Co-occurring Disorders Treatment at Homeless CalWORKs Families Project Sites

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http://www.cimh.org/Services/Adults-Older-Adults/CalWORKs/CalWORKs-Publications.aspx

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For over twenty-five years it has been known that a substantial proportion of persons seeking mental health services also need help with substance abuse and that a substantial proportion of persons entering substance abuse services also need help with mental health issues. These are persons with two (or more) diagnoses, or co-occurring disorders.

Yet the public mental health and substance abuse systems have been slow to respond. There is now general agreement that services for persons with co-occurring disorders work best when delivered at the same time, at the same place, and by the same treatment team. Yet this rarely happens, especially when it requires collaboration between mental health and substance abuse agencies and staff. There is also agreement that treatment of co-occurring disorders is a specialty in itself requiring knowledge and skills not commonly found among either mental health professionals or substance abuse professionals. Opportunities for developing and utilizing the necessary knowledge and skills, however, are not widely available.

The evaluation reported on here is important because it is one of a relatively few California attempts to provide co-occurring disorders services at the same time, the same place and by the same team. It is also one of few attempts to structure these services in terms of new professional standards for co-occurring disorders services. And it is a rare effort to do all this by means of collaboration between systems — in this case, not just substance abuse and mental health but also public welfare.

The strong success that is documented in this report should encourage administrators and policymakers to expand the number and types of programs where co-occurring disorders can be capably addressed. Such an expansion will in the long run require developing new infrastructure, new cross-training opportunities, and a commitment to meeting high co-occurring disorders service standards. But as this project has shown, increasing the availability of capable co-occurring disorders services is eminently doable right now.
Integrating Substance Abuse Treatment Capabilities into Homeless CalWORKs Families Project Sites

The Los Angeles Department of Public Social Services (DPSS) has initiated an attempt to make CalWORKs mental health programs capable of dealing with substance abuse problems as well as mental health problems. During FY 2009–2010 a pilot project co-located Department of Public Health (DPH) substance abuse counselors in the six Department of Mental Health (DMH) Homeless CalWORKs Families Project (HCFP) sites. DPSS, DPH, and the DMH are all interested in this pilot as a test of whether broader attempts at collaboration and integration between substance abuse and mental health providers are feasible.

The California Institute for Mental Health (CIMH) has had a contract with DMH for several years to evaluate outcomes of the HCFP. The contract was used this year to evaluate one specific component of the programs: the implementation of co-occurring disorders services through the interagency structure referenced above. The evaluation included site visits at which the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) fidelity scale was administered in each site. The evaluation also includes analysis of client outcomes, comparing those treated for substance abuse with others not having a substance abuse problem.

**What is the overall success of the initiative?**

The provision of co-occurring treatment services at HCFP sites by means of an interagency model is an unqualified success. Implementation has for the most part gone smoothly, and some sites have been very creative in how they facilitated integration of the two sides of treatment. All six programs scored as at least dual disorders capable on the DDCMHT fidelity scale. Site-level program staff from DPSS, DPH, and DMH all report that participants with substance abuse are being identified earlier and helped more.

The outcomes analysis showed that on every measure there was no statistically significant difference between those treated for substance abuse and all other participants. Since previous evaluations of the HCFP had shown a major negative impact of substance abuse on outcomes, this finding is an important indication of the success of the collaborative project.

**DDCMHT Fidelity Scale Scores**

The DDCMHT is the mental health version of the Dual Disorders Capability in Addictions Treatment (DDCAT) fidelity scale, which was developed to determine the extent to which programs reach the American Society of Addiction Medicine’s standards of dual diagnosis capable or dual diagnosis enhanced (the highest category). The DDCMHT fidelity scale has good psychometric properties and has been used in a wide variety of programs in several states. The scale covers seven different domains and has a total of thirty-five individual criteria within those domains. In this report we present data on the seven domains for each of the six programs and for the programs taken together. Note that the structure of the HCFP affects some domains for all programs (see Appendix 1).
Figure 1: DDCMHT domains

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Content of items</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Program Structure</td>
<td>Program mission, structure and financing, format for delivery of substance abuse services.</td>
</tr>
<tr>
<td>II Program Milieu</td>
<td>Physical, social and cultural environment for persons with substance use disorders.</td>
</tr>
<tr>
<td>III Clinical Process: Assessment</td>
<td>Processes for access and entry into services, screening, assessment &amp; diagnosis.</td>
</tr>
<tr>
<td>IV Clinical Process: Treatment</td>
<td>Processes for treatment including pharmacological and psychosocial evidence-based formats.</td>
</tr>
<tr>
<td>V Continuity of Care</td>
<td>Discharge and continuity for both substance use and psychiatric services, peer recovery supports.</td>
</tr>
<tr>
<td>VI Staffing</td>
<td>Presence, role and integration of staff with substance abuse treatment expertise, supervision process</td>
</tr>
<tr>
<td>VII Training</td>
<td>Proportion of staff trained and program's training strategy for co-occurring disorder issues.</td>
</tr>
</tbody>
</table>

Figure 2: DDCMHT aggregate scores (mean of the six HCFP program scores in seven domains)

Figure 1 shows the content of the seven domains. As seen in Figure 2, on the first domain, Structure, HCFP programs do well with a mean of 4.0 out of a possible 5.0. (A 3.0 or better indicates dual disorder capable and a 5.0 indicates dual disorder enhanced.) The second domain, Milieu, measures how welcome a substance user is in the program; the mean score for the six programs is a 3.6, with one program below 3.0. The next three categories reference assessment, treatment, and continuity of aftercare. In all these the mean is over 3.0, but for treatment and aftercare two programs are under a 3.0. Staffing adequacy and training make up the final domains. Training is the only one of the domains in which the average is less than a 3.0 (four out of six programs were lower than a 3.0).
Figure 3 shows that all six programs have an average score of 3.0 or greater, so all are dual diagnosis capable as is the HCFP program as a whole (average overall score is 3.4). One program achieved a 4.0. The differences between programs are of much less significance than the attainment of the dual diagnosis capable status in all. Appendix 5 presents in greater detail the domain scores for all six programs.

