THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by

MYREE HARRIS RSJ - 2002/2 Churchill Fellow

To study models of treatment for Dual Diagnosis of mental illness and substance abuse in Canada, USA and England, with an emphasis on the care of homeless people.

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Signed: Myree Harris Dated 29 September 2003

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INTRODUCTION

Dual Diagnosis of severe mental illness and substance abuse is emerging as a major social problem in Australia. My visits to Canada, USA and the United Kingdom revealed that all three countries acknowledged this challenge. However, with at least 20 years of research, the development of evidence based practice, models for system integration and consultancy support, toolkits for program integration, best practice guidelines and national program inventories, along with residential and outreach services, those countries are well ahead of us.

It is of the utmost importance that, at Federal and State levels, we learn from these countries and select and adapt what is most appropriate to address this challenge.

I wish to thank the Winston Churchill Memorial Trust for the Fellowship which made these visits possible.

I am most grateful to my referees for the Fellowship: Mr Robert Fitzgerald, Deputy Ombudsman, Professor Paul Fanning, Director of Mental Health for the Mid Western Area Health Services and the Reverend Harry Herbert, Executive Director of UnitingCare NSW and ACT, for their trust in me.

I appreciate some extra funding from the Alcohol Education and Rehabilitation Foundation which enabled me to visit extra facilities, including some which charged for admission.

Many organisations, groups and individuals in Canada, USA and the United Kingdom provided information as well as assistance with accommodation and transport. Their commitment and enthusiasm and the love and respect they have for their often profoundly disadvantaged clients, was inspirational. I was led to believe that this very difficult area of care attracts people with qualities of integrity, courage, ingenuity, compassion and humour.

EXECUTIVE SUMMARY

To investigate models of treatment and rehabilitation for people who have a dual diagnosis of mental illness and substance abuse with a focus on residential models, USA, Canada, UK.

Major Learnings and Key Resource People:

- Dual Diagnosis, among people with serious mental illness, is increasingly regarded as the expectation, not the exception in USA, Canada and UK. It is regarded as a major social problem and challenge to existing services. This is reflected in National documentation in all three countries.

- In USA, SAMHSA, the Substance Abuse and Mental Health Services Administration, made a major report to Congress on dual diagnosis in 2002. A National Dual Diagnosis Prevention, Treatment, Technical Assistance and Cross-Training Centre is planned for 2003. Drs Ken Minkoff and Christie Cline of Zialogic, currently work with 15 US States and three Canadian Provinces to integrate the two systems, at State levels for dual diagnosis service delivery.

- In Canada, there are Best Practice Guidelines and a National Program Inventory

- In UK, there are Best Practice Guidelines and Mental Health Policy Implementation Guide.

- Dr Robert Drake from New Hampshire-Dartmouth Psychiatric Research Centre is regarded everywhere as the leader in dual diagnosis research. Integrated treatment has been shown to be more effective than serial or parallel treatment by two agencies. This has emerged from Dr Drake's research into evidence-based practice over 20 years. SAMHSA commissioned a series of six EBP *Toolkits.* They are being used and evaluated over five years at 55 sites: States, cities and regions. The dual diagnosis toolkit, of which I have a draft version, shows how to provide integrated treatment. It will be available commercially soon.

- There are excellent models of residential and outreach treatment of people with dual diagnosis from all three countries.

- Assertive Community Treatment (ACT) teams which are multi-disciplinary, with people from diverse backgrounds, using a holistic not medical approach, and having a protected caseload of 10 clients per team member. This service model emerged, in all three countries, as the key element of care for dually diagnosed clients, including those with complex needs.

- In Canada, there are two excellent models of residential dual diagnosis treatment for Indigenous Youth aged from 7-18. These were Ranch Ehrlo Society at Pilot Butte, near Regina SK and Eagle Moon and Lone Pipe Lodges, part of Woods Homes, at Calgary, AB.

- In Washington DC at Community Connections, Dr Richard Bebaut has a supported housing program for homeless people with dual diagnosis. In Harlem, NY City, Dr Sam Tsemberis of Pathways to Housing has another model which has been evaluated to show its effectiveness in breaking the cycle of homelessness.

Dissemination of this information will be by links with non-Government agencies and ongoing advocacy with State and Federal Governments.

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PROGRAM

Visits to Dual Diagnosis facilities and to experts in the field at:

Vancouver BC	*Vancouver Community Mental Health Services:* Pohsuan Zaide
Nanaimo BC	*Acute Mental Health Services:* Robert Haubrich, Norma Winsper, Lori Mets
Guelph ON	*Homewood Health Centre*: Burns McLeod
Toronto ON	*Centre For Addiction and Mental Health:* Brian Rush and Wayne Skinner *Salvation Army Harbour Light* (addictions): Paul Casola *Canadian Mental Health Association:* Steve Lurie and team, Bonnie Pape *Ontario Peer Development Initiative:* Julie Flatt *St Stephen's Community House*: Gael Gilbert
London ON	*London Psychiatric Hospital*: Larry Lalone
Calgary AB	*Woods Home:* Teri Basi *Eagle Moon/Lone Pipe Lodge:* Jamie Adam
Regina SK	*Westview, Phoenix Residential Society, Dual Diagnosis Apartment Complex:* Carole Eaton, Alecia Weinheimer
Pilot Butte SK	*Ranch Ehrlo Society:* David Rivers, Geoff Pawson and Staff
Chicago IL	*Thresholds: Rowan Trees:* Samantha Handley and Staff *Thresholds: Grais Apartments:* Tim Devlin and Staff *Thresholds Bridge North:* Peggy Flaherty, Sam Guardino *Deborah's Place:* Patty Zuccarello, Kerry Frank
Boston Mass	*Vinfen Corp:* Tony Zipple (now at Thresholds, Chicago), Chuck Tuplin, Tom Cathcart, *Harbour Inn, Webster House, Winston Road, Dorchester Bay Recovery Centre: Mark Weaver, Elliot Square, Roxbury:* Randy Rice
Lawrence Mass	*Jackson House:* Beverley Milligan, Joe Flynn, Mary Thompson
Cambridge Mass	*Westbridge:* John Ahman, Deidre Petersen
Manchester NH	*Westbridge:* John Ahman, Mary Woods *The Mental Health Center of Greater Manchester:* Patricia Carty, Jean Fortier *Gemini House, Dual Diagnosis Residential Facility:* Jessica Lachance

