Project

**Location:** Rochester General Hospital and University of Rochester Department of Psychiatry at Strong Memorial/Monroe County

**Contact person:** Don Kamin, CCSI (716) 328-5190 ext.23

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**Program objective:** Specialized case management to identify homeless mentally ill individuals and link them with Shelter-Plus Care, refer them as needed to outpatient services and help them obtain entitlements.

**Program history:** This program was established 4 years ago using reinvestment dollars. It is licensed through OMH and DSS. The County Mental Health Department contracts with DSS to provide Shelter-Plus Care.

**Services offered:** Specialized Case Management (Homeless MICA Worker) in addition to intensive case management is provided. The intensive case management refers to obtaining housing referrals, entitlements and referrals to mental health services.

**Services linked:** Direct linkage to Shelter-Plus Care is provided as well as to all appropriate service agencies.

**Funding:** Reinvestment continues to be a stable source of revenue. It is, however, not increasing sufficiently to meet increased costs.

**Staffing:** There are 2 FTE at the mental health sites; 1.5 FTE at Shelter-Plus Care. The staff members have a Bachelor's level education. None of the staff are CSAC.

**Program benefits/Performance measurements:** The program looks at the number of referrals that have been made as performance measures.

**Monroe County: MICA Treatment and Support Services (MICANet) – Rochester  
Mental Health Center**

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**Program name:** MICANet

**Location:** Monroe

**Contact person:** Valerie Winnick, Program Manager (716) 922-2636

valerie.winnick@viahealth.org

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**Program objective:** This program provides aggressive outreach to engage individuals with co-occurring disorders and provides a comprehensive array of mental health and chemical dependency treatment and support services. During pre-engagement, staff enroll clients through successful relationship building in the community. In later stages of treatment they monitor substance use, continue to build relationships, and link clients with other community services. Length of stay in the program is approximately nine months.

**Program history:** This OMH licensed case management service was established in 1997 with grant funding to develop, implement and coordinate a comprehensive array of mental health and chemical dependency treatment and support services for individuals with co-occurring disorders. It is licensed by OMH. It is one of a number of programs run by Rochester Mental Health Center.

**Services offered:** There are currently 93 clients on books. Thirty-eight are active program participants and 19 have graduated. Case management and service linkage, 24 hour telephone consultation and some mental health and chemical dependency interventions are provided.

**Services linked:** The cooperation of the whole community is critical to the success of the program. Critical collaborations include:

- 1) The drug and alcohol team in prison
- 2) Other members of the VIAHealth Care system
- 3) Operation Friendship – community social club/drop in center (no programming)
- 4) Genesee Alcohol Treatment program
- 5) Averill Court Continuing Day Treatment Program
- 6) Criminal Justice system
- 7) Social Services
- 8) Vocational programs

This program also works with MAINQUEST, which is a chemical dependence treatment program. The MICANet registered nurse, located at MAINQUEST, provides mental health consultation and training to their chemical dependency staff as well as direct services to their clients. In exchange, MAINQUEST ensures that there are always 6 beds available for MICANET clients.

**Funding:** This is a Case Management program funded by OMH.

**Staffing:** The program is staffed by: 1 MSW; 1 BSW/CASAC; 1 RN; 1 Rehab Specialist and a contracted Psychiatrist. There are frequent trainings for the staff and MICANet is in the process of setting up mini-internships for the staff in order to hone their clinical skills. At present the staff comes primarily from a chemical dependency background. Caseloads are 20 clients/clinician.

**Program benefits/Performance measurements:**

Clinical outcomes are measured via the administration of standardized instruments: The Multnomah Community Assessment Scale and the Clinician Administered Social Functioning Scale. Graduation from program indicates engagement in chemical dependency treatment.

## Monroe County: Project Link

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**Program name:** Project Link

**Location:** Monroe

**Contact person:** Steve Lamberti, Director (716) 275-7550, ext.2237

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**Program objective:** The program is designed to provide culturally sensitive services to severely mentally ill adults with difficulty linking to services and/or who are involved or at risk of becoming involved with the criminal justice system. Goals are to prevent incarceration and hospitalization and to promote reintegration within the community.

**Program history:** Project Link was established in 1995 as a demonstration project by the Department of Psychiatry, University of Rochester. It is a consortium of five community organizations: Action for a Better Community; Ibero-American Action League; Monroe County Clinic for Socio-legal Services; Unity Health System and Urban League of Rochester.

**Services offered:** The project is intended to serve homeless persons of color. The focus is on patients with some sort of psychotic disorder. There are approximately 100 persons enrolled in this program. Although Project Link is not an ACT team, it incorporates principles of both ACT and ICM. High-risk clients (with co-occurring disorders) are assigned to the Project Link team. After assessment by the team, they are referred to the appropriate sources for intervention. Clients who refuse referrals are treated by the team's forensic psychiatrist and nurse practitioner.

Project Link possesses a mobile treatment team (the core Project Link staff that is on call 24 hours per day, 7 days a week). There is also a treatment residence for clients with chemical dependence in an existing ten-bed residential facility managed by DePaul Residential Services.

**Services linked:** Project Link is integrated with the criminal justice system. Staff members work with the consumers in courtroom and jail settings. There are also active links with DSS. Liaisons are designated within each local dept. of DSS to serve as points of contact for all consumers served by Project Link.

Collaboration exists between OMH and DSS, although Project Link only reports to OMH. It is currently trying to attract OASAS funding.

**Funding:** The majority of funding is provided by OMH, and supplemented by the Robert Wood Johnson Foundation and the Monroe County Office of Mental Health.

**Staffing:** Project Link is comprised of a multidisciplinary team: 5 BSW level case advocates, 1 nurse practitioner and a forensic psychiatrist. Although at present, none of the staff members possesses a CASAC or CAC certification, the goal is to have the staff members obtain this certification.