**Figure 3: Overall DDCMHT scores by program and overall**

![Bar chart showing overall DDCMHT scores by program and overall](chart1.png)

Figure 4 below shows data from the 2009 Summary DDCMHT report on 67 mental health programs in five states. It shows that 13 percent of the programs were dual diagnosis capable and another 13 percent achieved a score of 4.0 (DDC/DDE) for a total of 26 percent over a 3.0. The 100 percent score achieved by HCFP programs is unusual and highly commendable.

**Figure 4: DDCMHT categories for 67 programs in five states (dark blue indicates a 3.0 or better)**

![Bar chart showing DDCMHT categories for 67 programs in five states](chart2.png)
**Does organizational readiness for change predict variation in DDCMHT scores?**

Based on findings from the SAMHSA implementation study of Integrated Dual Disorders Treatment in four California counties, we anticipated that organizational readiness to change (organizational functioning) would account for much of the variation between programs.

**Figure 5: Amount each program is above or below the mean of all six programs for both the DDCMHT and the Organizational Readiness for Change (ORC) scale: .78 correlation between scores**

Figure 5 above shows the overall DDCMHT score for each program with the average score for all six programs subtracted. It also shows the scores from the Organizational Readiness for Change instrument that all staff members completed in January 2010, also with the mean of the six programs subtracted from individual site scores. The bars to the left of the “0” line down the middle indicate programs that were below the overall mean for the six programs. If organizational functioning is associated with DDCMHT fidelity we would expect the relationships to be similar in each site between DDCMHT scores and ORC scores. In fact, the .78 correlation between DDCMHT and ORC scores is quite high. In general, better than average programs on organizational functioning are better than average on the DDCMHT and vice versa (one program is an exception). Thus, a significant amount of the differences between programs on the DDCMHT appear to be reflective of differences in overall organizational functioning. Translation: better functioning programs are in general better able to implement the complex arrangements needed to have a well-functioning inter-agency co-occurring disorders program.
Outcomes for Persons Treated for Co-Occurring Disorders Compared to Outcomes for Those Without Co-Occurring Disorders

One reason co-occurring disorders treatment capacity has been built into the HCFP programs is that in previous CIMH evaluations persons with substance abuse problems were more likely than others to drop out; and even if they stayed in the program, they were less likely to acquire permanent housing and employment. So the primary analysis in this evaluation is to compare outcomes in the 2009–2010 study group between persons who were treated for a substance abuse issue with those of persons who were not treated for substance abuse. Do persons who have substance abuse issues but who also receive substance abuse treatment still have less favorable outcomes?

To answer this question we want to know both whether the two results are statistically different from each other and whether they are statistically “equivalent” (in the same way that generic drugs must be equivalent to brand-name drugs). But we also rely on easily interpreted bar graphs to determine how similar persons treated for substance abuse are to all others.

When feasible, we also compare results in 2009–2010 with results in 2007–2008, when most substance abuse treatment was by referral to an outside agency.

There are, however, both internal and external factors that may affect these comparisons. Internally, the program (with some exceptions) requires treatment for those identified as having a substance abuse barrier to employment or housing. For persons who are in the Precontemplation, Contemplation, or Preparation stages such a mandate may result in a decision to leave the program. Externally, shelters do not accept drug or alcohol use, so persons using may fail in qualifying for the short-term or transitional housing they need to remain in the program. In short, even though treatment is now provided there are reasons why the dropout rate might still be higher among those with substance abuse issues.

Please note that the focus of this evaluation is entirely on the impact of adding co-located substance abuse services. For extensive evaluations of the program as a whole using multiple data sources over time rather than staff ratings for a six-month period, refer to the previous evaluation reports (available at www.cimh.org/Services/Adults-Older-Adults/CalWORKs/CalWORKs-Publications.aspx).

HCFP staff provided information about the substance use, services, and outcomes of persons served after substance abuse counselors were added to the teams.

The study sample consists of 129 persons discharged between November 1, 2009, and May 1, 2010, with the addition of 91 persons still receiving services in May 2010. For each person who was discharged or still in service during the study period, HCFP staff completed a form reporting on their substance use, the substance abuse services they received, and outcomes. The outcomes measured are: leaving the project for positive vs. negative reasons; employment and welfare-to-work status; whether permanent housing was obtained; participation in the program; and amount of change in several domains, including mental health status.
Seventy-eight of 221 persons (35 percent) screened positive for substance abuse; 66 of these received substance abuse services. This represents a considerable improvement in detecting and treating substance abuse issues.

Of the 78 persons who screened positive, 63 were seen by a co-located substance abuse provider; 3 were seen by providers off site. In two cases, no referral to substance abuse counseling was made because the substance abuse counselor was not yet integrated into the team. In seven cases the participant refused the referral; for three cases no explanation was provided.

In addition to on-site treatment, 18 persons were referred for treatment off-site, 15 to outpatient and 3 to residential. Eight of these persons attended their off-site treatment regularly but 6 did not follow through with the referral and three attended only a few sessions (the status of one person was unknown).

In the most recent previous study cohort (from 2007–2008), a total of 22 percent were recorded as having any use of alcohol or drugs (including use without impairment). Only 18 percent of this cohort was referred for substance abuse treatment. So in 2010 — with a co-located substance abuse counselor available — a higher percentage of participants was identified as having substance abuse issues, and roughly twice the percentage was referred for treatment.