Lebanon NH	*New Hampshire-Dartmouth Psychiatric Research Center:* Dr Robert Drake, Dr Greg McHugo, Dr Will Torrens, Molly Finnerty, MD, Director of Evidence Based Medicine and Clinical Guidelines, State of New York, Karen Dunn, Secretary *West Central Behavioural Health:* David Pelletier
Burlington VT	*Howard Center for Human Services:* Craig Volatile-Wood *Supported housing: Safe Haven, Arroway and Seventy Two, Branches, Shelter Plus Care, Lakeview, The Next Door, Monroe Place, Allen House and St Paul:* Liz Mickenberg
Montpelier VT	*Washington County Mental Health Services:* Michael Hartman CRD Community Resource Development and Rehabilitation, Laurie Pontbriand, Bill Fogginger-Aver *Single Steps, a DBT Residential Facility:* Sue Swindell, Jeanette Bacevius, DBT residential counsellor *7 St Paul Street, Dual Diagnosis House:* Donna Dallett *Home Intervention: Rural Crisis Residential Service:* Michael Hartman
Washington DC	*Community Connections:* Dr Richard Bebaut *National Center for Trauma Recovery and Empowerment:* Dr Maxine Harris
New York	*Pathways to Housing*: Dr Sam Tsemberis *Encore Community Services:* Elizabeth Hassett OP
Montreal QC	*Centre Dollard Cormier:* Line Boudreau, Violaine Lalemend, Henriette Beauvilliers *Clinique Cornier Lafontaine:* Danielle Duhamel *Clinique Jeune Adultes:* Stephane Rivard, Ginette Comptois *Centre Dollard Cormier, 231 rue Ontario Est:* Francine Cote
London	*Camden and Islington Mental Health:* Claire Lynch, Campbell McNeill *Institute of Psychiatry, Denmark Hill:* Liz Bruin
Southend/Rochford Essex	*Roche Unit Dual Diagnosis Services:* Marie Henderson
Birmingham	*COMPASS Program Edbaston:* Michael Preece (Dual Diagnosis nurse)
Manchester	*Manchester Mental Health and Social Care Trust:* Mark Holland (specialist dual diagnosis nurse and trainer)

MAIN BODY OF STUDY

SECTION 1 - NATIONAL GUIDELINES REGARDING DUAL DIAGNOSIS

- USA: SAMHSA (the Federal Substance Abuse and Mental Health Services Administration) Report to Congress on Dual Diagnosis 2002.
  US Department of Health and Human Services Guidelines: TIPS (Treatment Improvement Protocols).
  Consultancy support and processes to assist system integration at State and other levels.

- UK: Best Practice Guidelines
  Methods of Implementation: The Pan London Dual Diagnosis Dissemination Project
  Manchester: A Managed Practice Network of Service Provision

- Canada: Best Practice Guidelines
  National Program Inventory

SECTION 2 – RESEARCH HISTORY AND EVIDENCE BASED PRACTICE

- New Hampshire-Dartmouth Psychiatric Research Centre: 20 years of research.

- Development and multi-site, long term evaluation of evidence based practice.

- The Toolkit: Co-Occurring Disorders Integrated Dual Disorders Treatment: Implementation Resource Kit.

SECTION 3 – DUAL DIAGNOSIS PROGRAMS

- Manchester NH: The Centre for Mental Health of Greater Manchester: Gemini Continuous Treatment Team and Gemini House Residential Program.

- Cambridge Mass and Manchester NH: Westbridge, Residential and Outreach Services.

- Montpelier VT, Washington County Mental Health Services: Residential Program and outpatient treatment.

- Burlington, VT, Howard Centre for Human Services: Forensic Outpatient Co-Occurring Disorders Treatment Program.

- Chicago: Thresholds, Rowan Trees Residential Dual Diagnosis (MISA) Program.
  Thresholds, Grais Apartments Residential Dual Diagnosis (MISA) Program.

- East Vancouver: BC Outpatient Dual Diagnosis Program with a Supported Housing Component.

- Nanaimo, BC Acute Mental Health Services, Concurrent Disorders Demonstration Project: Assertive, long term outreach treatment to clients with complex, multiple disorders, with an emphasis on harm reduction.

- Regina, SK, Westview Dual Diagnosis Program, Phoenix Residential Society

- Boston: Vinfen Corporation. Dual Diagnosis Programs at 12 sites:
  Winston Road (Residential Group Home),
  Harbour Inn (Residential Forensic Program),
  Jackson House at Lawrence, Mass (High Intensity Residential Program),
  Dorchester Bay Recovery Centre (attached to eight supported housing apartments),
  Elliot Square, Roxbury, a day program attached to 11 group homes and a supported housing development.

- Birmingham, UK, COMPASS Program.

- South Essex, Mental Health and Community Care, Dual Diagnosis Program at the Roche Unit, Southend/Rochford. Outreach with supported housing in two group homes.

- Montreal, QC: Centre Dollard Cormier an integrated continuous network of addiction services with a dual diagnosis component. This includes adult and youth inpatient services.
  Clinique Cormier Lafontaine, third line comorbidity outpatient services
  Clinique Jeunes Adultes: specialised outpatient psychiatric services for young people with schizophrenia, many of whom have dual diagnosis. This includes a specialised hight school

SECTION 4 – DUAL DIAGNOSIS PROGRAM FOR INDIGENOUS YOUTH

- Pilot Butte, SK Ranch Ehrlo Society: Residential Program

- Calgary: Woods Homes: Eagle Moon Lodge and Lone Pipe Lodge; Residential Programs.

SECTION 5 – TREATMENT FOR PERSONALITY DISORDER: DBT (DIALECTICAL BEHAVIOUR THERAPY)

- Manchester, NH, the Mental Health Centre of Greater Manchester: Outpatient Services.

- Montpelier, VT, Washington County Mental Health Services: Residential Group Home based on DBT Principles: Single Steps.

- Montreal, QC, Clinique Cormier Lafontaine, Outpatient Services

SECTION 6 – TRAUMA TREATMENT

- Washington, DC, National Capital Centre for Trauma Recovery and Empowerment.

SECTION 7 – ASSISTING HOMELESS PEOPLE WHO HAVE DUAL DIAGNOSIS

- Washington DC, Community Connections
- New York, Pathways to Housing
- Boston, Safe Haven Project

APPENDIX

1. DIRECT SERVICES TO THE HOMELESS
Montreal, Centre Dollard Cormier
New York, Encore Community Services
Chicago, Deborah's Place

2. RURAL SERVICES
Montpelier, VT Washington County Mental Health Services: Home Intervention Program

3. SUPPORTED HOUSING FOR PEOPLE WITH MENTAL ILLNESS
Burlington, VT Howard Human Services

4. HOUSING FOR PEOPLE RECOVERING FROM ADDICTION
USA: Oxford House Movement

INTRODUCTION

THE ISSUE OF DUAL DIAGNOSIS AND THE FATE OF SUFFERERS

In New South Wales, in 2003, mood altering substance are more widespread in their availability and effects. When personal, family and social difficulties arise, and particularly when serious mental illness is involved, one common way to make the situation worse is to increase the use of alcohol or take illicit drugs. Use may become abuse and may lead to serious addiction.

People who are doubly disabled in this way, are poorly served, tend to *fall through the cracks* of our mental health and drug and alcohol services. They are often shuttled back and forth between services which take responsibility for treatment of only half the condition. Drug and alcohol services often refuse to treat people who have been prescribed psychotropic medication. Mental health services address only the mental illness component of the condition. Hospitalisation is short term. There is little provision in our mental health system for adequate rehabilitation. These people are brutalised in the process of trying to live in the community (1) and are poorly cared for in the institutional settings of hospital and jail.

The community is also poorly served in its better aims of being a compassionate, civil society. People with such multiple disabilities are often uncomfortable neighbours, lacking the skills needed to sustain tenancy, maintain a healthy lifestyle and be integrated into the community. Many people with dual diagnosis are to be found on the streets, in homeless shelters and in jails, often unknown to mental health services.