**Program benefits/Performance measures:** Success is measured by the number of clients serviced.

## Monroe County: Recovery Case Management (RCM) – Unity Health System

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**Program name:** Recovery Case Management (RCM)

**Location:** Monroe County

**Contact person:** Roseanne Kilduff, Coordinator (716) 368-6900 ext. 8980

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**Program objective:** This is Chemical Dependency/Criminal Justice Pilot Program that provides Intensive Case Management for individuals with co-occurring disorders with a history of involvement with the criminal justice system. Clients may have any AXIS I and/or AXIS II diagnosis (inclusive of chemical abuse/dependence diagnosis). The program is intended to provide a comprehensive, closely monitored and coordinated system of care, including referrals and access to housing.

Criteria for inclusion in this program are:

Medicaid eligibility; Current or past (within 2 years) involvement with the Criminal Justice System; at least 3 inpatient admissions for chemical dependency services.

**Program history:** This is the third year of this county-funded pilot project. The program itself is licensed through Unity Health System by OMH, DSS and OASAS. The lead agency is the Park Ridge Hospital Behavioral Health Department and St. Mary's Hospital Department of Psychiatry.

**Services offered:** This program aims to provide continuity of treatment and supports in order to prevent relapse during transitions across levels of care and among providers. Case managers provide mandated clients who are chemically dependent with timely access to appropriate, local levels of care. Program staff provide support services on weekends as well.

**Services linked:** Clients are referred by the following programs etc.:

VOA; DePaul Mental Health Residence; Quarter House; HIIP program (drug and alcohol treatment program within correctional facility); Probation; ATI (Alternative to Violence program) Active collaboration with DSS provides some partnership with housing agencies mentioned above. This program relies upon OMH, OASAS and DSS for its service delivery.

**Funding:** Grant funding by Monroe County. This is a pilot project in its 3<sup>rd</sup> year.

**Staffing:** Staff members are cross-trained, although the chemical dependence model predominates. Several are currently preparing for the CASAC exam. Six general trainings as well and ongoing diversity training is scheduled each year.

**Program benefits/Performance measurements:**

Increased periods of sobriety and improved Quality of Life for clients; Improved linkages and coordination with criminal justice; Reduced arrests and jail days; Reduced Out-of County placements for inpatient CD treatment services; Increased utilization and higher completion rates of local, less restrictive CD services; Reduced number of behavioral health inpatient days.

**Monroe County: Averill Court Continuing Day Treatment Program  
VIA Health/Behavioral Health Network @ Genesee Hospital**

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**Program name:** Averill Court Continuing Day Treatment Program.  
(VIA Health/Behavioral Health Network @ Genesee Hospital)

**Location:** Monroe County

**Contact Person:** Dorothy Marion, CSW, Director (716) 263-5320

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**Program objectives:** This program aims to link clients with appropriate agencies and services. A multi-disciplinary team whose goal is to provide a holistic service staffs the program. The CDT specializes in working with clients with trauma related disorders, eating disorders, and personality disorders. A total of 160 clients are enrolled in the program; 60 have co-occurring disorders.

**Program history:** OMH licensed CDT, housed in a psychiatric setting, established in 1987.

**Services offered:**

The CDT provides the following MICA-specific services:

- initial screening
- orientation group
- individual and group psychotherapy for clients with co-occurring mental illness, substance abuse and personality disorders. A group approach used with clients who are at least 30 days into recovery combines Rational Emotive Therapy (RET) and Dialectical Behavior Therapy (DBT). Though not formally validated, this approach seems to be effective.
- rehabilitation
- case management
- medication management

**Services linked:** The purpose of the program is to link clients with programs and supports in the community, which will meet their extensive needs. This program works closely with DSS, as many clients with co-occurring disorders are homeless. Many of the referrals to the program are from Corrections.

**Funding:** OMH licensed CDT is a deficit-funded program with stable sources of revenue.

**Staffing:** Eight staff members work specifically with the clients who have co-occurring disorders. The composition is as follows: 3 CSW level workers, 1 CASAC level, 1 case Manager with a B.S. in recreational therapy, 1 BSN, 1 nurse practitioner, 1 program counselor and 1 supervising psychiatrist. All staff members are dually competent and attend MICA rounds on a continual basis; many have backgrounds as therapists in chemical dependency treatment settings.

**Program benefits/Performance measures:** Decreased recidivism rates; ability of the client to change behaviors which in turn allows them to function effectively in society.

**APPENDIX V**  
**RENSSELAER COUNTY**

## **RENSELAER COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Semi-urban. Population 165,000. Population centers: Troy, Rensselaer  
Unified Services County  
Provide and contract out services  
Growing Hispanic population in Troy

### **COUNTY LEVEL SYSTEM COORDINATION**

Cross attendance at MH and Alcohol/Drug abuse planning groups  
Forensic Task Force

### **MICA FOCUSED SERVICES**

MICA Coordinator  
COPEs (peer-operated drop-in center)  
MICA Housing Unit, Rensselaer County Correctional Facility

### **OTHER AVAILABLE SERVICES**

Samaritan Hospital: IP MICA, IP MH, MICA CDT  
Seton Hall Hospital: Detox, IP, Rehab, OP

### **CONSUMER PARTICIPATION**

COPEs Psychosocial Club w/ Double Trouble in Recovery group

### **APPROACHES TO OVERCOMING BARRIERS**

Training  
Active collaboration among systems  
MICA Coordinator  
Active consumer participation  
Collaboration to develop a single assessment tool that meets both OASAS and OMH requirements

### **BARRIERS REMAINING**

Paper work supports separateness philosophically and administratively  
No integrated, automated assessment that meets both OASAS and OMH requirements  
Training and experience limit perspective of MH staff  
Limited inservice training to foster development of chemical dependence skills  
Case management is neither valued nor paid for  
Limited consumer, family, agency dialogue

## Rensselaer County: COPES Peer Operated Drop-In Center

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**Program name:** Challenging Our Problems with Emotional Support (COPES) and YWCA

**Location:** Rensselaer

**Contact person:** Susan Frost, Administrator (518) 235-2173

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**Program objective:** Challenging Our Problems with Emotional Support (COPES) is a peer-run drop-in center that provides services and support in a recovery environment to individuals with mental health disabilities or co-occurring disorders. Last year, COPES provided 8,600 units of service (duplicated count). Approximately 70% of those using the Club have co-occurring disorders, and of those 10% have a severe mental illness diagnosis.