In the outcomes analysis we refer to the 66 persons who received substance abuse treatment as the treatment group, while the 78 who screened positive are termed the intent to treat group. For the treatment group, the outcomes indicate whether receiving services was effective in changing behavior. For the intent to treat group, the outcomes indicate whether the whole co-location program including screening and referral was effective. In general we show data for the treated group and note if it was different for the intent to treat group.

The substance abuse was mild or moderate with relatively few cases of active serious abuse.

The HCFP Steering Committee has defined the HCFP project participants as those with mild to moderate mental health and mild to moderate substance abuse issues. Staff completed two forms that classify the 78 participants who screened positive in terms of the severity of alcohol use and the severity of alcohol or drug use (at discharge or in May 2010) — comparable measurements at intake are not available. The categories used are:

- **Abstinent.** No alcohol or other drugs are used. For these participants this indicates that they are previous users now in recovery.
- **Use without impairment.** Alcohol or other drugs are used but do not have negative effects on the participant’s life.
- **Abuse.** Participant meets psychiatric diagnosis standards for substance abuse, which means there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use.
- **Dependence.** Meets criteria for abuse plus at least three of the following: greater amounts or intervals of use than intended; much of time used obtaining or using substance; frequent intoxication or withdrawal interferes with other activities; important activities given up because of alcohol/drug use; continued use despite knowledge of substance-
related problems; marked tolerance; characteristic withdrawal symptoms; substance taken to relieve or avoid withdrawal symptoms.

**Figure 6: Seriousness of substance use for 78 persons referred for substance abuse treatment — recorded by staff at discharge or in May 2010 for previous two months**

We can combine the categories by using the more serious status if ratings differ for alcohol or other drugs. Using this combined status, 22 percent were abstinent at discharge or in May 2010, 26 percent used alcohol or drugs but with no impairment, 36 percent were classified as having substance abuse for either alcohol or drugs or both, and 4 percent were classified as being dependent on one or both.

**Persons identified as having substance use issues were not more likely to leave the program for negative reasons.**

The reasons that participants left the program were recorded by staff and categorized into those which indicate a positive outcome (finding permanent housing or getting a full-time job or completing the program), those that are neutral (moving away, transferring to another program or to SSI) and those that are negative in character (incarceration, leaving dissatisfied, or being dropped for non-compliance.) Two categories are somewhat ambiguous but for purposes of this analysis were coded as negative. The first is completing 12 months in the program and being transferred to another program without having achieved the goals of housing and/or employment — which indicates considerably less than optimum results. The second ambiguous category is losing CalWORKs eligibility for reasons that were not always clear.

Overall, of the 129 persons who had left between November 1, 2009, and May 1, 2010, 36 percent left for positive reasons, 18 percent for neutral reasons, and 47 percent for negative reasons. (Exclusive of timing out and loss of CalWORKs eligibility, leaving for a negative reason was 30 percent). Figure 7 shows the reasons participants left the HCFP for the treated
group compared to all others discharged. Although there is a small difference between these groups, it is not close to reaching statistical significance.\(^5\)

**Figure 7: Positive, negative, and neutral reasons for leaving the HCFP, comparing clients treated for substance abuse (n=31) to all others (n=96). “Negative” includes losing eligibility for CalWORKs and exceeding the 12-month HCFP time limit.**

![Bar chart showing positive, neutral, and negative reasons for leaving the HCFP](chart)

However, those who received substance abuse treatment did spend significantly less time in the program that did all others (an average of 192 days compared to 245 days.\(^6\)).

**Persons treated for substance abuse were as likely to live in rental housing as were those not treated.**

Figure 8 shows the living situation of HCFP study participants at discharge or in May 2010, if not discharged yet. Differences by major category are very slight and do not approach statistical significance.\(^7\) (The same result is found if the analysis is limited to those already discharged.) In the 2007–2008 evaluation of the HCFP, persons with known substance abuse issues were far less likely than others to live in rental housing, so housing outcomes for persons with substance use issues appear better with co-located substance abuse counselors.\(^8\)
Participants treated for substance use issues were just as likely to be working or going to school over 20 hours a week as were other participants.

Figure 9 shows HCFP participants’ welfare-to-work status divided into those who worked or attended school at least 20 hours a week, those who worked or went to school fewer hours than that or who did volunteer work, and those who had no work-related activities as of discharge or in May 2010. The percentage of those treated for substance abuse who were in the highest category was identical to the percentage for all others. This overall table does not show statistically significant differences despite the higher percentage among those treated who had no work-related activities other than treatment services. However, the pattern for the intent to treat group (which includes 12 persons who were referred for treatment but refused it) is statistically different from the pattern for those not referred for substance use issues; so people in the referred for substance abuse treatment group exhibit less likelihood to be involved in productive activities.9
Participants treated for substance use issues were just as likely to attend mental health therapy or HCFP groups as were other participants.

Staff were asked to rate the level of participation in mental health services. About 70 percent overall participated in all or most sessions; another quarter participated sporadically, and a few clients participated to a minimal degree. However, as shown in Figure 10, there were no differences in participation between those receiving substance abuse treatment and all others; in fact, the groups are statistically equivalent. In contrast, in the 2007–2008 evaluation, those who had been identified as having substance abuse problems were much less likely to participate regularly.10
Figure 10: Extent of participation in HCFP mental health counseling and groups, rated at discharge or in May 2010, comparing clients treated for substance abuse (n=66) to all others (n=150)

![Bar chart showing the extent of participation in mental health counseling and groups, comparing clients treated for substance abuse to all others.]

Staff ratings of the amount of change accomplished in several life-domains do not differ for those who received substance abuse services and others.