There are two basic groups:

- Those with low prevalence psychiatric illnesses who suffer from schizophrenia, bi-polar disorder and major depression. However, it will usually apply mainly to schizophrenia and its variations of schizoaffective disorders. These people often self-medicate with alcohol and drugs in an attempt to lessen the distressing symptoms of their illness, for instance, to clear their minds or stop the voices. They are the most vulnerable group and the least able to find help for their condition. These people often lack the living skills to sustain tenancy and live independently in the community. Little can be done for this group if they do not have stable accommodation.

- Those with high prevalence conditions such as personality disorders: borderline, antisocial, narcissistic and anxiety based conditions along with co-existing substance abuse disorders. This may involve alcohol, marijuana, amphetamines, cocaine, heroin, crack ecstasy or a cocktail of these.

  Some members of this second group cause the most problems in charitable hostels, homeless shelters, psychiatric units, emergency departments, in jail and on the streets. They may become acutely disturbed and extremely violent. They may be scheduled as mentally disordered. As such, they can be hospitalised for three days, three times, maximum. May of these people are acutely suicidal, or develop toxic psychosis. Their behaviour demands secure accommodation and medication given with care because of poor physical health and uncertain background of intoxication. These are the people who

cause havoc in general psychiatric units, where they often share the unit with aged patients and young people with mental health problems. They are a danger to these people and to staff. The havoc continues on discharge. They still have their extreme personality disorders and addictions and have few places to go. Since they do not have a serious mental illness, they cannot be put on a community treatment order. They regress and often end up in jail.

MAIN BODY OF STUDY

FINDINGS OF VISITS TO DUAL DIAGNOSIS FACILITIES IN CANADA, UNITED STATES OF AMERICA AND ENGLAND

Dual diagnosis should regarded as the norm, rather than the exception. A recent study showed that 68% of our clients who have mental illness also abuse drugs and alcohol.

This comment by a clinician at Camden and Islington Mental Health Centre in London reflects trends observed in the three countries visited in the course of this research: Canada, USA and England.

The fact that dual diagnosis or co-occurring disorders is a major social problem is reflected in National level documentation issued by all three Governments.

SECTION 1

NATIONAL GUIDELINES REGARDING DUAL DIAGNOSIS

USA: SAMHSA

SAMHSA; the Substance Abuse and Mental Health Services Administration in USA, issued a report to Congress in 2002 (2). An early statement in the report agrees with the quote from England: *41% to 65% of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental health disorder.* In the USA this means that seven to ten million people are in this category. 43% of youth receiving mental health services in the USA have been diagnosed with a co-occurring disorder. Among adults with serious mental illness (SMI), 20% were dependent on or abused drugs and alcohol. According to a 2001 survey, an estimated three million adults had both SMI and substance abuse disorders. The report notes that they have particular difficulty finding and receiving diagnostic and treatment services. Too often, because of the two separate service systems, individuals bounce back and forth between the two, receiving treatment for the co-occurring disorders serially, at best.

If one of the disorders goes untreated, both usually get worse and additional complications arise, such as serious medical problems: HIV, hepatitis B and C, cardiac and pulmonary diseases, as well as unemployment, suicide, homelessness, criminalisation, and separation from families and community. High cost services are required such as inpatient and emergency room care.

However, evidence-based service models exist, including recovery oriented integrated treatment for mental illness and substance abuse within coordinated and organised systems and treatment settings. With training and other supports, the report notes, primary care services will be well prepared to undertake diagnosis and treatment of the interrelated disorders. SAMHSA defines integrated treatment as *any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting*.

SAMHSA agrees with the comment of the Camden and Islington clinician that individuals with co-occurring disorders should be the expectation not the exception in the substance abuse and mental health treatment systems. Many researchers and clinicians believe that both disorders must be addressed as primary and treated as such.

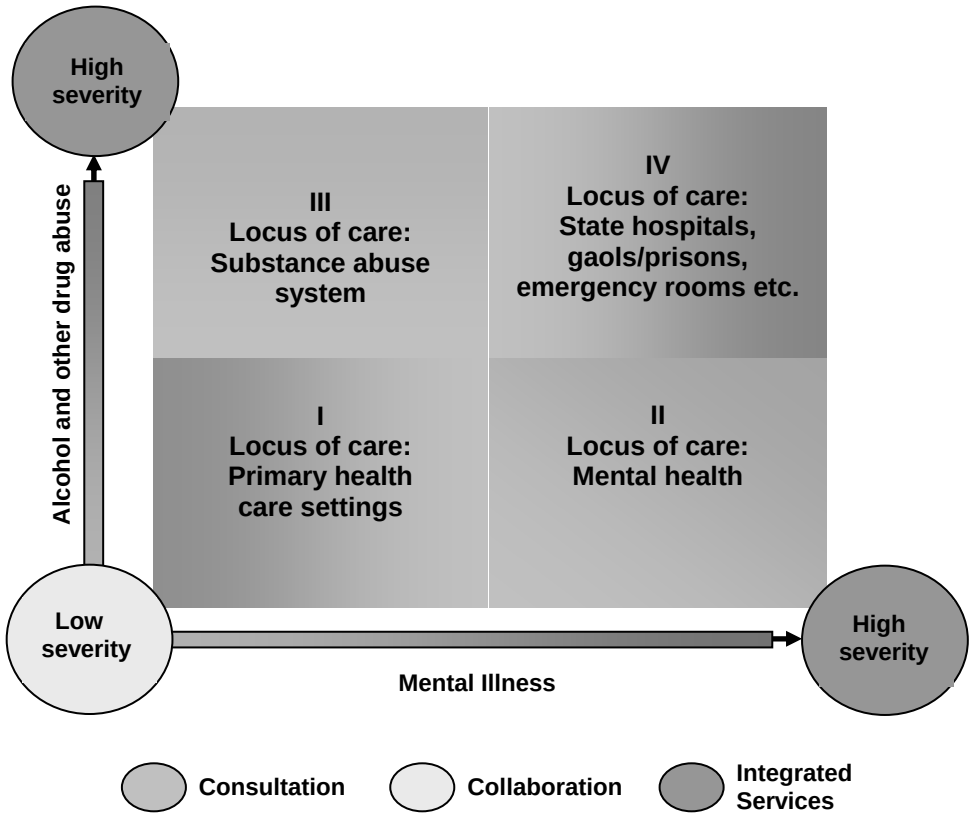
Barriers to effective treatment include the very different structures of the mental health and substance abuse treatment systems. They differ markedly with respect to staffing, resources, philosophy of treatment, regulations, training and credentials of staff, treatment approaches, assertive community outreach capabilities and routine types of evaluations and testing procedures performed. To receive needed treatment, individuals with co-occurring disorders must negotiate separate systems which are not always best able to meet the full range of their needs. Insufficient co-ordination means that services are often fragmented, isolated and rigid.

Current systems change approaches may lead to an integration of service delivery. This ranges across a continuum spanning single cross referral and linkage; through cooperation, treatment is provided through three levels of service provision:

- Integrated treatment
- Integrated programs
- Integrated system

To provide a *common language* between the two systems, a co-occurring disorders conceptual framework was developed. This provides a mechanism in addressing symptom severity and level of service. It also specifies the level of service coordination needed by people in each of the quadrants. The greater the severity, the more intense the level of coordination required.