In addition, 3 trained peer counselors provide services at the YWCA Residential Housing for women and their children. This housing project services 36 clients. Half of the clients have been defined as having co-occurring disorders.

**Services offered:** COPES is staffed by 8 peer counselors who have been trained to facilitate groups that blend the mutual aid principles of Double Trouble in Recovery and Rational Recovery. Three DTR groups run under COPES' auspices: two at COPES and one at St. Peter's residence. These groups run once per week with a total attendance of 50 people. One of the groups focuses specifically on young adults (16-23). It began running the first week of February 2000.

The peer counselors at COPES and at the YWCA support club members in meeting their daily living needs. They make necessary or requested referrals. Contact with another agency is only made upon the express request and with the written consent of the client. In addition, peer counselors at the YWCA are available to monitor supervised mother-child visits.

**Staffing:** There are 8 full-time peer counselors at COPES and 3 peer counselors (2 part-time; 1 full-time) at the YWCA. They have traditionally been trained by both COPES and the YWCA staff. The training now includes paid respite work at Joseph's House, followed by night-time coverage at the YWCA, respite counseling at Unity House and concludes with work at Good Samaritan Hospital.

**Program benefits/Performance measurements:** Ongoing attendance at COPES and participation in groups.

## Rensselaer County: MICA Coordinator

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**Program name:** MICA Coordinator

**Location:** Rensselaer

**Contact Person:** Kirsten DonVito, MICA Coordinator (518) 270-2842

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**Program Objective:** The MICA Coordinator provides outreach and direct services to clients with co-occurring disorders in jail, clinic and residential settings. The coordinator provides educational trainings to other providers and is a representative on the Forensic Task Force. She is also charged with providing consultations and with active memberships on other related committees.

**Program History:** The need for a MICA Coordinator was identified in Rensselaer County, and the position was created 3 years ago.

**Services offered:** The coordinator carries a caseload of 10-12 clients and provides training, consultation and jail-based services. She runs a woman's group at the Drug-Free clinic where 75% of the clients are identified as having co-occurring disorders. She provides assessments and runs a women's group for female inmates (approximately 80% with co-occurring disorders) in the county jail. At the YWCA residence she runs a women's open support group (approximately 50% of residents with co-occurring disorders).

**Services linked:** The MICA coordinator has identified a need for MICA-specific housing for women and has recently joined a committee to develop this type of housing. At present there is just one operating MICA-residential program in the county and a housing program at the YWCA for chemically dependent women and their children. Though some women with co-occurring disorders may use this program, they are not its target population.

The Forensic Task Force is currently focused on developing solutions with DSS to the problems faced by inmates identified with co-occurring disorders on release (e.g., the need for have Medicaid in place prior to release). The goal is to work with volunteer agencies to transport the inmate to DSS immediately upon release. The likelihood of re-arrest, incarceration or need for emergency room services is high for clients without benefits.

**Funding:** MICA Coordinator is funded by OMH moneys provided by the Task Force on Integrated Planning (TFIP).

**Staffing:** One MICA Coordinator

## Rensselaer County: MICA Housing Unit/Rensselaer County Correctional Facility

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**Program name:** MICA Housing Unit

**Location:** Rensselaer

**Contact Person:** Don Hogan, Forensic Mental Health Coordinator (518) 270-5448 ext. 267

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Rensselaer County Correctional Facility currently houses 270 male inmates of whom 10 are identified as having co-occurring disorders. There are 26 females in the facility of whom 4 or 5 have a co-occurring disorder. There is no special housing unit for these women. The County MICA Coordinator assesses them, sees them individually as needed and provides group therapy.

**Program objective:** This 20 bed unit is a medical/special housing unit that is designed to provide appropriate services and safe housing for the MICA-identified male inmate who has not been diverted. Inmates requiring medical attention also use this housing unit.

**Program history:** The County Forensic Mental Health Coordinator identified the need for these services for inmates with co-occurring disorders to establish this unit in 1992. The coordinator also provides training in forensic mental health to police and to mental health staff.

**Services offered:** Psychiatric assessments are performed as indicated on entry into the criminal justice system, using prior clinical/mental health records as needed. If co-occurring mental health and substance abuse disorders are present, the severity of the criminal charges are reviewed to determine whether diversion will occur.

Male inmates with co-occurring disorders are moved to the MICA Housing Unit based on the judgement of the jail Mental Health Coordinator. An inmate may opt to stay in regular detention if the symptoms are not severe. The range of lengths of stay for inmates with co-occurring disorders can be anywhere from 24 hours to 6 months. The MICA Housing Unit provides individual psycho-educational substance abuse therapy; medication management and discharge planning. Non-mandated AA and NA groups are held, but there are no dual recovery groups,

**Services linked:** Inmates are referred on release to McPike, a chemical dependency residential rehabilitation program in Utica (Oneida County). Efforts are made to link the inmate with DSS prior to discharge to establish benefits, including Medicaid, and referrals for outpatient treatment are provided.

**Funding:** All services in this unit are funded by OMH.

**Staffing:** Two staff members provide services for the MICA Housing Unit, which also houses non-MICA inmates. The Forensic Mental Health Coordinator assesses and provides the psycho-educational intervention. A second staff member who has a Bachelor's degree provides discharge planning.