The primary outcome domains of interest, beyond housing, are capacity to find and hold a job, the capacity to manage tasks of daily living, achieving mental health symptom reduction, and dealing with domestic violence situations. Staff were asked to rate (at discharge or in May) how much change each participant had achieved, ranging from strong positive change to negative change. In 2007–2008, persons with substance abuse issues made significantly less positive change than did others. This year, though, with co-located substance abuse services, the amount of positive change was very similar for each of these measures among those treated vs. all others. Figure 11 shows these comparisons for this year.11
In summary, outcomes for those treated for substance abuse are very similar to outcomes for the rest of the study participants.

In each of the comparisons reported above, differences between the treated group and others fail to attain statistical significance. That is, differences are small enough that it is highly plausible that they are due solely to chance. That was not the case in previous evaluations, as persons with substance abuse issues had less positive results to a statistically significant degree. It was possible to demonstrate statistical equivalence in the case of participation in mental health treatment and groups, daily living capacity, and attaining permanent housing. Since, largely due to sample size, we cannot definitely assert statistical equivalence for the other variables, you are encouraged to use your own judgment based on the bar charts. Do the outcomes for persons treated for substance use issues look similar enough to the outcomes of all the other participants to make you comfortable in viewing this as a positive finding?
Implementation and Administration Issues

How have administrative policies supported cross-agency co-occurring disorders treatment?

Collaboration. DPSS, DPH, and DMH have worked very hard to make implementation go smoothly. The success of the program is a tribute to this collaborative work.

Substance abuse treatment capacity. At the start of the project, the Department of Public Health identified six providers having more mental health experience than most and asked them to assign 1.5 FTE to each of the HCFP sites. The half-time position was for back-up, but was used in various ways at different sites. In none of the sites, apparently, has demand been sufficient to require actual employment of all 1.5 FTE in out-stationed treatment services. In at least one site, low numbers of persons with co-occurring disorders means that there is only a 0.5 position at the site as the remaining time is spent in the substance abuse agency. In at least two sites, the initial substance abuse counselor left and was replaced by another, causing some delays.

Interagency relationships. Three agencies — Pacific Clinics, Prototypes, and Shields — provide both substance abuse and mental health services through the CalWORKs program. At Prototypes and Shields the DPH contract went to this same agency, so the SA counselor was from a different program but the same agency. This did not happen at the Pacific Clinics HCFP site, which was required by the program to stop using an on-staff substance abuse counselor and integrate a new person from a different agency.

Pacific Clinics staff believe integration of substance abuse and MH services would have been much easier if they had been able to continue with their own staff member. However, while having the substance abuse counselor employed by the same agency made implementation easier for Shields it does not appear to have done so for Prototypes. In general, the relevant substance abuse and MH agency in each of the six geographic areas served have been able to work out viable and comfortable relationships.

Selection of substance abuse counselors. The most crucial element in the successful integration of the substance abuse treatment function into HCFP programming appears to be the personality, training, and background of the substance abuse counselor. While relationships between staff at most sites were amicable and productive, this was not always true. Program managers delineated some of the qualities of substance abuse counselors that they felt were important to success:

- Comfortable with new people, ideas, and procedures
- Some background in mental health
- Mature (but not rigid or doctrinaire)
- Able to work independently

If co-location across agencies is going to expand, availability of suitable substance abuse counselors may turn out to be a limiting factor — or the availability of cross-training will have to increase.

Substance abuse counselor supervision. In all sites the substance abuse agency is required to provide supervision to the substance abuse counselor. The HCFP sites vary considerably regarding how much supervision is provided by the substance abuse agency. This supervision can be extremely valuable. In addition to discussing specific cases it can cover:
Increasing the repertoire of interventions
Examining what is working
Helping with particular techniques, such as motivational interviewing
Ensuring that the counselor does required record keeping
Examining contractual requirements and understanding whether these conflict with MH practices or contractual components
Ensuring that the sole out-stationed employee is not overwhelmed, can pace her/himself, and is not burned out
Determining if any issues need discussion with the MH program manager

In addition, if the substance abuse supervisor is cross trained, s/he can provide some information on relevant mental health clinical issues.

Sites also vary in how much contact the substance abuse supervisor has with the MH supervisor. In general, more contact seems to work better, although there were two well-functioning sites with minimal contact.

Administration. Administrative decisions by DPSS/DPH/DMH have for the most part made implementation easier and more effective. For example, all clients must be screened for substance abuse by the substance abuse counselor (unless already known substance use has been identified, in which case the client goes directly to assessment). This requirement is known by all HCFP staff and is reinforced from the initial contact with DPSS eligibility and GAIN staff, through contacts with LAHSA, and in contacts by mental health staff.

One critical decision made early was not to require substance abuse counselors to bill on a fee-for-service basis. Program directors report that a large portion of the functions that make the substance abuse counselor so valuable would disappear if billing went to fee-for-service. These include such things as being able to accompany HCFP staff on home visits, or to accompany a client to a first visit of a 12-step meeting. Substance abuse counselors also are able to include partners or children in counseling sessions. Finally, substance abuse counselors spend a substantial amount of time in clinical planning meetings. The staff at four of the sites understood that the usual limiting conditions attendant on a fee-for-service system did not apply, but personnel at two sites were acting as if they did, so the policy needs further clarification.

There is a general policy that has had a good deal to do with structuring the way the co-occurring disorders services are provided: severity levels should be consonant with the goal of the program to achieve housing and employment within one year. There are, in fact, some significant differences between programs in this regard, from programs that accept virtually no one who is actively using alcohol or illicit substances to programs that will accommodate persons of high severity. All programs stated, however, that the overall goal and mandate of the program made dealing with more severe cases difficult, in large part because of the 12-month time limit on HCFP participation. Severity levels affected the DDCMHT scores because high scores on a number of the DDCMHT fidelity items require the program to be capable of serving all levels of severity.

