

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SERVICES TO PERSONS WITH
CO-OCCURRING MENTAL HEALTH
AND SUBSTANCE ABUSE DISORDERS**

PROVIDER PERSPECTIVES



**JUNE GIBBS BROWN
Inspector General**

**JUNE 1995
OEI-05-94-00150**

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This report was prepared under the direction of William Moran, the Regional Inspector General for the Office of Evaluation and Inspections, and Natalie Coen, Deputy Regional Inspector General, Office of Evaluation and Inspections, Region V. Participating in this project were the following people:

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EXECUTIVE SUMMARY

PURPOSE

Describe the experiences of staff that work directly with people who have co-occurring mental health and substance abuse disorders.

BACKGROUND

The National Comorbidity Survey, a large general population survey conducted from 1990 to 1992, estimates that in a given year, from 7.6 to 9.9 million Americans suffer from co-occurring mental health and substance abuse (MH/SA) disorders. Estimates of co-occurrence in non-surveyed populations (institutionalized or homeless persons, youth, and adults 55 and over) brings the total to 8.3 to 10.8 million individuals.

This population is heterogeneous in terms of types of mental disorders, levels of involvement with alcohol and other drugs, and degree of functioning. Few receive integrated treatment in a single setting, yet without it, response to treatment is likely to be poor. Information on effective treatment modalities is still emerging and co-occurring MH/SA disorders are not addressed in most higher education or on-the-job training curricula.

The Public Health Service (PHS) funds a number of services and activities relevant to this population, especially in the Substance Abuse and Mental Health Services Administration (SAMHSA), where their national advisory council established a work group on services integration which is currently focusing on this issue. Two programs are targeted at this population (Projects for Assistance in Transition from Homelessness and a special demonstration program). Clinical education, training, and technical assistance activities or programs are also funded by SAMHSA. The National Institutes of Health, Health Resources and Services Administration, Indian Health Service, Health Care Financing Administration, and Social Security Administration fund services that could serve this population. The extent to which any of these programs actually reach people with co-occurring MH/SA disorders is unknown.

This report conveys the experiences and perspectives of 71 people working in 30 community-based programs, located in 20 States, that treat people with co-occurring MH/SA disorders. Discussions with SAMHSA revealed that information on front-line workers was of interest and would complement the programmatic information coming from the special demonstration program mentioned above. Later in the study, SAMHSA staff expressed interest in knowing about the programs in which these respondents work. Hence we have produced a companion report (OEI-05-94-00151) with that information.

The combination of this survey analysis and the program descriptions provides as complete a picture as possible about issues, successes, and problems in the emerging field of treating this population.

FINDINGS

Most front-line staff work in new programs and have little education, training, or prior experience specifically related to co-occurring mental health and substance abuse disorders.

The majority of the programs in our sample are 3 years old or less, and 60 percent of the front-line staff have worked with this population for 3 years or less. Most front-liners work in teams, and are responsible for case management, counseling, or education. They lack formal education and training specifically on co-occurring MH/SA disorders. Many feel overburdened by the demands of the job and see burnout as a real threat.

The first challenge that front-line staff face in their working environment is that their clients have a host of serious problems in addition to mental illness and substance abuse.

Front-line staff report that many of their clients have severe, long-standing illnesses. Other common characteristics of their clients that they report include histories of homelessness, contact with the criminal justice system, and dysfunctional family backgrounds. Many clients are described as resistant to treatment.

Front-line staff have many goals for clients, with a long-term view of recovery.

Respondents named several goals they have for clients, such as long-term sobriety and increased self-sufficiency. They also emphasize that for most clients, "recovery" is a relative term and will take years to achieve. When asked to name the most important personal attributes needed to be effective, they most frequently said, "patience."

Front-line staff describe their approaches to clients as holistic, individualized, flexible, or creative. They say that establishing trust with clients is key, but very difficult to do.

The majority of staff say they are trying to address many client needs besides those related to mental illness and substance abuse, primarily through case management. They are trying to be flexible and creative in adapting their approach to meet the individual needs of clients. They say that building trust and a personal relationship with clients is key to making progress but very difficult to do.

Front-line staff define success for most clients as making incremental progress over time.

Given the severe, longstanding problems of clients, staff view treatment for most as an ongoing, lengthy process. They take satisfaction from seeing small steps toward recovery such as improved compliance with medications or reduced substance use.

RECOMMENDATION

The Public Health Service should develop a plan to increase knowledge about co-occurring mental health and substance abuse disorders and their treatment among clinicians, other professionals, and service providers.

Front-line staff working with this population face tremendous challenges. Their clients are often seriously ill and highly dysfunctional, and staff lack the education, training, and experience needed to work effectively with them. Furthermore, the number of such clients is reportedly growing nationwide.

We recommend that PHS develop a plan to use its arsenal of education, training, and technical assistance resources more strategically on behalf of clinicians, other professionals, and the programs they work in. In this effort, we suggest that PHS collaborate with other Federal agencies with relevant services, including the Social Security Administration and the Departments of Veterans Affairs, Housing and Urban Development, and Justice. We also suggest that they consult with grantees, national associations, professional organizations, experts, researchers, clinicians, and other practitioners. Finally, we suggest that existing technology be used as much as possible to produce and disseminate curricula and educational materials at a reasonable cost.

AGENCY COMMENTS

The Public Health Service concurred with our recommendation. Their comments are attached as Appendix A. They also submitted a number of technical comments on which we have based some revisions to the text.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION	1
FINDINGS	5
• Background and experience of front-line staff	5
• Characteristics of their clients	9
• Their goals for clients	10
• Their approaches to serving clients	10
• Their views of success	13
RECOMMENDATION	15
APPENDIX A	A-1

INTRODUCTION

PURPOSE

Describe the experiences of staff that work directly with clients with co-occurring mental health and substance abuse disorders.