Service Coordination by Severity



The framework provides a mechanism in addressing symptom severity and level of service

Evidence based treatment interventions

These are interventions that respond to an individual's stage of recovery and motivation to change, that focus on building a therapeutic relationship, and that offer services for needs such as housing and work. Such interventions have been found to have a greater effectiveness (Drake et al 2001) (3). These are integrated clinical and psychosocial treatment interventions are being tried in a range of settings.

Because of the gap between what research shows to be effective and what is practiced in the clinical setting, SAMHSA has an initiative. Implementing Evidence-Based Practices for Severe Mental Illness Project is developing toolkits to promote the delivery of effective practices at State and local levels.

During my visits to Westbridge at Cambridge Mass and at Manchester NH, in June, I saw the draft version of the toolkit *Co-occurring Disorders: Integrated Dual Disorders Treatment* developed by the Dartmouth-Hitchcock team, led by Dr Robert Drake.

While visiting Dartmouth-Hitchcock Research Centre in Lebanon NH, soon after, I was able to appeal from there to SAMHSA in Washington for a copy to bring back. I was allowed to do so on condition that it was a Dartmouth copy and seen to be in draft form. It is designed to be a resource for consumers, family members, practitioners, program leaders and mental health authorities. These resources assist in the delivery of evidence-based, integrated treatment for people with dual diagnosis. This is one of a series of six toolkits which will be available through SAMHSA in the near future.

National Summit on Co-Occurring Disorders

SAMHSA indicates that it has a key Federal role in moving evidence-based and other effective practices into the field. It will take the lead in bringing together researchers, clinicians and other specialists in a National Summit to share practices, and lessons learned in areas such as prevention, the adoption of evidence-based practices, funding and service system changes.

System Change

System wide responses are needed to meet the needs of people of all ages who have co-occurring disorders. However, there are difficult and long standing barriers to the integration of mental health and substance abuse treatment. The most significant of these are inadequate funding for both systems and lack of staff trained in co-occurring disorders treatment.

System-level Integrated Service Delivery

SAMHSA notes that an increasing number of States and communities are initiating system level changes and developing innovative programs. Such States or communities build consensus around the need for integrated response, develop aggregated financing mechanisms, cross-train staff and measure achievements in improvement in client functioning and quality of life. Some innovative State practices are highlighted in a recent report NASMHPD/NASADAD, 2002. Some shared qualities of such innovative programs were:

- A shared vision and set of expectations with respect to co-occurring disorders treatment.
- All featured comprehensive service systems capable of responding to most or all of the clients' needs.
- Staff *expected* clients to present with a full range of co-occurring symptoms and disorders and screened them for related conditions, including HIV/Aids, physical and/or sexual abuse, brain disorders, physical disabilities etc.
- Staff were cross trained in both mental health and substance abuse disciplines. However, they did not work outside their own field of expertise. They delivered care as part of a multi-disciplinary team that shared responsibility and was culturally appropriate.

- Services were client centred. Staff engaged with clients who were at various stages of acceptance and recovery.

SAMHSA's Five Year Blueprint for Action

Over the next five years, SAMHSA will take the lead in helping States, tribes and communities promote accountability, capacity, and effectiveness in prevention, early identification, and intervention and treatment for co-occurring substance abuse disorders and mental disorders.

Among a range of **strategies** to achieve this will be:

- Helping move evidence-based practices to the field.
- Supporting a new State Incentive Grant for Co-occurring Disorders to help enhance States' supporting infrastructure and treatment system capacity.
- Ensuring development of a workforce educated and trained to address co-occurring disorders. To this end, a National Co-occurring Disorders prevention and Treatment Technical Assistance and Cross-Training Centre is planned for this year (2003). This will, on a national scale, develop, coordinate, and provide cross training to mental health, substance abuse, education, homeless, criminal justice and primary care providers.
- Supporting State to State peer technical assistance by States that have implemented recognised, statewide, system-level change for co-occurring disorders.
- Convene a National Summit on Co-occurring Disorders.

SAMHSA's Overall Goal

To improve outcomes for individuals of all ages who are at risk for or who have a full range of co-occurring disorders. This means addressing alcohol, tobacco, and other drugs and a wide range of mental disorders, in both the substance abuse and mental health treatment systems. This will happen by improving access and an initial evaluation at any door *any door is the right door*. SAMHSA will promote the development of seamless systems of prevention, early identification and intervention, treatment and follow-up care.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES GUIDELINES

A series of manuals have been prepared and disseminated by the Centre for Substance Abuse Treatment (CSAT) called TIPS or Treatment Improvement Protocols. One such manual called Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug abuse (4). Starting from the perspective of a drug and alcohol treatment service, this provides practical information about the treatment of patients with dual disorders, including those with mood and anxiety disorders, personality disorders and psychotic disorders.

CONSULTANCY SUPPORT AND PROCESSES TO ASSIST SYSTEM INTEGRATION AT STATE LEVEL

Kenneth Minkoff MD, based in Washington, is one of the USA's leading experts on integrated treatment of individuals with co-occurring disorders, or dual diagnosis, and on the development of integrated systems of care. This is done through the implementation of a national consensus best practice model for systems design: the Comprehensive Continuous Integrated System of Care (CCISC) (5). This was referenced in SAMHSA's report.

Comprehensive Continuous Integrated System of Care has the following characteristics:

- System level change so that CCISC is implemented throughout an entire system of care.
- Efficient use of existing resources. It requires additional resources only for planning, technical assistance and training.
- Incorporation of Best Practices. It is recognised by SAMHSA as a best practice for systems implementation for treatment of dual diagnosis.
- Integrated treatment philosophy.

Guiding Principles:

- Dual diagnosis is an expectation, not an exception.
- All individuals with dual diagnosis are not the same: the Four quadrant model (Quoted in the SAMHSA report) can be used for service planning.
- Empathic, hopeful, integrated treatment relationships are key to treatment success. Continuous integrated treatment relationships is an evidence based best practice for people with the most severe forms of psychiatric and substance difficulties.
- Case management and care must be balanced with empathic detachment, expectation, contracting, consequences and contingent learning.
- When psychiatric and substance disorders co-exist, both disorders must be considered primary and integrated primary dual (or multiple) primary diagnosis-specific treatment is recommended.
- Both mental illness and addiction can be treated within the philosophical framework of a *disease and recovery model* (Minkoff 1989). Stages of change and the value of stagewise treatment has been emphasised in the literature from both fields.
- Interventions and clinical outcomes must be individualised.

IMPLEMENTATION OF CCISC

Minkoff (2001) has described the 12 Step Program for Implementation of a CCISC and in collaboration with Christie Cline MD, has organised a **CCISC Implementation Toolkit** to promote successful implementation. Implementation of the CCISC takes place incrementally in complex systems over a period of years as the following elements are established:

- Integrated system planning process.
- Formal consensus on the CCISC model.
- Formal consensus on funding the CCISC model.
- Identification of priority populations and locus of responsibility for each.
- Development and implementation of program standards.
- Structures for intersystem and interprogram care coordination.
- Development and implementation of practice guidelines.
- Facilitation of identification. Welcoming and accessibility.
- Implementation of continuous, integrated treatment.
- Development of basic dual diagnosis capable competencies for all clinicians.
- Implementation of a system wide training plan.
- Development of a plan for a comprehensive program array.