**Program benefits/Performance measurements:** Jail incidents, decompensation and suicidal gestures/attempts have decreased substantially since this unit began to include men with co-occurring disorders.

## Rensselaer County: Forensic Task Force

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**Program name:** Forensic Task Force

**Location:** Rensselaer

**Contact person:** Arlene Walsh, Director of Clinical Administration at Unified Services  
(518) 270-2811

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**Goals:** The Forensic Task Force views the jail as a central “hub” linking pre-trial diversion, jail treatment and education, aftercare to drug court and day reporting programs. Its goal is to address service system gaps for people in the criminal justice system with mental health and substance abuse problems by forging partnerships that create new, targeted services, initiative and funds.

**Process:** This Task Force was created in 1996 by a 3-person team who attended a GAINS Center Forum focused on building partnerships and collaboration to improve service delivery to offenders with co occurring disorders. The Task Force now represents a cross section of systems, disciplines and interests: treatment agencies, local jail, courts, probation, parole, defense and DA offices, health department, DSS, MRDD, city police, housing, shelters, consumers, religious and cultural diversity groups. Rensselaer County Unified Services, the key player role in this collaborative effort, has administrative oversight of mental health and substance abuse services.

**Resources:** Initial efforts and links were accomplished without substantial new funding. In its third year, agencies that used the Task Force as a conduit and advisory board began to bring substantial new funding into the county: \$796,000 in grants; \$600,000 HUD Shelter + Care; \$2.9 million HUD capital improvements; \$1.2 million HUD Section 8 housing.

**Target Population:** MICA population in jail with no or with unsuccessful prior contact with treatment system. Those at highest risk of re offending and of relapse who need planned linkages with community treatment agencies.

**Services Offered:** Creation of partnerships to address gaps for target population at points of Jail diversion; Jail assessment and treatment; Jail aftercare

### Jail assessment and treatment

- ❑ County MICA Coordinator assesses co occurring disorders for women inmates so treatment and education services can be planned.
- ❑ Reinvestment \$ were used to employ a jail aftercare and discharge planner and to provide follow up services for released inmates with mental health problems.
- ❑ Many small agreements were made to facilitate inmates' application/access to SSDI and Medicaid immediately on release. For instance: Newly released inmates, accompanied by treatment staff, can apply for emergency Medicaid and receive same day assignment of benefits; DSS also agreed to allow local volunteers provide transportation and wait for these applicants; SSI sends an employee to begin the application process while the person is in jail; a single DSS worker was assigned to handle all mental health problems; For a small fee, arrangements were made to obtain id needed to apply for Medicaid for individuals who are MICA and need emergency Medicaid.

## **Rensselaer County: Forensic Task Force - continued**

### Jail treatment and aftercare

- ❑ Women released from jail are at high risk for pregnancy and sexually transmitted disease, the Health Dept nurse provides in jail education and consultation, follow up after release, and information about community based bilingual shelter services for pregnant women
- ❑ Division of Probation and Correctional Alternatives funded a transitional residence for men released from jail who are waiting for substance abuse inpatient rehab. DSS agreed to fund similar beds at a local crisis center for women
- ❑ Five days of medication can be sent with newly released inmates going to a supervised setting. Jail assists with follow up outpatient appointments to maintain continuity in medication

### Residential support and resources

There are few residential options for women with co occurring disorders during the high risk period immediately post release and there is no support to reunite them with minor children.

Task Force activities facilitated the following:

- ❑ \$1.60,000 grant to provide outreach and coordination to parents who fall under TANF rules
- ❑ County DMH MICA coordinator provides: follow up on co occurring disorder evaluations and recommendations made while women are incarcerated, consultation and training to YWCA (residence) staff on issues related to women with co occurring disorders, assessment, individual treatment and referral services for mica women at YWCA residence
- ❑ YWCA received: a capital improvement grant to expand their ability to house mica women and their children; 5 support staff from OMH for supportive housing beds; HUD section 8 grant for 10 years of rent subsidies
- ❑ The psychosocial club, COPES received \$70k to provide 1 peer counselor and 2 part time support counselors to support women with co occurring disorders in transition from jail

Individuals with co occurring disorders need supportive housing, drop center support and case management. Task Force activities supported:

- ❑ Contract with NYS Corrections to provide aftercare
- ❑ MICA coordinator does a drop in group at St Joseph's shelter
- ❑ Troy Homeless Services Collaborative is able to provide up to 30 scattered site housing units for people with co occurring disorders who are hard to place, 26 studio units, permanent supportive housing projects + a drop in center for homeless adults with co occurring disorders who are hardest to reach/ place. They use HUD shelter plus Care for housing stipends, \$89,000 from OMH for support services for MICA homeless and \$9000 from community reinvestment

### **Outcomes:**

Easier jail management; Decrease jail overcrowding; Improve clients' ability to cope throughout incarceration; Better treatment for clients in jail; Improved follow up; Ultimate goal is to reduce recidivism; Jail diversion efforts save the county jail \$7,000/ day.

### **Problems Encountered:**

Is the target population the responsibility of the mental health system, the substance abuse system or the criminal justice system? Can these systems With three separate funding streams, regulation and methods of service delivery collaborate?