BACKGROUND

The National Comorbidity Survey, a large general population survey conducted from 1990 to 1992, found that 53 percent of respondents with alcohol abuse or dependence over their lifetime also had a mental disorder over their lifetime, while 36 percent had a lifetime illicit drug use disorder. Fifty-nine percent of the respondents with a history of illicit drug abuse or dependence over their lifetime also had a mental disorder over their lifetime, and 71 percent had a alcohol use disorder over their lifetime. In any given year, Survey data reflect that an estimated 7.6 to 9.9 million persons suffer from co-occurring mental health and substance abuse (MH/SA) disorders.¹

The literature strongly emphasizes the heterogeneity of this population in terms of types of mental disorders, levels of involvement with alcohol and other drugs, and degree of functioning. People with these co-occurring disorders can be very difficult to treat, with chronic and severe medical, social, and emotional problems and particular vulnerability to relapse. Few receive integrated treatment in a single setting, from a single clinician who addresses both disorders at the same time. Yet if treated for only one disorder, response to treatment is likely to be poor.

Information on effective treatment modalities is still emerging and few studies document effective service delivery, treatment approaches, and outcomes. Also, co-occurring MH/SA disorders are not addressed in most higher education or on-the-job training curricula.

The broad social consequences of failing to adequately treat this population include homelessness, violence, crime, the spread of HIV/AIDS, tuberculosis, and sexually transmitted diseases, with their attendant demands on hospital emergency rooms and the public welfare and criminal justice systems.

Programs and Activities for Persons with Co-Occurring MH/SA Disorders

In the Department of Health and Human Services (HHS), the Public Health Service funds many services and activities relevant to this population.

¹ Since NCS data reflect only the household population ages 15-54, a true picture of the magnitude of this problem must reflect an additional .1 million institutional population, .1 million homeless, .05 million youth age 0-14, and .4 to .6 million adults age 55 or over, for a total estimated 8.3 to 10.8 million individuals.

The *Substance Abuse and Mental Health Services Administration (SAMHSA)* has many programs that are directly or indirectly targeted to serve people with co-occurring MH/SA disorders. The national advisory council of SAMHSA has a working group on services integration which is currently focusing on this issue. A SAMHSA work group has also been created to address this population.

Two SAMHSA service programs are specifically targeted at people with co-occurring MH/SA disorders. Projects for Assistance in Transition from Homelessness (PATH) is a formula grant program to States and territories with a specific legislative mandate to serve this population. Funded at \$29 million in Fiscal Year (FY) 1994, PATH provides mental health and other services to homeless individuals and at-risk populations that are severely mentally ill or have co-occurring MH/SA disorders. Secondly, a demonstration program for homeless individuals with such disorders is overseen jointly by the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT). Sixteen providers received grants in September 1993 totalling \$4 million to develop and test models of effective assessment and intervention for this population. In FY 1994, several providers will receive continuing grants to undertake a formal evaluation of their specific service delivery modalities.

Other SAMHSA programs include the mental health services block grant (\$278 million for FY 1994) and the substance abuse prevention and treatment block grant (\$1.1 billion in FY 1994). Nine Access to Community Care and Effective Services and Support demonstration grants (\$19.4 million) are testing services integration approaches for persons with severe mental illnesses and/or substance abuse and the Community Support Program has funded demonstration projects. SAMHSA also funds various clinical education, training, and technical assistance activities or programs.

Elsewhere in HHS, the *National Institutes of Health* fund research and services demonstrations through the National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism. The *Health Resources and Services Administration* funds the Health Care for the Homeless Program and Ryan White programs for persons with HIV/AIDS. The *Indian Health Service* funds services for American Indians and Alaska Natives. The *Health Care Financing Administration* funds Medicare and Medicaid for health care and related services. The *Social Security Administration* funds the Social Security Disability Income and Supplemental Security Income programs.

Outside HHS, the *Department of Veterans Affairs* and the *Department of Housing and Urban Development (HUD)* both deal with this population in their homeless as well as other programs. The *Department of Justice* deals with this population via the courts, prisons, and jails.

While the above list of agencies and programs is long, we do not know the extent to which their services reach this population. We did not find national data on the number of such clients served by any of these agencies and their programs.

Scope and Methodology

This report describes the experiences and perspectives of people working directly with clients in community-based (as opposed to inpatient) programs established specifically to treat people with co-occurring MH/SA disorders.

One impetus for this study was previous studies which we conducted on services to homeless people, especially those with mental illness or substance abuse, and community mental health services. In those studies, respondents pointed to persons with co-occurring MH/SA disorders, specifically, as underserved both in homeless and traditional service programs.

A second impetus was the SAMHSA joint demonstration program noted previously. In our early discussions with SAMHSA staff, we learned that a report on the first year of the demonstration was planned that would address certain aspects of program structure, operation, and effectiveness. It would not, however, focus specifically on the staff in these programs - the background, experiences and perspectives of those who work day-to-day with this difficult population. We learned that this type of information was also of interest within SAMHSA and would serve to complement the programmatic information coming from the special demonstration.

In addition, our early reading and discussions with more than 25 experts in the field confirmed that an increasing amount of literature addresses the nature of co-occurring MH/SA disorders and treatment approaches, but that there is very little information about front-line staff. These experts also expressed interest in this type of information.