Four important areas that must be addressed in each CCISC are:

- Evidence based best practice.
- Peer dual recovery supports; the system must identify at least one dual recovery self-help program (eg Dual Recovery anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.
- Residential supports and services. The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs including:
    - DDC/DDE addiction residential treatment (eg modified therapeutic community programs).
    - Abstinence-mandated (dry) supported for housing for individuals with psychiatric disabilities.
    - Abstinence encouraged (damp) supported housing for individuals with psychiatric disabilities.
    - Consumer-choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness.
- Continuum of levels of care.

- All categories of service for people with dual diagnosis should be available in a range of levels of care, including outpatient services of various levels of intensity, intensive outpatient or day treatment, residential treatment and hospitalisation.

CCISC implementation requires a plan which includes attention to each of these areas in a comprehensive service array.

Ken Minkoff MD and Christie Cline MD (Director of Behavioural Health Services for New Mexico) have formed a consultancy called Zialogic. They have written a technical assistance document: *A Strength-based Systems Approach to Creating Integrated Services for Individuals with Co-occurring Psychiatric and Substance Use Disorders* (Dec 2002)(6).

Dr Minkoff and/or Dr Cline have provided or are currently providing consultation for CCISC implementation in fifteen US States and three Canadian Provinces.

During my visit to Washington County Mental Health Services, in Montpelier, Vermont, in June, I attended a full staff seminar, led by a senior member, at which the results of a survey of program competencies was fed back to the group for discussion. The time line for further action was revealed. Vermont is one of the States which is working with Ken Minkoff to bring about systems integration.

UK BEST PRACTICE GUIDELINES

This document *Mental Health Policy Implementation Guide* (7)reiterates the fact that substance misuse is usual rather than exceptional among people with severe mental health problems. Individuals with dual diagnosis should receive high quality, patient focused and integrated care.

In a process called *mainstreaming* this care should be delivered within mental health services. Patients should not be shunted between different sets of services or put at risk of dropping out of care completely.

Mainstreaming requires the following to be effective:

- Local services must define dual diagnosis in a way that reflects local patterns and identifies the target group.
- Relevant agencies must agree on this definition.
- Specialist teams of dual diagnosis workers should support local mental health services.
- All staff in assertive outreach teams must be trained and equipped to work with dual diagnosis.
- Adequate numbers of staff in crisis resolution, early intervention, community mental health teams and inpatient services must also be suitably trained.
- All health and social care economies must map services and need.

- All services must ensure that clients with severe mental health problems and substance misuse are subject to the Care Program approach and have a full risk assessment.

Integrated care, delivered by one team, appears to deliver better outcomes that serial care (sequential referrals to different services) or parallel care (more than one service engaging the client at the same time).

There is seen to be a need for more UK based research.

It is considered that well organised parallel care can be used as a stepping stone to integration. Integrated treatment, in UK, can be delivered by existing mental health services following training and support from substance misuse services.

The Policy in Practice

- Most of the activity will be in secondary care.

- There are specialist dual diagnosis teams where there is high morbidity and a special commitment to this issue. These teams are seen as needing to offer outreach and consultancy in order to support local mental health teams.

- In areas where comorbidity is at or below an average level, assertive outreach teams will have the greatest level of contact with the target group, while inpatient, crisis resolution, early intervention and generic community services will have significant contact.

The standard model will be to mainstream people with dual diagnosis so that:

- All staff in assertive outreach teams are trained and equipped to work with people with dual diagnosis, with appropriate support and professional supervision.

- Adequate numbers of staff in the other teams and settings mentioned are similarly trained and equipped and can be readily identified by other staff as such. All staff need some basic knowledge of substance misuse issues to allow them to make appropriate referrals or seek help when required.

- One or more staff in such services become specialists in dual diagnosis. Service level agreements are set up with drug and alcohol services to ensure appropriate skills and knowledge are available.

Implementation of this Policy in UK

The Pan London Dual diagnosis Dissemination Project

Liz Bruin, from the Institute of Psychiatry in Denmark Hill, London, has prepared a treatment manual designed to be used in the training of mental health staff in the treatment of people with dual diagnosis (8).

I visited Camden and Islington Mental Health and Social Care Trust in Central London and participated in one of the six days of the training program. The course was run by Claire Lynch, a dual diagnosis nurse specialist. I joined the 12 people already in the group. They were from inpatient mental health wards in local hospitals. The members of the nine community mental health teams in the area had already done the training. Though five teams had two specialist dual diagnosis workers, it seems important to train the whole team in basic issues. They are now training every qualified member of staff on the wards and will train staff of residential services and charitable workers. There is a constant need to train new staff. Long term support and help with dual diagnosis assessment is also provided. The team also runs groups for patients on each ward. A Workbook and Therapist's manual (9) have been developed by Camden and Islington for use in these training programs.

Campbell McNeill, another specialist dual diagnosis nurse, visits each ward once a week and talks to staff about new clients. He assesses the new clients and feeds back the outcome to staff. He works with the client on the ward in conjunction with the primary nurse and links with the drug teams.

Manchester:

In Manchester, I accompanied Mark Holland, a specialist dual diagnosis nurse, as he visited mental health wards and met with groups of nursing staff to go through the Mental Health Policy Implementation Guide. He was following the pathway laid down in a Manchester document, which he co-authored *Co-morbid Mental Illness and Substance Misuse. A Managed Practice Network of Service provision* (10).

We visited four wards and Mark engaged staff in discussion of problems they encounter with the use of drugs and alcohol on the wards. He also showed them a drug identification kit, one of which was left on each ward. There was discussion of legal issues relating to search of patients or visitors, and exclusion of visitors thought to be drug couriers.

We went to a group home for people with mental illness and met with staff. They believed the problem of drug use was less there because of the constant interactions with residential clients.

I accompanied him to a meeting of senior management of the hospital, to discuss issues related to security, detection of drugs being brought into the facility. Mark referred to the policy issued by Manchester Mental Health (11).

The final meeting was with the medical support group, comprised of psychiatrists and a drug and alcohol specialist. Discussion related to educating psychiatrists, GP's and hospital medical staff in the dual diagnosis policy and its implementation.

CANADA: Best Practice Guidelines

In Toronto, **the Centre for Addiction and Mental Health** is the focal point of many new developments in the field of dual diagnosis throughout Canada. Set up in 1998 through the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute, and the Queen Street Mental Health Centre, it is a public hospital which provides direct patient care for people with mental health and addiction problems. The Centre is

also a research facility, an education and training institute, and a community based organisation that provides health promotion, prevention and treatment system planning services across Ontario. It operates central clinical and research facilities in Toronto, and its influence extends throughout the province. The Centre has consultants in 12 community offices and 16 satellite locations across the province who support local communities in health promotion, prevention and treatment system planning efforts in mental health and addictions. The Centre also works with government to influence public policy and resource development processes to ensure that it promotes health and works towards eliminating the stigma associated with mental illness and addiction.

In 2001, the Centre published two documents:

- Best Practices: Concurrent Mental Health and Substance Use Disorders (12)
- National Program Inventory: Concurrent Mental Health and Substance Uses Disorders (13)

In defining integrated treatment in the Best Practice document, it distinguishes between program integration and system integration.

Program Integration: mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, in the same program, to ensure the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.