**APPENDIX VI**  
**ROCKLAND COUNTY**

## **ROCKLAND COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Suburban; population: 300,000

Population centers: Nyack, Spring Valley, Village of Haverstraw; Suffern, Pearl River

### **COUNTY LEVEL SYSTEM COORDINATION**

Unified Services County – enhanced funding; County takes lead in all 3 disabilities; County is Core agency for mental health

Performance Improvement Project

### **MICA FOCUSED SERVICES**

Co-occurring Disorder Performance Improvement Project

Central Assessment Unit

Special Case Conference Group

MICA Community Residence

### **OTHER AVAILABLE SERVICES**

Assessment/Crisis Team

Young Adult Center

### **CONSUMER PARTICIPATION**

STEMMS-like group beginning

2 peer case managers (not dually diagnosed)

### **BARRIERS REMAINING**

Diminishing resources for an increasingly difficult population

Loss of shared staff

With additional \$ might choose to develop a separate MICA program

Would like to see single licensure

DSS Housing difficult to access

More housing with a spectrum of support, including intensely supported residences

Minorities under served

Minority staff difficult to recruit

Cultural minorities in county are under served

Programming 7 days a week

Provide more services to people in jail

Services for families of origin

## Rockland County: Rehabilitation Programs

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**Program name:** Young Adult Center; Continuing Support Center

**Location:** Pomona

**Contact person:** Bill Goldberg, Director of Rehabilitation Programs (914) 364-2413

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**Program objective:** The Young Adult Center is an OMH licensed Continuing Day Treatment serving individuals with severe mental illness between the ages of 18-45.

**Program history:** This program was established 18 years ago as a Social Rehabilitation Program to support people coming out of long term institutionalization. The program receives clients from the County's Central Assessment Unit, which uses practice guidelines to assign clients to programs and to develop an initial treatment plan. A client cannot be turned away from any program once assigned.

**Services offered:** The Young Adult Center treats clients with severe mental disorders with and without co-occurring substance use problems. The staff member who assesses an individual chooses the most appropriate program for that client. Program staff then assess mental health and chemical dependence needs in detail in order to develop a treatment plan.

**Services linked:** Clients are referred to case managers at specific programs for services as needed.

**Funding:** Payers are primarily Medicaid, with some commercial insurance. A sliding fee scale is used for self pay clients, and deficit funding is available.

**Staffing:** Staff is comprised of paraprofessionals and currently no staff are CACs. Substantial in-service cross-training is provided. Cross-cultural barriers for the Hispanic, Hasidic and immigrant communities, remain program challenges and remain to be addressed.

**Program benefits/Performance measures:** The program has a zero-tolerance policy and has identified the goal of recognizing substance use, as such urine and random drug screenings are given.

## Rockland County: Assessment Unit

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**Program:** Centralized Assessment Unit

**Location:** Rockland

**Contact person:** Marge Davott, Assessment Center Director 914-364-2212

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**Program Objective:** Assessment Unit procedures are keyed to improving identification of co-occurring disorders and providing integrated treatment for co-occurring disorders. The unit provides a single point of entry for all admissions to mental health and substance use services in the county, and has the authority, for County programs, to develop an initial (30 day) treatment plan with uncontested referrals. It diverts hospital admissions, and integrates mental health and substance abuse concepts and requirements into single assessment and triage process.

**Program History:** The Assessment Unit opened in 1995 to proactively increase integration of services for co occurring disorders in the face of anticipated changes in financing and resources. Based on empirical study of admissions, the Co-occurring Disorders Performance Improvement Committee recommended improved identification of substance use problems through Centralized Intake and Assessments, increased chemical dependency focus in Rehabilitation and Partial Hospital programs and increased skills and linkages across programs. The Assessment Unit provides the linkage for these goals. In order to be effective, it was necessary to disentangle federal, state and local regulations governing each of 17 program units.

**Services offered:** Screening, assessment and referral to clinical programs takes place in a single day and in a single location. Universal instant urine testing takes place during the initial assessment process and randomly during active treatment in order to support accurate incorporation of substance use problems. There is a clearly stated expectation that no drugs or alcohol will be used during treatment; however, the overall orientation of the program is toward harm reduction, and no client is refused or terminated from services because of substance use. A single assessment form combines the required data elements for both OMH and OASAS, making the form redundant but simplifying the assessment and record keeping process.

Assessment results in a program assignment and a preliminary treatment plan that program units are required to follow for 30 days. The treatment plan adheres to locally developed practice guidelines (appropriateness of programs and lengths of stay/number of sessions) for diagnostic groups and levels of disability. Screening is also provided in the county jail.

**Services linked:** In addition to walk-ins and family initiated visits, referrals can come from DSS, Probation, Article 28 hospitals, private clinicians, and schools. A mental health worker from the assessment center leads a psycho-educational group for clients mandated to treatment in probation.

**Funding/license:** OMH certified program. Although a Unified Services county, all county programs are singly certified.

**Staffing:** The Assessment Unit is staffed by six clinicians. Besides assessment, these staff also provide training to staff in other units based on an OASAS assessment model. Inservice training has helped to develop a common language for critical substance use and mental health concepts and skills among treatment programs.

**Program benefits/Performance measurements:** Out of 170 assessments a month, 60-65% are identified as having co-occurring disorders.

**APPENDIX VII**  
**SULLIVAN COUNTY**

## **SULLIVAN COUNTY SUMMARY**

### **COUNTY DESCRIPTION**

Rural, population 70,000 Pop centers: Monticello, Liberty  
High rates of drug/alcohol problems (recent influx from NYC)

### **COUNTY-LEVEL SYSTEM COORDINATION**

MICA Planning Committee  
Multi-agency workshops

### **MICA-FOCUSED SERVICES**

Co-located MI and CD services  
CDT Program with MICA-specific groups  
MICA residential continuum (RSS)  
MICA Case Conferences  
MICA-training grant

### **OTHER AVAILABLE SERVICES**

Recovery Center – OASAS (soon to establish a MICA track)  
Daytop Village (Drug Rehab)  
Phoenix House (Drug Rehab)

### **CONSUMER PARTICIPATION**

MICA Alternatives (Self-help clubhouse)  
MICA Compeer

### **APPROACHES TO OVERCOMING BARRIERS**

Co-locating services in same building  
Frequently scheduled cross-agency meetings  
Contract with multi-county agencies (RSS)

### **BARRIERS REMAINING**

Not enough MICA Coordinators statewide  
Ideological differences of staff (MH, CD, DSS)  
(Resistance to adopting harm-reduction model)  
Common assessment procedure

## Sullivan County: Revonah Hill MICA Residence

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**Program Name:** Revonah Hill MICA Residence/Rehabilitation Support Services (RSS)

**Location:** Sullivan County

**Contact person:** Lonnie Beckham, Program Director (914)-794-1521

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**Program objective:** Provide stable, supportive, home-like environment as an initial step to recovery for dually diagnosed adults.