One issue — the “mandatory” nature of substance abuse treatment — has been the subject of much discussion but as of the date of the site visits was still unclear in the minds of some site
staff. The field of substance abuse is not entirely consistent regarding preferring voluntary or involuntary treatment. However, both the DDCMHT and the Integrated Dual Disorders Treatment fidelity scales put great emphasis on motivational approaches for persons with dual diagnoses. The two primary motivational approaches\textsuperscript{12} are the use of the Prochaska and DiClemente motivational \textit{stages of change} model and motivational interviewing.

Five of the six programs use the stages of change framework for structuring treatment to at least some degree. One program received a score of 5 and one a score of 1 on use of stages of change in assessment and in treatment; the mean scores were 3.3 and 2.8, indicating a greater use in assessment than in treatment. See Appendix 3 for a summary of how interventions can be structured around stages of change.

Perhaps more important are the techniques involved in motivational interviewing, an approach that is very clearly an evidence-based practice in substance abuse treatment. Unfortunately, only three of the substance abuse counselors interviewed knew about motivational interviewing, and only one used it regularly and considered herself proficient.

\textit{Paperwork.} A facilitating factor has been that DMH replaced its Initial Assessment Form with one much more focused on dual disorders. It includes a screening form developed by a statewide dual disorders committee (COJAC). If clients screen positive, it requires collecting a substantial amount of useful supplemental information. It also makes available a version of the stages of change model rating form.

\textbf{How much should the programs attempt to achieve “integration” of services?}

In Appendix 2 the DDCMHT definition of consultations, collaboration, and integration are presented. Both the DDCMHT and the other dual disorders fidelity scale\textsuperscript{13} set integration as the goal. This goal, however, has more than one meaning and there is more than one way to attain it.

\textit{A single treatment plan.} The motto of the California Co-occurring Joint Action Council is “One Person, One Team, One Plan For Recovery.” The DDCMHT definition of integration similarly stresses the necessity of having a single treatment plan.\textsuperscript{14} In California that is not a possibility if funding is provided through separate substance abuse and mental health funding streams. The lack of a single chart resulted in a number of DDCMHT items being scored at a 3 (“capable”) rather than a 5 (“enhanced”).

HCFP programs, however, came up with a variety of ways of pursuing integration despite having two charts and, therefore, two separate treatment plans.

- All programs involved the substance abuse counselor in team treatment planning meetings. Program managers all viewed this as a way to integrate the services. However, in two sites the substance abuse counselor did not understand these meetings this way and stated that they did all the substance abuse treatment planning themselves.

- Two programs used another approach to obtain integration. The program manager (or clinical supervisor in one case) in these programs was cross-trained and provided clinical supervision to the substance abuse counselor. In one site, the substance abuse counselor was an employee of the same agency, so the supervisor monitored both charts.
A third approach is to make the mental health chart comprehensive by documenting consultations with the substance abuse counselor. However, the substance abuse counselor does not have access to this chart. For some reason none of the sites used a specific records release that would have permitted shared access to charts.

Finally, and most effective, two programs developed forms that are filled-in jointly by the substance abuse counselor and a mental health clinician. These included stage of treatment, diagnoses, and plans. In both programs the form is updated weekly. In both cases the identical form was kept in both substance abuse and mental health charts, so that people were literally “on the same page.”

There is actually a simple way of having one chart: achievable when the mental health agency hires the substance abuse counselor. California’s implementation of the Integrated Dual Disorders Treatment model was done this way. In this case, the funds for both services come from DPSS so it should be possible — if desired — to simply provide funds to mental health agencies for substance abuse treatment rather than using an inter-agency approach. Similarly, if co-occurring disorders are to be treated in substance abuse agencies, funds for mental health services can be provided to substance abuse agencies.

Interacting disorders require integrated treatment. There is another sense to “integration of services” that is reflected in most writing about dual disorders treatment. In this meaning, the disorders are considered in relationship to each other. It is not that the client has two separate disorders, but that s/he has two disorders that are intimately related and interact and must therefore be treated together. Alcohol use, for example, may be triggered by feelings of depression or anxiety, but drinking, in turn, makes those feelings more difficult to confront. Appendix 4 contains a diagram from the SAMHSA publication called TIP 42, the Center on Substance Abuse Treatment manual on how to treat dual disorders. The diagram shows concretely how symptoms of both disorders interact and how the treatment plan takes account of this interaction. This level of integration appears to occur to some extent in the HCFP program clinical team meetings; and some cross-trained mental health clinicians provide interventions on the interacting disorders. However, the extent of its use is limited by the fact that none of the substance abuse counselors are cross-trained in mental health, and few of the mental health clinicians are cross-trained in substance abuse.

The TIP 42 recommendation to provide integrated treatment in the sense of considering the interaction of the disorders is clearly important for persons with severe mental illness. How important it is for persons whose mental health problems are not severe is still an unresolved issue. It appears to be a desirable capability but not a necessary one for effective treatment.

Two important steps toward integration would be: a) for one or more of the DPH or DMH administrators working on the program to have extensive cross-training and b) for all HCFP clinical program managers to be cross-trained. Cross-trained clinical supervisors also can supervise substance abuse counselors — not as a replacement for the supervision from the substance abuse agency but as a way of increasing treatment integration and sensitivity to the ways in which the disorders interact.
What has reduced the productivity of the HCFP program sites?