System Integration: the development of enduring linkages between service providers or treatment units within a system or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore brought together by two or more clinicians/support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan.

All this needs to be done within *a broader psychosocial perspective.* An increased awareness of the need for psychosocial rehabilitation leads to advocacy for supporting the person in a wide variety of areas including housing, budgeting, cooking, cleaning, hygiene, medication management, employment, recreation, and social networks.

What is needed is *integrated treatment and support.*

The aim of the project was to identify best practices related to concurrent mental health and substance use disorders. The project was initiated by Health Canada as part of the research agenda developed by the Federal/Provincial/Territorial Committee on alcohol and other drug issues.

The mandate of the working group for this project was to oversee the development and implementation of research studies that contribute to innovative substance abuse treatment and rehabilitation programs by identifying best practices, evaluating model treatment and

rehabilitation programs, and identifying emerging issues. The knowledge was then disseminated across the country.

Prior to this study, most of the provinces had sponsored work leading to specific policy and program recommendations. Among them were:

- A Quebec government committee on drugs placed comorbidity as a priority in both 1996 and 1997. In consultations held across Quebec in 1995 and 2000, concerns were expressed about concurrent disorders within all age groups.
- In Ontario, individuals with concurrent disorders have been identified as a priority population by both addictions and mental health service delivery systems.
- An Inter-Ministry Task Force in British Columbia was formed to investigate how to improve services for individuals who have a severe mental illness and a substance use disorder.

Rationale for Best Practice Guidelines

- The prevalence of comorbidity is high in the general and treatment seeking populations and has largely been ignored in planning, implementing and evaluating both mental health and addiction services.
- The high variability in prevalence rates across studies results from studying different sub-groups of people in different settings with different methods.
- Comorbidity changes the course, cost and outcome of care and presents significant challenges for screening, assessment, treatment/support and outcome monitoring.
- Substance abuse and mental health services in the community have typically worked in isolation, and often from competing perspective.

The document then outlines:

Best Practice for Concurrent Disorders at the Service Delivery level

- Best practice in screening for substance use and mental health disorders.
- Best practice in the assessment of people with concurrent disorders.
- Best practice for the treatment of people with concurrent disorders.
    - Co-occurring substance abuse and mood and anxiety disorders.
    - Co-occurring substance abuse and severe and persistent mental illness.
    - Co-occurring substance abuse and personality disorders.

- Co-occurring substance abuse and eating disorders.

Implications of Best Practice Guidelines at the System Level

- Historical perspective and current practice.
- The consumer's experience and perspective.
- Service providers and planner perspectives.
- Mechanisms and models for system level integration for concurrent disorders.

Implications for Research

In Appendix 1 is shown the Dual Disorders Integrated Treatment Fidelity Scale from Meuser et al 2003, *Integrated Treatment for Dual Diagnosis; a Guide to Effective Practice* (13)

Federal Support for Best Practice

In 1997, as part of the Best Practices in Mental Health Reform discussion paper, the question of how to promote the implementation of best practices across entire systems of care was addressed. Some models of excellence in service delivery were presented. One such was the Dual Diagnosis Westview Program in Regina, Saskatchewan. This will be outlined later in this report, following my visit there in May 2003.

NATIONAL PROGRAM INVENTORY

A companion volume to the Best Practice Guide, it was also issued in 2001. It lists all dual diagnosis programs in Canada. For each service is provided:

- Name, address, phone and fax numbers, and some e-mail addresses.
- Contact person.
- Geographical area served.
- Services provided under these headings with Yes/No answers:
  - Case management
  - Outpatient
  - Residential
  - Withdrawal management
  - Day/evening treatment
  - Supportive housing

- Other

❖ Treatment interventions

❖ Fee for service

❖ Inclusion criteria for service

❖ Exclusion criteria for service

There are 37 programs listed.

They are based in the Provinces of British Columbia, Ontario, Quebec, Alberta and Saskatchewan.

In February 2003, the final report on the concurrent Disorders System Models project was released. *Increasing Linkages between Addiction and Mental Health Services in Ontario* by Kim Calderwood and Richard Christie (14) from the Centre for Addiction and Mental Health is the result of a community development process to develop, implement and sustain a model of co-ordination among addiction and mental health services in two counties in Ontario.

Key Learnings about Model Components:

- The two most successful components of the models were training by front line workers and support groups for people with concurrent disorders (a life skills group co-led by an addiction and a mental health worker and a self-help group: Double Trouble).

- Networks among workers were considered useful for increasing communication between services and exploring opportunities to pool resources.

- A mental health and addiction web site was considered useful for those who had visited it, but many did not have Internet access.

- Service agreements led to positive relationship - building but were not implemented to the extent intended.

- Consumers were wary of increased communication among workers as they felt it might compromise confidentiality and client choice.

- Mechanisms for identifying concurrent disorders and client overlap between the mental health and addiction systems were lacking.

In Toronto, Dr Brian Rush, one of the co-authors of the reports, said that momentum for better system integration for dual diagnosis was building. Canadian mental health authorities were aware of SAMHSA's report to the US Congress.

Dr Wayne Skinner, also from the Centre for Addiction and Mental Health, commented that the rates of concurrent disorders do not allow for minimisation. They can be threatened by the

complexity and miss the roundedness of peoples' problems. Instead of just adding addictions to mental health, look at all the issues: housing, income support etc. Get workers outside the therapeutic framework so they look at issues more widely. They are excluded populations. People who are homeless don't keep the rules and regulations. They will not present at a clinic for an appointment. Even community care in an office environment cuts people out. Threshold requirements are too high and we may miss the neediest group. A recent report on homelessness found that 30% had concurrent disorders, 21% had addiction issues and 19% had severe mental illness. He believed that the approach taken in Arizona, where programs were integrated, was the way to go. Change at a government level, with policy, funding, and integration, within and between programs. There are two clear areas of need: more Assertive Community Treatment teams, with a maximum of 10 per caseload, who can assist clients in a range of life issues. The issue of harm reduction needs to be addressed. Some people cannot and will not meet requirements of abstinence. For instance, there need to be "damp" houses where people can drink outside the house, as well as "dry" houses.

SECTION 2

RESEARCH HISTORY AND EVIDENCE BASED PRACTICE

T**he New Hampshire-Dartmouth Psychiatric Research Center in Lebanon, NH** is the focal point of most research into dual diagnosis and has been a leader in developing evidence-based treatment. Dr Robert Drake has been leading research in this field for at least 15 years and has published extensively throughout that period. He leads a highly respected research team, all of whom have collaborated with him and each other in researching aspects of dual diagnosis and many other areas of psychiatry.

It emerges that, after 20 years of development and research, dual diagnosis services for clients with severe mental illness are emerging as evidence-based practice. Effective dual diagnosis programs combine mental health and substance abuse interventions that are tailored for the complex needs of clients with co-morbid disorders. Drake et al 2002 (3).

The *critical components of effective programs* are:

- A comprehensive, long-term, staged approach to recovery.
- Assertive outreach.
- Motivational interventions.
- Provision of help to clients in acquiring skills and supports to manage both illnesses and to pursue functional goals.
- Cultural sensitivity and competence.

Barriers to Implementation

- **Policy barriers**: Policy relating to organisational structure, financing, regulations and licensing in USA often militate against the functional integration of mental health and substance abuse systems.