**Program history:** Open in 1991 as a community residence. In 1995 became a MICA residence.

**Services offered:** Room and board for 12 individuals, 24-hour supervision, substance abuse counseling, independent living skills training, service planning and coordination, medication assistance and supervision.

**Services linked:** Residents are required to participate in rehabilitation program through Sullivan County Department of Community Services and Recovery Center.

**Funding:** Supported by OMH Reinvestment dollars; residents pay own rent and fees through insurance and entitlements (staff can help them obtain)

**Staffing:** One on-site staff member at all times; a CASAC provides on-site substance abuse counseling 20 hrs/wk.

**Program benefits / Performance measurements:** Residents advance through program of motivational stages leading to greater degrees of responsibility and independence. Can move into independent living in supported apartments also operated by RSS. During their transition into independent living, former residents are required to attend meetings at the MICA residence. They both serve as role models for current residents and support their own transition process.

## Sullivan County: MICA Training Seminars

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**Program name:** The Recovery Institute MICA Training Seminars

**Location:** Sullivan

**Contact person:** Wayne Solomon, MICA Planning Committee Chair 914-292-8770

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**Program objective:** To lay the groundwork for providing integrated services to persons with co-occurring disorders.

**Program history:** For two years TRI has consulted with Sullivan County Department of Community Services TRI ran a series of training seminars that have included all agencies in the county that have served this population. These ranged from the county's mental health and substance abuse providers to hospitals, community residences, adult homes, jail and probation, the vocational committee, school districts, and consumer advocates.

**Services offered:** These trainings encompassed holistic approaches to assessment and treatment of the target population driven by a harm-reduction model. In the initial training, providers defined the systems issues in the county, and established work groups for future sessions.

**Services linked:** To date, only the assessment piece of the TRI approach is being implemented

**Funding:** Sullivan County

**Staffing:** NA

**Program benefits/Program measurements:** Each agency's roles and responsibilities with respect to integrating services for persons with co-occurring disorders were specified. Additional trainings addressed issues of intra-agency intake, assessment, placement and referral procedures, and the design of vocational preparation and placement programs. While the value of such opportunities for agencies to get together is undeniable, the ultimate success is often dependent on factors out of the control of the organizers. The Department of Community Services is finding that the harm reduction approach is a hard sell at all levels and across all agencies in the county.

## **APPENDIX VIII**

### **ADDITIONAL PROGRAMS AND RESOURCES**

## New York City: MICA Residence

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**Program name:** Rosebud/Pibly Supported Housing

**Location:** Bronx

**Contact Person:** Susan Jacobs, Director of Pibly Supported Housing (718) 863-4100

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**Program objective:** This program has adapted a modified Therapeutic Community (TC) approach to housing for the client with co-occurring disorders. The objectives are sobriety and the transfer of clients into more mainstream supported housing.

**Program history:** This program opened its doors on 10/99. It is funded with OMH monies and a 3-year HUD contract.

**Services offered:** After an initial assessment by a clinical director, the client enters the first stage of recovery. The client is expected to maintain complete sobriety. Once 6 months of sobriety has been met the client continues to the next program level. If the client relapses before the 6 months, he must start from the beginning. The staff provides drug and alcohol counseling and referrals are made to outside providers for mental health services.

**Services linked:** Clients are referred from a variety of sources (jail, emergency rooms, treatment agencies, etc.). All clients are approved by HRA but are not mandated to attend. Formal mental health services are provided primarily by the Fordham-Tremont Clinic and St. Barnabas Hospital.

**Staffing:** There are 15 paraprofessional counselors on staff, 1 psychiatrist, 1 nurse, 1 director and a clinical director. The program hopes to develop paraprofessional staff who can employ a non punitive, non authoritarian approach that is more conducive to wellness for individuals with severe mental illness than the traditional TC.

## Columbia County: MICA Residence

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**Program name:** Homeless MICA/Mental Health Center

**Location:** Columbia County

**Contact person:** Michael O'Leary, Director of Community Services (518) 828-9446  
Linda Herring

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**Program objective:** This program allows for the maintenance of 4 scattered, supportive housing apartments. They are specifically for severely mentally ill clients with co-occurring disorders at the pre-engagement level of readiness to change. Clients are free to remain indefinitely in apartments. However, as a client requires less support, his/her apartment is reassigned to a less supportive housing status and a new apartment is sought to maintain the 4 supported housing apartments.

**Program history:** The Homeless MICA project has been in existence since 1999. It is a collaborative effort between the Columbia County Mental Health Center and the Columbia County Mental Health Association. It is funded by reinvestment dollars and is certified via the Mental Health Association.

**Services offered:** The client is provided with an apartment and supports are provided by a psychiatric social worker who links the client to services and promotes treatment engagement. As the client moves from pre-engagement to engagement and active treatment, the program's goal is to move him/her toward more independent living. There is no time limit on the program.

**Services linked:** The social worker works closely with Corrections at the local jail, and at the Emergency Room to identify clients who would benefit from supportive housing. Mandated referrals are not included in this program. Close links with DSS are important to maintain clients in this housing.

**Funding:** The program receives all funding through reinvestment monies.

**Staffing:** Services are provided by one staff member who is a psychiatric social worker.

**Program benefits/Performance measurements:** Homeless severely mentally ill individuals with co-occurring disorders are provided with an apartment with no time restrictions. There are also no mandated referrals.