In the second phase of the study, we spoke with 71 people in 30 programs, identified through references in the literature, descriptions of the special demonstration programs and other Federal programs, and suggestions from experts. Almost all of the programs treat persons with co-occurring MH/SA disorders exclusively, although a few also have some clients with mental illnesses or substance abuse problems only. At each program, we spoke with a supervisor or manager, and one or more staff working directly with clients in treatment-related activities (as opposed to outreach). Most discussions were by telephone; we visited two programs to conduct interviews in person.

The programs are located in 20 States² and are very diverse both demographically and programmatically. The 28 provider agencies running the programs include: 17 mental health providers, 3 substance abuse providers, 4 private non-profit social service agencies, 3 hospitals, and a veterans service agency. A quarter of the programs were located in metropolitan areas (cities over 500,000), 15 percent in small cities or rural areas, and the rest in medium size cities.

² *Alaska, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Missouri, Nebraska, New York, Ohio, Oklahoma, Oregon, South Carolina, Texas, Vermont, Virginia, Wisconsin, and Wyoming.*

We did not explore the funding of these programs in depth. However, we deliberately included seven recipients of CSAT-CMHS demonstration funds, and we found two programs that receive PATH funding. Other sources of funding reported by the managers we talked to were Federal funding from HUD, the National Institute on Drug Abuse, CSAT, and Medicaid or Medicare reimbursement; State or county mental health or substance abuse funds (some of which may be Federal block grant dollars); special State "community support services" funds (one State); client fees; and United Way or other private donations.

Though we did not delve deeply into the origins of these programs, our strong impression is that the major impetus in their development was the recognition by key staff that this segment of their client population was growing, and that their needs were not being adequately met by existing services.

Chart A shows the programs by type, as described to us by respondents, and the respondents by type of job responsibility. Readers will note that the 46 respondents working directly with clients ("front-line" staff) fall into two categories. Thirty-two people have front-line responsibilities only. Fourteen people combine front-line duties with supervision or management.

We asked all 71 respondents to describe the clients in their programs, their goals for clients and how they are trying to achieve them, and their success in meeting those goals. We asked the 46 staff with front-line responsibilities, specifically, about their prior job experience, education, and training. We did not verify the information respondents gave us or evaluate these programs.

We have also issued a companion report entitled "Services to Persons with Co-Occurring MH/SA Disorders: Program Descriptions" (OEI-05-94-00151), which provides descriptions of the 30 programs whose managers and front-line staff we interviewed. The combination of this survey analysis and the program descriptions provides as complete a picture as possible about issues, successes, and problems in the emerging field of treating persons with co-occurring MH/SA disorders.

We conducted this inspection in accordance with the *Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

CHART A

PROGRAMS	RESPONDENTS			
	Managers Only	Front-Line Only	Both Mgr/FL	TOTAL
6 Residential	6	10	3	19
8 Out-Patient	4	7	5	16
10 Day Tmt or Partial Hosp.	11	12	3	26
5 CTT-type*	4	3	2	9
1 Other**	0	0	1	1
TOTAL	25	32	14	71

* Continuous treatment team or assertive community treatment team.
 ** Single room occupancy hotel with day manager funded by community mental health center.

FINDINGS

MOST FRONT-LINE STAFF WORK IN NEW PROGRAMS. THEY HAVE LITTLE EDUCATION, TRAINING, OR PRIOR EXPERIENCE SPECIFICALLY RELATED TO CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

The majority of front-line staff work in relatively new programs. Half of front-line staff have worked clients with co-occurring MH/SA disorders, specifically, for 3 years or less.

Sixty percent of the *programs* in our sample are 3 years old or less. Only four programs are more than 5 years old. Sixty percent of the 46 front-line *staff* are working in programs 3 years old or less. One quarter work in programs that are 1 year old or less.

We asked front-line staff how many years they have worked with clients with co-occurring MH/SA disorders, specifically (as opposed to working with them as part of a broader client population). One half said they have worked with this population for 3 years or less; another 25 percent have worked with them for 4 or 5 years. As a group, the 14 people with both management and front-line duties tended to have more years experience with these types of clients than strictly front-line staff.

Most front-line staff report being responsible for case management, counseling of some sort, or education. They work as part of multi-disciplinary staff teams and most of their work is with groups of clients.

We asked front-line staff to generally describe their job, and where it fit in with the jobs of other staff in their programs.

It is difficult to cleanly and distinctly describe their job responsibilities because many of them are involved in such a variety of activities, and their titles, per se, usually do not tell the entire story of what they do every day. For example, a "case manager" might be a nurse on a continuous treatment team who besides making sure clients get the services they need, administers medications and counsels clients in some capacity. We contacted one program director as she was cooking lunch with clients; of herself and other staff, she said: "We all do everything around here. We cook, we drive the van, we go on outings with clients." Thus the following descriptions are meant to provide only a general picture of what front-line staff are doing.

About 60 percent of front-line staff described themselves as case managers (13) or counselors (14). Seven of the case managers are people who combine management responsibilities with handling a small caseload. We did not ask respondents to define or describe "case management" in their programs in any detail. However we found that case managers are the most likely to be dealing with individual clients, monitoring

treatment plans and connecting them with other services. We also found that case managers may be involved in counseling, education, or social activities.

The duties that the counselors described ranged from individual and group counseling in mental health or substance abuse, to vocational rehabilitation or job counseling, to education and, in some cases, involvement in 12-step or 12-step based groups.

The other 40 percent of respondents include: nurses, most often responsible for medication management (under the supervision of a psychiatrist) and education; and others with a variety of titles³ who report being involved in counseling of some sort, social or recreational activities, or ancillary services such as transportation.