The HCFP program was designed so that five sites would have 50 participants at any one time and one site, and the downtown facility would have 100. At various times some programs have had fewer participants than they were funded for, but this year enrollment is down at all sites, with most reporting roughly 30 clients. Most of the program directors cited the lack of availability of Section 8 housing vouchers. In past reports CIMH has emphasized the documented roles of housing subsidies in helping homeless families, and presented evidence that housing subsidies were important if not critical in the long-term success of most but not all HCFP participants. During the current sites visits, programs reported that they are able to place clients in housing even without the Section 8 vouchers, but that it takes more time. In some cases, participants might end up in as many as three different transitional housing placements.

One additional minor factor is the DPSS policy that participants may stay only 12 months in the HCFP program. Ten participants were discharged with the notation that they were being transferred to regular CalWORKs mental health services at the end of the 12 months. When enrollment is so low this practice does not seem to make sense.

Recommendations for Improving HCFP Dual Disorder Capability

Although the co-occurring disorders programs at HCFP sites are doing well, there are some relatively simple steps that could improve DDCMHT fidelity.

1. **HCFP administration should provide some services to all sites in a centralized fashion.** Programs received their lowest scores on training all staff on the basics of substance abuse treatment and on cross-training at least some substance abuse counselors and mental health staff. It does not make sense for the six sites to duplicate training programs. Basic training should be made available through monthly lectures and workshops by DMH and DPH. Cross-training opportunities should be explored and incentives provided to staff if they obtain this training.

2. **One early focus of training should be the motivational stages of change and how they can be used to structure treatment interventions. A related focus should be motivational interviewing.** Both substance abuse and mental health staff need these trainings.

3. **HCFP administration should require a version of the forms used by ENKI and Shields that summarize the key element of both treatment plans and update them frequently; the form should be kept in both charts. Clients should also be asked to sign a records release permitting sharing of chart access between mental health and substance abuse staff.**

4. **DPH should continue to reimburse for substance abuse counselor time rather than moving to a fee-for-service system.** Much of the value of the substance abuse counselor would be lost in a fee-for-service system with its limits on the functions the substance abuse counselor can play in the program. Alternatively, the contracts that govern the SA counselors should be revised by DPH to permit the broader range of functions to be billed within a fee-for-service framework overall.

5. **DPSS should be more flexible in the expected duration of service, at least until the program once again can offer Section 8 vouchers.** As long as programs are below capacity it would make sense to determine the length of stay in HCFP programs on an individual basis rather than imposing a 12 month limit.
6. DPSS may want to experiment with providing extra resources to DMH in order to hire substance abuse experts and extra resources to DPH in order to hire mental health experts. This is an alternative model to the cross agency model used this year. It has a number of potentially important advantages in terms of the degree of integration of services.

7. HCFP should encourage clinical supervision of substance abuse counselors by cross-trained mental health supervisors, when they are available.
Appendix 1: DDCMHT Scoring Issues

In addition to reflecting practices at each of the six HCFP sites, the DDCMHT ratings also reflect some more systemic considerations.

Severity. The DDCMHT was developed to use in mental health agencies attempting to collaborate or integrate with substance abuse services. (Appendix 2 of this report defines different levels of integration.) The mental health agencies, however, were those that serve persons with severe mental illness — rarely the case in CalWORKs programs (including the HCFP programs). The primary way this affects ratings of the HCFP is that the DDCMHT rates higher programs that have established the capacity to serve substance abusers of any severity. There are several items (especially III E and F, and IIA) that require capacity to handle higher levels of severity in order to achieve a high score of 5.

Single chart. “Integration” requires having a single chart. No HCFP program does or can meet this standard. However, in two programs the intent was met by developing a combined MH-SA form that is kept in both mental health and substance abuse records and updated frequently. We also gave credit when the program manager or clinical director did supervision with both mental health and substance abuse staff and reviewed both charts. We also gave some credit for integrated planning that occurs in staff meetings.

Improved DMH initial assessment. The new screening and initial assessment forms are a great improvement. The use of the stages of change form that is included on the Supplement was widespread and resulted in generally high scores.

Psychopharmacology. The scale rates the ability to get both psychiatric and substance abuse medications; a separate item rates this for after care. No HCFP site reported that any substance abuse medications (such as naltrexone or disulfiram) were ever considered for use with an HCFP client. This is strange as the California Department of Drug and Alcohol Programs best practices document says: “All clients diagnosed with alcohol dependence should be provided with information on the efficacy of pharmacotherapy (e.g. naltrexone, acamprosate) and supported in making an informed choice best suited to their needs.” We rated these items based on what clinical (but not psychiatric) staff told us.

Staff Training. This was the lowest rated domain overall and for most programs. It does not make sense that individual programs (12 of them if you count the substance agencies) should each mount a training and cross-training program. The HCFP should address training needs — at least the basic training needs — for all sites. Cross-training is a more ambitious undertaking that DMH and DPH will need to address if more co-location is to occur.

Recovery. The DDCMHT requires that programs focus on “recovery” for both mental health and substance abuse. The recovery concept is not really relevant for persons with mild and moderate mental health issues, and even for substance abuse it is limited because the focus is by design on short-term barriers such as housing and employment. Programs do focus on relapse prevention, which is a critical part of substance abuse recovery.
Appendix 2: DDCMHT Definitions of Collaboration

Minimal coordination, consultation, collaboration, and integration are not discrete points but bands along a continuum of contact and coordination among service providers. “Minimal coordination” is the lowest band along the continuum, and integration the highest band. Please note that these bands refer to behavior, not to organizational structure or location. “Minimal coordination” may characterize provision of services by two persons in the same agency working in the same building; “integration” may exist even if providers are in separate agencies in separate buildings.

Minimal coordination. “Minimal coordination” treatment exists if a service provider meets either of the following criteria: 1) is aware of the condition or treatment but has no contact with other providers, or 2) has referred a person with a co-occurring condition to another provider with no or negligible follow up.