## Genesee County: Drug Treatment Court

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**Program name:** Batavia City Drug Treatment Court

**Location:** Batavia City, Genesee County

**Contact person:** Mary France, Program Coordinator/Investigator Social Worker  
(716) 344-2550, ext. 2312

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**Program objective:** This program seeks to divert people with chemical dependence from incarceration. This County has added a focus on co-occurring disorders which is not present in the basic drug court model.

**Program history:** This program is based on a nationwide drug court program. It began on February 21, 1999 under the leadership of the county public defendant. He had identified an increasing number of jail incarcerations, many of which involved substance use and/or mental illness. This program attempts to provide more appropriate settings than incarceration for these people.

**Services offered:** Although the program coordinator initially identified 40 potential clients, ultimately 26 were serviced (7 identified as severely mentally ill MICA). Since then, 3 clients have terminated. The client appears before the judge with the coordinator as his advocate. The goal is to contract to maintain sobriety and/or receive appropriate mental health treatment as deemed appropriate. The client and coordinator continue to reappear periodically to insure that the client is complying. The coordinator links the client with mental health and chemical dependency treatments.

**Services linked:** Services include outpatient mental health services, day treatment, inpatient drug/alcohol rehabilitation, supportive apartments, vocational rehabilitation, inpatient psychiatric services and Veterans services.

**Funding:** At present, the co-occurring disorder piece of this program operates on a 10 hour a week donation of the Investigator/Social Worker's by the public defender.

**Staffing:** The coordinator/social worker is the only staff person for this program.

**Program benefits/Performance measurements:** Support for jail diversion for offenders with co-occurring disorders.

## DOUBLE TROUBLE IN RECOVERY

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**Program name:** Double Trouble in Recovery

**Location:** NYC; Binghamton; Rensselaer; Buffalo

**Contact person:** Howie Vogel, Director Double Trouble in Recovery, Inc. (718) 996-6324

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**Program objective:** Double Trouble in Recovery (DTR) is a mutual aid/self help program adapted from the 12 step method of AA specifically for people with dual diagnoses of substance abuse dependency and psychiatric disability. DTR differs from traditional self-help by offering people a safe forum to discuss their substance abuse, psychiatric disabilities, and medications. **The only requirement for attending is a desire to achieve abstinence.**

**Program history:** Spearheaded in NYC in 1989 by Howie Vogel, DTR has grown as a grassroots initiative providing a forum where consumers feel at ease, which is an important part of developing and maintaining the fellowship. There is minimal involvement from the professional community, even when groups are held in institutional settings.

**Target population:** People with severe mental illness diagnoses and substance use problems who are seeking dual recovery. Current research on DTR groups in NYC indicates that participants have long histories of psychiatric disabilities and of substance abuse and extensive experience with treatment programs in both areas.

**Services offered:** Currently over 100 DTR meetings in the US—40 in NYC, 20 more in NYS (see above for locations), Colorado, Georgia, Nebraska, New Mexico and Pennsylvania. Groups meet in psychosocial clubs, hospital inpatient treatment units, community based organization, day treatment program. All groups are led by dually recovering individuals.

DTR, Inc. is a small not for profit organization that supports the growth of DTR groups by training consumers to start and run a DTR group, and by providing ongoing support to existing groups. DTR also regularly organizes dialogues where consumers and service providers gather in round tables and exchange ideas and concerns outside of the therapeutic environment.

**Services linked:** DTR is not formally linked to other services. However, DTR members report that they first hear about the group through professionals or therapists. Consumers who attend DTR groups also report that they attend other 12 Step fellowships (AA/NA) to deal with their substance use only.

**Funding:** None. DTR is a mutual aid fellowship.

**Staffing:** DTR is a true mutual help group: members are invited early on to take an active role by “qualifying” (being the main speaker at a meeting), by making a presentation about DTR at another facility or by becoming a group facilitator, or as in the AA model, “chairman”.

**Program benefits:** Social support in recovery. Members report that the combination of mutual support (sharing experiences with similar others), role models (seeing others who are further along in their recovery) and becoming a helper to other newer members bring about feelings of self confidence and empowerment which facilitates the struggle for staying clean and taking one's medications.

### **Additional sources of information:**

The 12 Step Book for DTR is now available. Contact Iveth at 1-800-643-7462.

The Mental Health Empowerment Project is a point of contact for existing DTR groups.

## THE RECOVERY INSTITUTE

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**Program names:** Continuing day treatment  
Comprehensive 18 month rehabilitation program  
Training and workshops

**Location:**

**Contact Person:** Alex Marsal, Director (518) 373-0470

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**Program objective:** Unification of service components based on a holistic model.

**Program history:** Direct provider of dual diagnosis services for 12 years in an integrated MICA CDT, licensed by OMH, but developed in conjunction with both OMH and OASAS as a TFIP. Both agencies participate in site review and monitoring. The CDT was located in an Article 28 hospital in Rensselaer County (moderately sized, unified services county with both urban and rural dispersion of population). The CDT serves about 100 clients per year.

Clients were assessed holistically in 16 functional domains over time. Treatment was keyed to severity of functional impairment. The perspective of stages of change (pre contemplation to maintenance) are applied to both clients and staff, who need training in change as well.

Currently providing direct service in an OASAS licensed long term rehabilitation program located in St Peter's in Albany county (over 200,000 population with large city and suburban dispersion of population). There are currently 40 patients in this program, with 100 expected to be enrolled by the end of 2000. The program is applying for joint OASAS/OMH license so they can offer crisis services.