Front-line staff spend most of their time with groups of clients. Also, 75 percent described working as part of a multi-disciplinary staff team rather than independently. This may in part account for the variety in terms of job duties, as staff with different expertise combine forces in counseling or education sessions, "cover for each other," and participate together in social and recreational activities with clients. Teams may consist of only two or three people, or more. They most often are comprised of a manager or supervisor (who may also carry a small caseload), case managers, counselors, nurses, and a part-time psychiatrist; some of the other staff on teams that were mentioned included an art therapist, vocational or recreational rehabilitation specialists, social workers, mental health aides, and a secretary.

Despite receiving college degrees in fields such as psychology and counseling, few front-line staff have been educated or trained specifically on co-occurring MH/SA disorders.

Chart B shows the highest educational level attained by front-line staff.

The most common fields in which people received college degrees are psychology and counseling, including rehabilitation counseling, but they also received degrees in human services, health sciences, recreation therapy, and organizational communications. In addition to their degrees, 22 people reported having some sort of special certification or license, 12 of them for drug and alcohol counseling.

CHART B

HIGHEST EDUCATIONAL LEVEL	RESPONDENTS REPORTING (N=46)
High school diploma	4 (9%)
Bachelor's degree	13 (28%)
Master's degree <i>Social Work: 5</i> <i>Other: 18</i>	23 (50%)
Nursing (RN, LPN, LVN)	5 (11%)
Other: Psychologist	1 (2%)

³ such as: substance abuse supervisor; partial hospitalization specialist; substance abuse or dual diagnosis specialist; recreational therapy coordinator; community support worker; human services technician; consultant (to a continuous treatment team).

As might be expected, we found that the educational level of the 14 people with management responsibilities, as a group, was somewhat higher than that of staff with front-line duties only. For example, the psychologist falls into that group, and a higher proportion of the group has master's degrees. Conversely, the four individuals with high school diplomas have front-line duties only.

Notably, half of the staff with only front-line duties said they are currently pursuing additional education, licensing, or certification, from Associate Degrees to PhDs. This compares with 2 of the 14 persons with some management duties.

Eleven respondents revealed that they are in recovery from alcoholism or drug addiction. Two of the 11 reported combining supervision with case management; 9 reported front-line duties only including counseling, social and recreational activities, or transportation. This group was most likely to report having a high school diploma only, although just as many had bachelor's or master's degrees. Four of them have experience in business, as well as in social services of some sort.

About half of the front-line only staff said they have had some training on co-occurring MH/SA disorders on the job, for the most part in workshops, but they were vague about exactly how much training they have had and specifically what was covered. We are not convinced that the majority of this training was on co-occurring MH/SA disorders, per se. In the managerial group, five people spoke more convincingly of attending conferences or other training specifically on co-occurring MH/SA disorders. Exposure to national experts in the field led two people to take leadership roles in developing programs. One program director, a person who received her Master's in Social Work through a grant from the National Institute on Alcoholism and Alcohol Abuse, said that 4 years ago, "(co-occurring disorders) was a new concept. Very little was written and there was no research. I went to (an expert's) workshop and it got me thinking about what might be done."

Front-line staff credit their job experience more than their education or training with helping them work with clients with co-occurring MH/SA disorders.

We asked front-line staff what has been most helpful to them in terms of their education, training, or job experience in working with clients with co-occurring MH/SA disorders. Twenty people, including almost two-thirds of the 32 with front-line duties only, credited their past or present job experience, including "my supervisor," with being the most helpful.⁴ Comments such as "I learn a lot from my co-workers" or "clients taught me" were common. Also, people who have worked with developmentally disabled clients in the past are likely to have found that experience helpful in their current jobs.

⁴ Such comments also came from the 11 people who reported no prior job experience in either the mental health or substance abuse fields, one third of this group of respondents.

Ten people (a fifth of all front-liners) said that their education or, especially, on the job training had helped them the most. Others were more critical: "Formal education is not preparing people very well for this work," or "Textbook theories don't matter at all. What matters is the experience and the desire to help people."

Eight of the people who are in recovery said that this was most helpful to them.⁵ Several others mentioned personal characteristics as being helpful: commitment to clients or motivation to help people, an outgoing personality, a motivation to learn on the job, and even a sense of humor.

We asked all 71 respondents, managers and front-line staff alike, what education and training is needed to work effectively with clients with co-occurring MH/SA disorders. We heard a strong emphasis everywhere on the need for direct experience with clients. Respondents generally advocate a solid academic grounding in the theories and practices of both fields, as well as co-occurring MH/SA disorders per se, but they clearly believe that nothing surpasses experience on the job. Many of them advocate practicums that are attached to academic curricula, saying that "there's nothing like being there." A minor theme running through these comments seems to be that to be effective, one needs to develop a philosophy in addition to technical expertise, to internalize what one does, to really become invested in the clients and care about them.

While appearing challenged and energized by their jobs at the moment, many front-line staff also see burnout as a real threat.

We asked front-line staff if they had the resources, supervision, and support they need to do their jobs. We heard some complaints, and quite a few wishes for more staff, space, or materials, but the vast majority say they are getting the supervision and support they need. Sixty percent credited being on a team with giving them the support they need, and 34 percent credited their supervisor; some credited both.

Nevertheless, our question, "What do staff working with this population need in order to prevent burnout?" elicited the most spontaneous and vigorous responses of any question we asked. This was clearly a question near and dear to the hearts of these respondents. Their answers included: being on a team and having supportive co-workers (mentioned by all 14 people with both management and front-line duties), setting boundaries between personal lives and work, maintaining perspective, making sure to take time off and get away, maintaining personal health and stability, getting good supervision, and having access to education and training.