Consultation. Consultation is a relatively informal process for treating persons with co-occurring disorders, involving two or more service providers. Interaction between or among providers is informal, episodic, and limited. Consultation may involve transmission of medical/clinical information, or occasional exchange of information about the person’s status and progress. The threshold for “consultation” relative to “minimal coordination” is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.

Collaboration. Collaboration is a more formal process of sharing responsibility for treating a person with co-occurring conditions, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated by different providers; the roles and responsibilities of the providers are clear; and the responsibilities of all providers include formal and planned communication with other providers. The threshold for “collaboration” relative to “consultation” is the existence of formal agreements and/or expectations for continuing contact between providers.

Integration. Integration requires the participation of substance abuse and mental health services providers in the development of a single treatment plan addressing both sets of conditions, and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. The threshold for “integration” relative to “collaboration” is the shared responsibility for the development and implementation of a treatment plan that addresses the co-occurring disorder. Although integrated services often may be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be performed by a single individual, if s/he is qualified to provide services that are intended to address both co-occurring conditions.
Appendix 3: How Stages of Treatment Structure Dual Disorder Interventions

In the Integrated Dual Disorders Treatment model, reference is made to “stages of treatment.” These parallel the motivational stages of change of Prochaska and DiClemente but do so from the treatment standpoint. So Engagement is parallel to Contemplation, Persuasion to Preparation, Active Treatment to Action, and Relapse Prevention to Maintenance.

Below is a reproduction of a page from the basic IDDT handbook showing how interventions differ depending on stage of treatment.24

<table>
<thead>
<tr>
<th>Activity</th>
<th>Engagement</th>
<th>Persuasion</th>
<th>Active treatment</th>
<th>Relapse prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>• Help clients gain access to housing, medical care, or legal representation.</td>
<td>• Explore consequences of substance abuse in the context of advocating for client needs.</td>
<td>• Help clients obtain services, housing, or privileges that their substance abuse formerly prevented access to.</td>
<td>• Help clients learn how to advocate for themselves.</td>
</tr>
<tr>
<td>Promoting follow-through</td>
<td>• Reinforce follow-through on basic services.</td>
<td>• Use motivational interviewing to ease lack of follow-through.</td>
<td>• Support client decision making by shifting responsibility for follow-through to client.</td>
<td>• Step back from promoting follow-through.</td>
</tr>
<tr>
<td></td>
<td>• Coordinate treatment appointments with other activities (e.g., money management).</td>
<td>• Conduct a functional analysis to troubleshoot poor follow-through.</td>
<td>• Use motivational interviewing when follow-through wanes.</td>
<td>• Allow clients to learn from own mistakes.</td>
</tr>
<tr>
<td></td>
<td>• Involve family in promoting follow-through.</td>
<td>• Enlist family support for appropriate follow-through.</td>
<td>• Encourage logs or journals to develop follow-through skills.</td>
<td>• Encourage logs or journals to develop follow-through skills.</td>
</tr>
<tr>
<td>Providing practical help and benefits</td>
<td>• Furnish practical help and benefits without expectations or demands.</td>
<td>• Address needs for which client previously rejected help.</td>
<td>• Help clients experience increase in standard of living (e.g., more control over money soon after achieving sobriety).</td>
<td>• Expand clients’ ability to get own basic needs met.</td>
</tr>
<tr>
<td>Obtaining and maintaining housing</td>
<td>• Help clients find housing.</td>
<td>• Help client make connection between housing problems and substance abuse.</td>
<td>• Help client improve quality of housing after achieving sobriety.</td>
<td>• Help client find more independent, higher-quality housing.</td>
</tr>
<tr>
<td></td>
<td>• Help client improve quality of housing.</td>
<td>• Explore “dry” (substance use permitted outside residence).</td>
<td>• Explore “dry” (substance use not permitted) housing.</td>
<td>• Provide skills training and supports to foster living in independent housing.</td>
</tr>
<tr>
<td></td>
<td>• Explore “wet” (tolerant of substance abuse) housing.</td>
<td>• Help client change housing to setting with less substance abuse.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Example of an Interactive Treatment Plan from TIP 42

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>INTERVENTION</th>
<th>GOAL</th>
</tr>
</thead>
</table>
| 1. Cocaine Dependence  
• Work problem primary reason for referral  
• Family and work support  
• Resists 12-Step  
• Mental symptoms trigger use  
• Action phase | Outpatient treatment  
• EAP monitoring  
• Family meetings  
• Work support group  
• Teach skills to manage symptoms without using  
• 12-Step meetings | Abstinence  
• Clean urines  
• Daily recovery plans |
| 2. Rule Out Alcohol Abuse  
• No clear problem  
• May trigger cocaine use  
• Precontemplation | Outpatient motivational enhancement; thorough evaluation of role of alcohol in patient’s life, including family education | Move into contemplation phase of readiness to change  
• Willing to consider the risk of use and/or possible abuse |
| 3. Bipolar Disorder  
• Long history  
• On lithium  
• Some mood symptoms  
• Maintenance phase | Medication management  
• Help to take medication while in recovery programs  
• MDDA meetings  
• Advocate/collaborate with prescribing health professional  
• Identify mood symptoms that are triggers | Maintain stable mood  
• Able to manage fluctuating mood symptoms that do occur without using cocaine or other substances to regulate his bipolar disorder |

http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf
Appendix 5: DDCMHT Domain Scores for each HCFP Program

Legend: MHOS=Mental Health Only Services, DDC=Dual Diagnosis Capable, DDE=Dual Diagnosis Enhanced
Endnotes

1. The term *co-occurring disorders* is generally preferred in the field but *dual diagnosis* and *dual disorders* are also used with the same meaning.