Provides training and consultation to Sullivan County which is trying to bring down its higher than average costs for high utilization clients. The Recovery Institute has provided a series of training workshops on as the county develops an approach to coordinate services for co occurring disorders that are delivered by local contract agencies. The County plans to adopt the Recovery Institute's holistic method of assessing clients over time in 16 functional dimensions. This approach is not keyed to integrating OMH/OASAS documentation requirements

**Program benefits/Performance measures:** Key treatment package to holistic functional assessments

Key case rates to treatment package

Diminish symptoms and SA, episodes of crisis and IP use

Progress in multiple dimensions

**Services offered:**

The Recovery Institute provides assessment, case management, ACT-like crisis response, primary medical care, training and workshops and vocational apprenticeships. It utilizes an ongoing clinical model ranging from intense rehabilitation to stable outpatient services. The model incorporates stages of change for clients and staff and is capable of engaging particular populations, for example in shelters.

## Erie County: Change Unlimited

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**Program name:** Change Unlimited

**Location:** Buffalo, Erie County

**Contact Person:** Candy Berthiaume, peer counselor (716) 832-2007

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**Program objective:** This is a self-help/mutual-aid initiative that takes the form of group work specifically to meet the needs of the dually diagnosed.

**Program history:** This model was developed by Michael Bricker out of Milwaukee in 1988 and was originally named STEMMS. It was renamed Change Unlimited in 1999 due to the possible association of the word stem with crack pipe. Currently there are 20 groups run out of Transitional Services in Erie County.

**Services offered:** Groups are run to meet the need of the client with co-occurring disorders; however, all are welcome to participate. At present, there are 20 groups held a week, all of which are run by the same peer counselor. This peer counselor has been running the Change Unlimited groups for the last 5 years and has been identified as being a significant factor in its success. Open discussion groups as well as educational, literacy, self-help and childhood issues groups are held.

Change Unlimited utilizes a 6-step approach towards intervention with an understanding that a 12-step approach can be too intimidating for this population. The members are, however, encouraged to join a 12-step program at any time that they feel prepared to do so.

**Services linked:**

**Funding:** Transitional Services provides meeting spaces for the groups.

**Staffing:** One peer counselor runs the 20 groups currently held per week. A steering committee of 10 meets regularly to review the progress of Change Unlimited and to identify new directions.

**Program benefits/Performance measurements:** The number of group participants measures the success of Change Unlimited.

## **Suffolk County: Dual Recovery Training and Advisory Group**

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**Program name:** Division of Community Mental Hygiene Services: Dual Recovery Training and Advisory Group

**Location:** Suffolk

**Contact person:** Thomas MacGilvray, Suffolk County Director (516) 853-3114

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**Program objective:** To develop services to individuals who are identified as having co-occurring disorders. The group is working on developing at least one dual recovery integrated service model track in each of the County's five service areas.

**Program history:** Since the early 1990's, the Suffolk County Division of Community Mental Health Services and the Division of Alcohol and Substance Abuse Services have been involved in the development of services to individuals who were identified as having co-occurring disorders. Prior to 1999, when the two Divisions were merged into the Division of Community Mental Hygiene Services, Suffolk County has participated in the Long Island MICA Training and Advisory Group.

**Services offered:** Each year at least two trainings are targeted to members of the professional community covering a broad range of issues including standards for assessment, referral, and ongoing case management. The trainings feature specific opportunities for skill development and include follow-up support groups to facilitate implementation. The Division publishes a newsletter, Matrix, which summarizes all presentations made at the conferences for dissemination to the provider community and produced a television show, Something of Substance, highlighting the need for a dual recovery system of care.

The Division has been involved in a research project under the auspices of the Suffolk County Criminal Justice Coordinating Committee. This multi-departmental project involves Health Services, Probation, Sheriff, Police, Corrections and the New York State Division of Parole. The results will provide evidence of mental illness prevalence indicators within the full spectrum of the justice system.

**Services linked:** During 1997 and 1998, the Division of Community Mental Hygiene Services conducted focus groups with OMH and OASAS clinicians, consumers and family members regarding the "hard-To-Serve" population, many of whom have dual disorders. Agencies have been asked to submit written agreements committing to active participation in the collaborative initiative to provide comprehensive services to the MICA-identified population. A Memorandum of Understanding is being drafted that makes explicit assumptions about the population and the treatment system and identifies clinical skills that need to be developed at the agency level.

**Funding:** The group meetings are funded by OMH.

**Staffing:** NA

**Program benefits/Program measurements:** This group focuses its efforts in fostering the increased efficacy of service delivery for the population identified with co-occurring disorders through agency collaboration and skills training.

## MICA TELECONFERENCE

### TRAINING VIDEOS

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#### **PROGRAMMATIC INTERVENTIONS**

**FOR INDIVIDUALS IN DUAL RECOVERY (3)** Kim Mueser

- 1 Educational programs
- 2 Social skills training
- 3 Family interventions

#### **USING MOTIVATIONAL INTERVIEWING TO CHANGE ADDICTIVE BEHAVIORS (3)**

Julina Sojda

- 1 Dynamics of Change
- 2 Stages of Change
- 3 Commitment to Change

#### **DUAL RECOVERY AND TRAUMA (3)**

Nancy Smyth

- 1 Impact of trauma
- 2 Assessment strategies
- 3 An integrative approach to treatment

#### **TREATING AND SUPPORTING DUALY DIAGNOSED PARENTS (1)**

Joanne Nicholson &  
Judy Vega

#### **RELAPSE PREVENTION: UTILIZING STRENGTH & HOPE (1)**

Mary Agnew &  
Allen Agnew

#### **HIV PREVENTION (1)**

Rich Herman, Meg Kaplan  
& James Satriano

#### **HELPING SELF HELP: A ROLE FOR PROFESSIONALS (1)**

Howie Vogel &  
Ed Knight

#### **THE BORDERLINE PERSONALITY: HEALING THE TRAUMA WITHIN (1)**

Marilyn Gewacke

#### **A MICRO AND MACRO VIEW OF MICA (1)**

Bert Pepper &  
Darren Skinner