Many clearly feel pressured and overburdened by the demands of the job. With a lack of education and experience in this field, they are feeling their way in trying to find the right kind of approach to reach each client, and they are concerned about the lack of

⁵ This may be a controversial topic. Some respondents were not sure about the importance of being in recovery.

progress made by so many clients. One comment expresses the sense of many other interviews: "We're exhausted but still excited. Yet I see burnout coming."

THE FIRST CHALLENGE FRONT-LINE STAFF FACE IN THEIR WORK ENVIRONMENT IS THAT THEIR CLIENTS HAVE A HOST OF SERIOUS PROBLEMS IN ADDITION TO MENTAL ILLNESS AND SUBSTANCE ABUSE.

We asked all 71 respondents to describe their clients who have co-occurring MH/SA disorders. In most cases, their descriptions dovetail with those in the literature of clients with severe mental illnesses, and substance abuse.

In terms of general demographics, in most programs male clients outnumber females by at least two to one⁶, and the majority of clients are in their 20's and 30's. The majority are on public assistance, typically Supplemental Security Income and Medicaid.

In terms of treatment needs, respondents report that their clients have severe, long-standing illnesses. The majority are suffering from schizophrenia, and a smaller but significant number suffer from major or bipolar depression; a quarter of all respondents reported that some of their clients also have personality disorders. Clients are using or abusing alcohol (mentioned by 70 percent of respondents), cocaine or crack (60 percent), marijuana (40 percent), and heroin (13 percent; a number of people commented that heroin use is on the rise in their areas). Polyabuse (abuse of two or more substances) is not uncommon.

Chart C shows more characteristics mentioned, in descending order by frequency of mention. Most respondents named two or more of these characteristics.

Respondents mentioned other characteristics that make treatment difficult: long histories of disability and deeply entrenched substance abuse; resistance to treatment (they have "burned their clinical bridges" by failing in numerous treatment programs); and extreme social isolation, with little or no support network of family or friends.

CHART C

CLIENT CHARACTERISTICS MENTIONED

- ▶ Homeless/at risk of homelessness
 - ▶ History of arrest, jail, or prison
 - ▶ Dysfunctional family
 - Physical/sexual abuse in family
 - ▶ Mental retardation
 - ▶ Organic damage (liver, brain)
-

Further complicating treatment for staff, many programs accept clients who are at very different levels of functioning, from those with a host of severe impairments and a long history of illness and dysfunction, to those judged to be capable of living and

⁶ In contrast, 26 of the 32 front-line (only) workers in this study are female.

working in the community with minimal support. A few programs treat persons with co-occurring MH/SA disorders along with others with mental illness or a substance abuse problem only. One program treats clients who are homeless and living at a shelter, others who are on parole, living in the community, and mandated to attend, and still others, living in the community, who are clients of the community mental health center. Most clients have co-occurring MH/SA disorders, but some have only substance abuse problems.

FRONT-LINE STAFF HAVE MANY GOALS FOR CLIENTS, WITH A LONG-TERM VIEW OF RECOVERY. RELATIVE TO SUBSTANCE ABUSE, THEY URGE CLIENTS TO ACHIEVE ABSTINENCE BUT PRIVATELY DO NOT EXPECT MOST OF THEM TO ACHIEVE IT IN THE SHORT TERM.

We asked all 71 respondents to describe their goals in working with clients, specifically, what client outcomes they seek to achieve. They mentioned a host of changes they would like to attain over a long period of time. Eighty percent of respondents named at least two goals; 30 percent named four goals. Chart D shows the most common responses.

In terms of substance abuse problems, specifically, most respondents believe that in the very long-term, sobriety or abstinence should be a goal, and say that this is the goal they "preach" to clients. However, as one program director said: "We don't feel most people are going to be abstinent. We assume treatment will be long-term (2 years or more) and involve a lot of support and intervention in a lot of arenas."

In discussing goals, respondents repeatedly emphasized that for most of their clients, "recovery" is a relative term and will take years to achieve. When asked to name the most important personal attributes staff need to be effective with these clients, the one most frequently named (by half of all respondents) was "patience."

FRONT-LINE STAFF DESCRIBE THE APPROACH THEY TAKE TO HELP CLIENTS AS HOLISTIC, INDIVIDUALIZED, FLEXIBLE, OR CREATIVE. THEY SAY THAT ESTABLISHING TRUST WITH CLIENTS IS KEY, BUT VERY DIFFICULT TO DO.

We asked all 71 respondents, managers and front-line staff alike, to describe their approach to working with clients with co-occurring MH/SA disorders. Given the great

CHART D

GOALS MENTIONED

- ▶ Long term sobriety/abstinence
- ▶ Increased independence, self-sufficiency, coping skills
- ▶ Increased mental stability, including compliance with medications
- ▶ Reduced drinking/drugging
- ▶ Increased stability, better quality of life
- ▶ Increased self knowledge, understanding, awareness*
- ▶ Increased self-esteem, hope

* Respondents were talking about such things as understanding one's illnesses, the need for compliance with medications, and substance abuse triggers.

variety in client disabilities, histories, and levels of functioning, it is not surprising to learn that approaches are being adapted in a number of ways.

Almost two-thirds of all respondents report taking a "holistic" approach in trying to address many client needs besides those related to mental illness and substance abuse. Case management is used in many programs to connect clients with services.

In addressing the *mental health and substance abuse problems* of clients through counseling and education, respondents emphasize compliance with medications, problem solving, and "learning ways to avoid drinking and drugging." They also try to build self esteem and a sense of hope, and help clients learn to live independently in the community.

Respondents also mentioned other services their clients need, especially in terms of long-term recovery.