- **Program barriers**: At local levels often lack the clear service models, administrative guidelines, contractual incentives, quality assurance procedures, and outcome measures needed to implement dual diagnosis services.

- **Clinical barriers:** Clinicians hold the beliefs of both the mental health and substance abuse traditions. This diminishes the opportunity for cross fertilisation. Educational institutions rarely teach the integrated clinical philosophy and practical approach to treating dual diagnosis clients, even though this had been clearly delineated for more than a decade. Hence mental health clinicians lack training in dual diagnosis treatment and often avoid diagnosing substance abuse, believing it to be irrelevant or they cannot treat it. Clinicians trained in substance abuse treatment, as well as recovering dual diagnosis clients, could add expertise and training, but they are often excluded from jobs in the mental health system.

- **Consumer and Family barriers:** Clients and families rarely have good information about dual diagnosis programs. Few programs offer psychoeducational services. Consumers often deny or minimise substance use, so lack motivation to engage in substance abuse treatment.

- **Implementation Strategies for dual diagnosis clients with severe mental illness**

Policy strategies: Commonly used system level strategies include:

- Building a consensus around the vision for integrated services and then conjointly planning.

- Specifying a model.

- Implementing structural, regulatory, and reimbursement changes.

- Establishing contracting mechanisms.

- Defining standards.

- Funding demonstration programs and training initiatives.

As preliminary step, the mental health authority often assumes responsibility for comprehensive care, including substance abuse treatment, for people with severe mental illness. Substance abuse authorities assist by helping with training and planning. This allows the mental health system to attract and train dual diagnosis specialists who can then train others and advise on programs. **However, without structural, regulatory and funding changes to reinforce the training, the expertise may be lost. This often happens after demonstration projects. Many**

experts advise, therefore, that policy issues should be addressed early in implementation, to avoid wasting efforts on training.

Program Strategies:

- Consensus building activities.
- Staff training and supervision in new skills followed by reinforcement.
- The integration of substance abuse awareness and treatment into all aspects of the mental health program
- Monitoring and reinforcement of these through medical records, quality assurance activities and outcome data.

Key strategies:

- Having a single leader for program change.
- Having fidelity measures for integrated dual diagnosis services.

Clinical Strategies:

Essential knowledge and skills for clinicians:

- Assessing substance abuse.
- Providing motivational interviews for clients who are not ready to participate in abstinence-oriented treatment.
- Providing counselling for those who are motivated to try to maintain abstinence.

The recognition and address of substance abuse in daily interactions by:

- Case Managers.
- Housing Staff.
- Employment specialists.

Those who become dual diagnosis specialists will lead dual diagnosis groups, family interventions, residential programs and other specialised services.

Consumer and Family Level Strategies

Clients and family members need accurate information in order to request information and advocate for system changes. Consumer demand and family advocacy can move the health care system towards evidence based practices. Researchers can help by giving information about the

forms, processes and expected outcomes of evidence based practices. Local programs should provide information about dual diagnosis services to clients and families.

Dr Drake commented that research is now looking at implementation. We think we know programs that work. The question is, what does it take in terms of administration, support, funding and advocacy?

Longitudinal Study of Evidence Based Practices in Dual Diagnosis

This is looking at the progress of 55 mental health programs as they try to implement evidence-based practices. We hope to identify the basic organisational factors that bring about successful implementation. The study began in July 2002 and will continue until 2005.

Each State has a set of monitors. They will interview key stakeholders, observe what is happening, review records in a structured way, evaluate programs using fidelity scales, take note of input data. They will look at strategies and barriers. There is a coding scheme for qualitative data.

Dr Drake emphasised the need to take an organisational approach to dual diagnosis. It involves changing everything you do in mental health, because half the population has dual diagnosis. It affects how you work with every group. Unless your approach is integrated, it won't work. The Toolkit and literature provide some guidance in this.

TOOLKIT: CO-OCCURRING DISORDERS: INTEGRATED DUAL DISORDERS TREATMENT: IMPLEMENTATION RESOURCE KIT (15)

Developed by Dartmouth-New Hampshire Psychiatric Research Centre.

Evidence-Based Practices: Shaping mental health services towards recovery Draft Version 2002 (Issued to me by Dartmouth-New Hampshire, with the permission of SAMHSA, Washington DC).

This kit provides:

- Information for program leaders, mental health authorities, practitioners, consumers, family and supporters.
- Implementation Tips for program leaders
- Tips for mental health authorities on: Use of the Fidelity Scale Organisational Index Client Outcomes.
- Practitioners and Clinical Supervisors Workbook.
- Videotapes of client-practitioner interactions.

This Toolkit is one of a series on evidence-based practices. The series comprises:

- Standardised Pharmacological Treatment

- Illness Management and Recovery Skills
- Supported Employment
- Family Psychoeducation
- Assertive Community Treatment
- Integrated Dual Disorders Treatment

The series will be available from SAMHSA in the near future. These Toolkits are the basis of the long term study of evidence-based practices.

In 2003, a basic resource for Dual Diagnosis practitioners was published. *Integrated Treatment for Dual Disorders: A Guide to Effective Practice by Kim Meuser, Douglas Noordsy, Robert Drake and Lindy Fox*. (16) These are team members at Dartmouth-New Hampshire.

RECOMMENDED EXTRA CONTACTS

During my visit to Lebanon NH in June, I met Dr Drake and discussed the application of research models to the Australian setting, with particular reference to the plight of the homeless people who have dual diagnosis. As well as clarifying aspects of the evidence-based practice models, he recommended two people who had developed models of care this group. They were Sam Tsemberis of Pathways to Housing in Harlem, New York City and Richard Bebaut of Community Connections in Washington DC.

Geoffrey McHugo, from Dartmouth research team, also recommended that I visit Maxine Harris in Washington DC. Dr Harris is a leader in the field of trauma. Since it has been established that most people with dual diagnosis, especially those who are homeless, have suffered extreme trauma, SAMHSA has now included trauma treatment into protocols for treating dual diagnosis.

SECTION 3

DUAL DIAGNOSIS PROGRAMS

Manchester, NH: The Mental Health Centre of Greater Manchester. This is a private, non-profit agency which is mainly funded by mental health contract.

It is a centre of excellence, having won eight major awards in the field of mental health since 1997.

Among these are the 1998 Organisational Achievement Award presented by the National Association of Drug and Alcohol Abuse Counsellors *for innovative approaches to serving people with a dual diagnosis of mental illness and substance abuse***.** It was the first community mental health centre to receive this award.

In 1999, it received the Mental Health Case Management Organisation of the Year Award presented by the National Association of Case Management.

In 1998, it received the Psychiatric Services Gold Achievement Award from the American Psychiatric Association for having a clinically integrated approach to dialectical behavioural therapy for the treatment of persons with a borderline personality disorder.

The community services of the Centre serve 1300 people a year. It currently has 850 clients. It looks after the poorest of the poor, including those who are at risk and susceptible to HIV/AIDS. Because no one wants to pay for poor and sick people, in the ere of managed care, the Centre has begun its own public endowment fund, People contribute, money is invested and the interest raised helps to pay for services affected by cutbacks. The Board, senior leadership, staff, retirees and friends of staff have contributed. There are two annual fundraisers. Staff are not well paid, but are highly committed and motivated.