2. Information about the DDCMHT from its developers is available at [http://dms.dartmouth.edu/prc/dual/atsr/](http://dms.dartmouth.edu/prc/dual/atsr/)


4. Statistical equivalence is a concept and procedure that grew out of testing to see if generic drugs are “equivalent” to patented drugs. The standard we use is the same as that used by the FDA, namely that means or proportions should not be more than 20 percent of the mean of the control group apart. In reporting the data we will thus be providing information on statistical significance (the likelihood that observed differences are greater than would be obtained by chance) and the equivalence test (the likelihood that the confidence interval of the difference between the two groups falls within a predefined limit so that the means are thus equivalent). See Stegner, B. L., Bostrom, A. G., & Greenfield, T. K. (1996). *Equivalence testing for use in psychosocial and services research: An introduction with examples*. *Evaluation and Program Planning, 19*(3), 193-198. If we are only interested in whether one group is inferior to the other (we don’t care if it is better), then we describe the results as being “non-inferior.” Both statistical significance and equivalence are affected by sample size, but much larger numbers are needed to show equivalence. Since numbers are small for some comparisons it is possible to have a situation in which the difference between treated and untreated groups is not large enough to be statistically significant, but it is not small enough to be called equivalent. This is a common finding in mental health service research (HSRI, Fast Facts, Volume 2 Issue 4, [www.hsri.org/](http://www.hsri.org/)).

5. Statistical significance tells us the likelihood that our results are not due to chance. In this case, results look like chance rather than being patterned. For the Treated vs. Untreated comparison chi-square was .83, with one degree of freedom, p<0.66; for the Intent to Treat vs. No Substance Abuse Issue group the chi-square was 1.66, degree of freedom 2, and p<0.44. We further tested whether the results for negative reasons were “equivalent.” Since the confidence interval for the significance test does not fall within the Equivalence Interval, the two groups are also not equivalent on this measure.

6. T-test = 2.53, df=218, p<0.02. This difference between the groups is still statistically significant if limited to those already discharged. The groups are not equivalent.

7. Chi-square = .695, df=2, p<0.71. Although differences are not different to a statistically significant degree, they are slightly larger than required to be able to say that the treated and untreated groups are equivalent, given the sample size. Data were not collected in exactly the same way in previous evaluations, so no statistical comparison with previous cohorts on this measure is possible.

8. If they had substance abuse issues 5 percent lived in rental housing; if not 21 percent did; more persons with a substance abuse issue lived in temporary shelters than lived with family members — a statistically significant difference (Chi-2=16.64, df=5, p<0.01). Note that the comparison between study groups in 2007–2008 and 2009–2010 is very approximate. To draw causal inferences we would need a randomized controlled study.

9. For the comparison using the treatment group, Chi-square=2.46, df=2, p<0.29; for the comparison using the intent to treat group, Chi-square=5.66, df=2, p<0.06. The differences in the groups are somewhat greater among those discharged than among those still in treatment. The treated group is nearly identical to the untreated group on full-time employment (and is statistically equivalent), but it is “inferior” with regard to having no work-related activity.

10. In 2009–2010: Chi-square=1.185, df=3, p<0.76. In 2007–2008, Chi-square=12.19, df=3, p<0.01. The 2009–2010 group was also statistically equivalent.

11. The statistical significance for the two cohorts and equivalence for 2009–2010 is summarized below. The statistical significance differences remained unchanged if limited to those who already had been discharged.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Job capacity</td>
<td>Chi-2 13.8, df 1, p&lt;0.01</td>
<td>Chi-2 1.2, df 1, p&lt;0.27</td>
<td>Not equivalent</td>
</tr>
<tr>
<td>Daily living capacity</td>
<td>Chi-2 11.6, df 1, p&lt;0.01</td>
<td>Chi-2 0.17, df 1, p&lt;0.68</td>
<td>Equivalent</td>
</tr>
<tr>
<td>Mental health symptoms</td>
<td>Chi-2 13.0, df 1, p&lt;0.01</td>
<td>Chi-2 0.11, df 1, p&lt;0.74</td>
<td>Not equivalent</td>
</tr>
<tr>
<td>Domestic violence situation</td>
<td>Chi-2 3.9, df 1, p&lt;0.05</td>
<td>Chi-2 0.34, df 1, p&lt;0.56</td>
<td>Not equivalent</td>
</tr>
</tbody>
</table>
12 See the TIP 42 for other approaches (http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf)
13 Integrated Dual Disorders Treatment (IDDT) fidelity scale, a part of the SAMHSA evidence-based practice toolkit on dual disorders.
14 For a full explication of the rationale and procedures see the SAMHSA document that details an integrated process of screening, assessment, and treatment planning: http://coe.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf
15 See the SAMHSA document on services integration at: http://coe.samhsa.gov/cod_resources/PDF/OP6ServicesIntegration5-17-07.pdf
16 It can be downloaded at: http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf
17 There is a tendency in both mental health and substance abuse treatment literature showing that for some persons treatment of (the primary) disorder results in remission of the other disorder. It is summarized in Room, Robin (1998). The co-occurrence of mental disorders and addictions: Evidence on epidemiology, utilization and treatment outcomes (no. 141). Centre for Addiction and Mental Health, Ontario, Canada.
19 In theory, with the vouchers available through the Los Angeles City Housing Authority a voucher could be obtained within three or four months of entering the program.
20 This policy is fiscally based as clinicians consistently report that a substantial minority need more time than 12 months. Indeed among those discharged since November 1, 2009, 24 percent had stayed longer than 12 months, so there is some discretion involved still.
The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CiMH is dedicated to a vision of “a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.” Based in Sacramento, CiMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CiMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.

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