Housing: Sixty percent of all respondents said that their clients need housing - not only a roof over their heads, but more importantly, clean, safe, and affordable housing located in sober living environments, often with supportive services of some kind available. Many of their clients are living in substandard housing in poor neighborhoods where drug abuse is prevalent. In such housing, people said, clients are almost guaranteed to relapse no matter how effective a treatment program is.

Social or recreational activities, including volunteer activities, and vocational education or job-related services: A quarter of all respondents said that clients need such activities to facilitate recovery, because they provide structure which is critical to achieving mental stability and sobriety. We heard many comments such as: "Boredom leads to substance abuse;" "(Clients) need structure and something to do;" and, "You need to fill the vacuum that drugs filled ."

Aftercare or relapse prevention programs, long term mental health services, and programs designed specifically for clients with co-occurring MH/SA disorders: Each of these was mentioned as a long-term need of clients by 15 percent of all respondents.

Case management is the most common mechanism for connecting clients to services both in and outside these programs. Two thirds of all respondents reported that case management is a part of their program.

Within the structured activities of their programs, respondents are trying to be flexible and creative in adapting their approach to meet the individual needs of clients.

Almost half of all respondents used the word "individualized" to describe their approach to clients, trying to "blend and adjust to each individual's needs" in order to be effective; 25 percent named creativity and flexibility as personal attributes needed to be effective with clients with co-occurring MH/SA disorders: "You must learn to do things differently, follow your instincts and adapt your approach." One of the most

difficult challenges is that "some (clients) need a certain toughness, others need nurturing."

Adaptations can be as simple as going for a walk to counsel a client who is having difficulty sitting still, or much broader. For example, we heard comments that while structure and boundaries are important for clients, rigid adherence to rules and schedules is often not effective. Most respondents reported that if clients violate rules regarding abstinence, "they can lose privileges, but they don't get thrown out automatically. We use it as a therapeutic tool." Relapses are discussed individually and in groups to increase clients' understanding of the causes and consequences of relapses and how to avoid them in the future. "Slips are allowed," said another director, "with gradual attempts at shaping of behavior."

Staff may minimize confrontation, simplify concepts, or proceed very slowly for clients who have a short attention span, are paranoid or delusional, illiterate, mentally retarded, or otherwise have difficulties with abstract thought. One of the more common activities in which these kinds of adaptations are made is 12-step groups.

Many staff report that they routinely seek client feedback on the subjects covered in education or counseling sessions, and recreational or social activities. For the most part, feedback is verbal and informal, although some programs do written client surveys periodically. Almost uniformly, respondents view client input as valuable if not crucial in running effective programs with active client participation.

The use of multi-disciplinary staff teams also stimulates flexibility and creativity as staff share their expertise, experience, and perspectives to come up with ideas about ways to structure program activities or reach individual clients.

Front-line staff view building trust and a personal relationship with clients as key to making progress but very difficult to do.

We asked front-line respondents how well they know clients and if it is important to establish a personal relationship with clients. We found that "building a personal relationship of trust and respect" was the number one factor they mentioned when asked to describe "what works" to help clients. However, many would probably agree with the supervisor in a residential program who said that this is "both the most important and the most difficult thing" of all to do.

To overcome cultural and other barriers between themselves and clients, especially suspicion or lack of trust that many clients exhibit, requires a respect for clients as individuals, and "time, consistency, and a certain chemistry." Half of all 71 respondents said that being "caring," "non-judgmental," and "respectful" towards clients are attributes of effective staff. Working in teams is also viewed as a plus, as members share their perspectives on client behavior and ways to break through barriers, and take over for each other in difficult situations: "I need the team. There are times I just can't deal with a client, and someone else can step in."

In terms of activities, music or art therapy, social activities, and recreation are touted as ways of building bridges between clients and staff. Some say that men-only or women-only groups are the best way to discuss certain sensitive issues - sexual abuse, for example.

Success in creating relationships is mixed. As a group, case managers are the most likely to say that they know their clients well, especially in "their world" (their homes, their family and friends). Several people commented that case managers are the most likely to get closer to clients since they help them with many needs, see clients mostly in their homes or the community, and work with them for a long time. Also: "Often the case manager is the only person (clients) know," and, "Lots of what dually diagnosed people do drives people away. Case managers will stick around."

Other staff, especially counselors, are less likely to know clients well, or commented that client distrust or dysfunction makes it difficult to establish a relationship. Some also are unsure about how to balance professionalism and friendship with clients.

FRONT-LINE STAFF HAVE NO SINGLE OPINION ABOUT "WHAT WORKS" TO HELP CLIENTS. THEY DEFINE SUCCESS IN RELATIVE, SUBJECTIVE TERMS, AND TAKE A LONG-TERM VIEW.

Views of front-line staff on "what works" to help clients, a question that many experts urged us to ask, are many and varied: building a personal relationship (mentioned previously), being slower and more concrete with clients, providing levels or a continuum of services, working with clients over a long period of time, individualizing one's approach, providing activities to replace substance use, providing "structure" or "boundaries," and being flexible, creative or eclectic in approach.

Taking a broader view, we asked all 71 respondents how successful they are in achieving the goals they have set forth for clients. We found that few programs conduct formal evaluations⁷ or have data on client outcomes. Therefore, most views of success are highly subjective.

Views were mixed at best. In terms of the managers, a third said their programs were too new to judge success or have had little or no success, 25 percent labelled their programs a success, and the rest said that their programs are able to make some progress with some clients, or that attendance and participation rates are good.

In terms of front-line staff, only two labeled their programs an unqualified success.

⁷ *The programs with the most formalized evaluation efforts were two affiliated with hospitals and a few others with some Federal funding from HUD, the National Institute on Drug Abuse, or the CSAT-CMHS demonstrations. The director of one agency, who has done some outcome evaluation, said that a recent cut in their Federal grant had led to the elimination of the evaluation component of the program. Many programs do routinely seek client feedback, however, either through periodic written surveys or discussions.*

We heard about high drop-out rates in some programs, as much as 50 percent, and many people said that only clients who are motivated or "willing to change," who stayed with the program, were likely to make progress: "We're able to touch 40 percent of our clients," and, "Half drop out, but the program is pretty successful for the others." Respondents reportedly have a very difficult time helping clients who are the most severely ill, have borderline personalities, or are crack addicts.

Over 50 percent do report taking some satisfaction from seeing a few clients make progress, or many clients take "baby steps" towards recovery over time: reduced substance use, housing stability and the like. However many people would probably agree with this member of a continuous treatment team who said, "I know that any success will be a long and lengthy process."

RECOMMENDATIONS

PHS SHOULD DEVELOP A PLAN TO INCREASE KNOWLEDGE ABOUT CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS AND THEIR TREATMENT AMONG CLINICIANS, OTHER PROFESSIONALS, AND SERVICE PROVIDERS.

This report highlights the tremendous challenges facing staff who work directly with persons with co-occurring MH/SA disorders. It reinforces the descriptions in the literature of the degree of illness and dysfunction of the clients, and it reveals the lack of appropriate education, training, and experience of front-line staff. In terms of approaches, it supports the view of one expert we spoke with that, "right now everyone is fumbling around locally with trial and error."

The PHS funds many programs, noted in the Background, that do or could serve persons with co-occurring MH/SA disorders and which routinely provide technical assistance or training to their grantees. Some have begun to respond to increasing demand from grantees; we understand that the PATH program, the mental health services block grant program, and Health Care for Homeless all provided training on co-occurring MH/SA disorders at regional and national conferences in FY 1994.

The PHS also funds education and training programs for clinicians and other professionals. Two respondents in this study benefitted from such programs. One received her master's degree thanks to a grant from the National Institute on Alcohol Abuse and Alcoholism. The other, a psychiatrist, reported receiving a National Institute on Drug Abuse career award in this field; he noted that an added plus of this award is that it allows him to do research related to his work. Relatively recent educational efforts include the issuance by the Center for Substance Abuse Treatment of a special Treatment Improvement Protocol on co-occurring MH/SA disorders, and the development by the National Institute on Drug Abuse of an educational videotape.

We applaud these efforts. However we also point out that they do not appear to be coordinated, either between the various offices which have undertaken them or with other Federal agencies or other entities who deal with this population. Given the growing number of clients with co-occurring MH/SA disorders, their degree of illness and dysfunction, and the inexperience and lack of proper training of the staff who help them, we call for PHS to develop a plan to use its existing arsenal of education, training, and technical assistance resources, and to provide Federal leadership with entities outside PHS, to increase knowledge and understanding of co-occurring MH/SA disorders among professionals and programs that serve this population.

The plan should encompass the development of academic curricula, training materials for those already in the field, and technical assistance materials. Many experts we spoke with for this study ask for strong Federal leadership in this arena. One of the

most highly respected said, for example: "Training programs are not teaching people to do this (provide integrated treatment). This is a desperate situation. We have to train the current workforce, and we have few experts to do it. It looks just as bad for the future. I can't think of one single clinical training program doing this." Also, a meeting last year of the National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Directors, National Association of Counties, and SAMHSA resulted in a lengthy recommendation, not yet implemented, that SAMHSA mount a strong technical assistance and training effort on co-occurring MH/SA disorders.

We suggest that in developing a plan, PHS collaborate not only with other departmental programs serving this population, especially the Health Care Financing Administration (Medicaid), but with State and local grantees, national associations, professional organizations, experts, researchers, and clinicians and practitioners who have direct experience with this population.

Collaboration with other Federal agencies that serve this population is especially important, we think: with the Departments of Veterans Affairs, Housing and Urban Development, and Justice, and with the Social Security Administration. One especially notable cooperative Federal effort newly underway is the mental health and substance abuse work group under the auspices of the Interagency Council on the Homeless charged with developing an action plan in connection with *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*. Some of the action steps initially developed by this work group are consistent with, and indeed support, our recommendation here.

We also suggest that PHS use existing technology (for example, the Internet, teleconferencing, videotapes) to produce and disseminate training and educational materials at a reasonable cost. Curricula and materials should be disseminated not only via universities, but through the community college network. Also, resource centers established in connection with specific departmental programs (the Community Support Program is one example) are a useful conduit for such information.

We hope that PHS will find the information we provide in this report useful in developing their response to this recommendation.

AGENCY COMMENTS

The Public Health Service concurred with our recommendation. Their comments are attached as Appendix A. They also submitted a number of technical comments on which we have based some revisions to the text.

APPENDIX A

AGENCY COMMENTS



Memorandum

Date . MAY 30 1995

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Reports "Services to
Persons with Dual Disorders: Provider Perspectives,"
OEI-05-94-00150 and "Services to Persons with Dual Disorders:
Program Descriptions," OEI-05-94-00151

To Inspector General, OS

Attached are the PHS comments on the OIG draft reports on Services to Persons with Dual Disorders. We agree that a plan for increasing knowledge about co-occurring mental health/substance abuse disorders and their treatment is critical to improving services and service delivery to this population. Our comments describe PHS' efforts to address this issue. In addition, we offer technical comments on both reports for your consideration.

Philip R. Lee, M.D.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE (PHS) ON THE OFFICE OF
INSPECTOR GENERAL (OIG) DRAFT REPORTS, "SERVICES TO PERSONS
WITH DUAL DISORDERS: PROVIDER PERSPECTIVES," OEI-05-94-00150
AND
"SERVICES TO PERSONS WITH DUAL DISORDERS: PROGRAM
DESCRIPTIONS," OEI-05-94-00151

GENERAL COMMENTS

The OIG draft reports provide the results of the OIG's survey of programs that serve people with co-occurring mental health and substance abuse disorders (co-occurring MH/SA disorders) and describe the programs and the experiences of program staff in providing services to this population.

The reports recognize the broad social consequences (i.e., homelessness, violence, crime, the spread of HIV/AIDS, tuberculosis, etc.) of not adequately treating people who have a history of substance abuse and mental illness. The personal devastation and individual treatment needs should not be minimized; but the overall impact of a person's illness must also be viewed in the context of his or her children, family and community. Where substance abuse and mental health problems are not recognized and treated, there is increased stress on family, friends, and care givers. We believe that improving collaboration and the exchange of information among researchers, program staff, and patients and their families could help to alleviate these social consequences.

The reports also discuss ways to encourage innovative approaches to the development of training programs and curricula. Federally-sponsored educational programs usually are designed for one profession or another; however, profession-specific approaches are not necessarily appropriate for complex pathologies. Educational programs developed to train clinicians, other professionals and service providers should be designed to include both traditional and alternative therapies. In addition, it is essential that people affected by co-occurring MH/SA disorders--and people at risk for co-occurring MH/SA disorders--be educated as well. Therapies have a much greater likelihood of being successful when people who suffer from co-occurring MH/SA disorders and their families are active participants in developing treatment modalities.

Finally, the reports stress the importance of training; however, we believe the reports should also acknowledge the importance of evaluation. Unless we understand what effect the training, the work of the therapists, and the availability of funding is having on the amelioration of the problem, we will continue to operate in the dark. While this aspect is painful because it uses some of the resources (fiscal and clinical) that could be used to treat patients, it is

important to find out if the patients are getting well or better, establish how many of them there are, how many there are a year or two after treatment, what treatment is effective, and exactly how the Federal programs are cooperating (i.e., how Federal funds are being used).

OIG RECOMMENDATION

1. **PHS should develop a plan to increase knowledge about dual disorders and their treatment among clinicians, other professionals, and service providers.**

PHS COMMENT

We concur. Individuals with co-occurring MH/SA disorders present unique challenges for the alcohol/drug abuse/mental health (ADM) services field. We agree that a plan for increasing knowledge among service providers in the ADM specialty sector and in primary care settings is critical to improving services and services delivery to this population. We also agree that all stakeholders, including consumers and their families, should be included in the development and implementation of such a plan.

2. **The plan should encompass the development of academic curricula, training materials for those already in the field, and technical assistance materials.**

PHS COMMENT

We concur. However, before developing new curricula we should review what currently exists. Some efforts have already been made in this area. The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse have funded curriculum development and faculty development projects.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has also begun several efforts to improve services for individuals with co-occurring MH/SA disorders. An Action Plan (Attachment I) has been drafted which addresses the need to improve provider knowledge within current agency programs. In addition, the SAMHSA National Advisory Council is planning a national conference on this issue which is expected to yield recommendations for action in several substantive tracks, including education and training. SAMHSA Centers are also engaged in efforts designed to learn more about effective service provision for this population and to disseminate that information to the field. (See Attachment II for activity descriptions.)

In addition, SAMHSA's Center for Substance Abuse Treatment (CSAT) has been chairing an Interagency Committee on education and training as part of its training initiatives. There is a need for skills-based clinical training which is not specifically mentioned in the OIG reports' recommendations. CSAT awarded a contract to Lewin-VHI to develop a report on training needs.

Also, SAMHSA's Center for Mental Health Services (CMHS), in collaboration with CSAT, is planning a training curriculum that could be used for in-service training of an array of service providers for homeless populations and which focuses specifically on persons with co-occurring disorders.

In the development of training initiatives it will be important to collaborate with the professional organizations which are developing practice guidelines on the appropriate treatment for these patients. This does not appear to be mentioned in the OIG report. In addition, training materials must include the development of academic curricula for health professionals.

3. PHS should collaborate with other HHS agencies, State/local grantees, national associations, professional organizations, experts, researchers, clinicians and other Federal agencies (the Departments of Veteran's Affairs, Housing and Urban Development, and Justice, and the Social Security Administration) and consider recommendations made by existing reports such as "Priority: Home! The Federal Plan to Break the Cycle of Homelessness."

PHS COMMENT

We concur. Coordination of existing resources across HHS would benefit persons with co-occurring disorders. Perhaps an HHS Coordinating Group on Co-Occurring Disorders could serve this purpose. However, there are already coordinating groups in HHS whose focus includes persons with co-occurring disorders - such as persons with HIV/AIDS and persons who are homeless.

We would like to point out that the Department of Veteran's Affairs is represented on the SAMHSA National Advisory Council that is planning the national conference referred to above. SAMHSA will make every effort to include appropriate Federal Agencies in the planning process and obtain their participation in the conference. SAMHSA will also disseminate any recommendations resulting from the conference to these Federal Agencies and work with them to implement the

recommendations.

As noted above in our comments on recommendations 1 and 2, we concur that collaboration with professionals in the field is necessary to develop the appropriate training materials.

4. PHS should use existing technology (e.g. Internet, teleconferencing, videotapes) to produce and disseminate training and educational materials through universities, community college network, and resource centers.

PHS COMMENT

We concur. We would encourage producing and disseminating information through the use of both traditional and innovative means of knowledge transfer.