Gemini Continuous Treatment Team GCIT

Clients: Up to 60 clients diagnosed with severe and persistent mental illness and substance abuse are followed up by GCIT clinical case managers (RB or MA level clinician) and a part-time psychiatrist. Vocational and residential specialists support the team and participate in team meetings.

Assertive community service admission criteria: clients must meet 1-7 and two out of 8-12.

1. Clients must have a substance abuse or dependence diagnosis of at least two years' duration. Current sobriety must be less than six months.

2. Client is diagnosed with a DSM-IV Axis 1 diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder or psychotic disorder.

3. Client must be between the ages of 15 and 59.

4. Client demonstrates a pattern of behaviour which requires community based case management services.

5. Client demonstrates marked functional impairment in one or more of the functional domains: activities of daily living, interpersonal functioning, adaptation to change, concentration, task performance, and pace due to mental illness and substance abuse.

6. Client demonstrates a need for engagement, stabilisation and recovery model services.

7. Client demonstrates a persistent pattern of drug seeking behaviours, which require intensive substance abuse education.

8. Client demonstrates a need for services at the rate of more than two contacts a week.

9. Client demonstrates an inability to develop and maintain a health and sober social support network.

10. Client demonstrates an inability to recognise relapse triggers.

11. Client demonstrates the inability to initiate the relapse prevention plan.

12. Client demonstrates the inability to benefit from Centrewide, after hours Emergency Services response.

Discharge Criteria: client must meet all criteria.

1. Client has been clean and sober for at least one year or has not reached an action stage of treatment after and extended period of time and does not require assertive case management.

2. Client demonstrates the ability to recognise relapse triggers for both illnesses.

3. Client demonstrates the ability to initiate the Relapse Prevention Plan for both illnesses as part of a recovery plan.

4. Client demonstrates none to moderate impairment in one or more of the following domains: activities of daily living, interpersonal functioning, adaptation to change, concentration, task performance and pace.

5. Client demonstrates the ability to engage in healthy and sober alternative community activities.

6. Client demonstrates the ability to maintain stable housing.

7. Client demonstrates the ability to effectively use multiple providers after hours.

Gemini Residential Program: Gemini House

This is a 15 bed modified therapeutic community.

Inclusive criteria:

1. Over age 18 and certified or certifiable as persistently and/or severely mentally ill.

2. A DSM-1V diagnosis on Axis 1 of schizophrenia, schizoaffective disorder, bi polar disorder or other major Axis 1 diagnosis.

3. A DSM - 1V substance related disorder diagnosis (abuse or dependence), excluding nicotine.

4. A less restrictive treatment has been tried and found to be inappropriate or unsuccessful in stabilising the client's condition (Gemini residence only).

5. A pattern of housing instability as evidenced by frequent hospitalisations, homelessness, inability to maintain independent housing, incarceration and/or prior temporary residential placements (Gemini residence only).

Exclusion criteria:

1. Significant organic impairment.

2. Primary diagnosis of personality disorder, without schizophrenia, schizoaffective disorder, bi-polar disorder or other Axis 1 diagnosis.

In the documentation, there follow:

- Criteria to assist the referring therapist
- Admission requirements
- Admission process
- Continued stay criteria
- Discharge process
- Program graduates

Clinical Part of Gemini House

Gemini Continuous Treatment Team works directly with the clients at Gemini House. Staff who work at the house come to their team meetings. They are on the same pager and deal with issues together.

It began as a research project out of Dartmouth-New Hampshire, a continuous treatment team working with dual diagnosis clients. At that point, in 1988, clients with dual diagnosis had no treatment and services were not linked. This is one of the few that continues. It survives because it saves money, by keeping people out of hospital and the clients have an improved quality of life.

The team tries to get four things for its clients:

- Sobriety
- Something to do during the day: a job or volunteer work
- Leisure skills
- A social support group

The team either start out as mental health professionals and learn substance abuse skills, or start out a drug and alcohol abuse counsellors and learn about mental health issues. Colleges in New Hampshire now are training people in dual diagnosis. There is a dual diagnosis track in many institutions.

Team members have a MA level degree. They go out into the community and work on issues such as food shelter, housing, hygiene, budgeting, shopping, cooking.

In treatment, the team uses the Prochaskska model (17) *Changing for Good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward. James Prochaska, John Norcross, Carlo Diclemente Harper Collins 1994* [for bibliography]. It usually starts with the substance abuse element. They identify the stage of change the client is in and work with him/her to move through the stages.

Pre-contemplative: Client has no desire to start. Strategy: take the client out, talk non-judgementally: What used you love to do.

Contemplative: Maybe drugs stop me from doing things I used to enjoy. Perhaps I can stop using.

Preparation: How will I do this? Perhaps find an AA group that accepts people with mental illness who are on medication.

Action: Staying sober. Changes needed to do this. Doing it.

Maintenance: What do you need to maintain this?

Motivational Interviewing is used extensively.

Community care managers all have different areas of expertise:

- 2 social workers
- 2 mental health counsellors
- Drug and alcohol counsellor

Some on the team are recovering from addiction.

The team has 12 clients each, responsible for paperwork and follow up. They don't mix caseloads, but everything goes through the case manager.

They do a lot of work with lawyers, probation officers, police, family members, primary care physicians, emergency rooms, to check client is not getting addictive medication, anything that will motivate clients.

GCTT is on call 24 hours, 7 days a week.

Each member is on call one week in six, all week. It can be onerous.

Shared Goals: psychiatric stability, drug and alcohol abstinence, healthy relationships, independent living skills and mutual support.

All residents also have a case manager on the GCIT. There are men and women who have dual diagnosis. Many are homeless or at risk of homelessness. Referrals come from State Hospitals, homeless shelters, family. It can take 15 people. There are currently seven there, with 34 in

interview stages. There are two double rooms, the rest are single. There are shared lounges, kitchen, bathrooms.

People come because they want to. People in the Preparation or Action stages do well. They don't do well if they are not ready. The structure and expectation is that they are working towards sobriety. There is an open door policy, as long as people keep the rules and take part in programs. Most of the rules were developed by residents. There is a community meeting each day. They may decide to add to the house rules so that the house runs smoothly and is safe.

Residents are expected to be looking for work, either employment, community service or education programs. Most are working part time. Those not working are helped by vocational outreach workers.

Residents help with cooking meals. Staff go grocery shopping with clients.

AA meetings are held five nights a week: four nights out and one night in. Each month, an AA group from the area commits to coming in for a month. Alumni come in for the meal and meeting.

People may relapse and come back.

Staffed 24 hours a day. 7 staff total.

Shifts: 7.00am - 3.00pm or 8.00am - 4.00pm (2 staff)

3.00pm - 11.00pm (2 staff)

4.00pm - 12.00 midnight

midnight - 8.00am (1 staff)

Clients self administer medication. Staff check side effects. Education re mental illness/medication.

Psychiatrist on team attends team meetings.

Jessica Lachance is currently supervisor of Gemini House. She supervises seven staff.

It is a dry house. If someone comes home drunk, staff send him/her to a shelter for the night. If it becomes a habit, they set up a meeting between the client, house person, case manager and decide if the person is ready for Gemini House. Assist in finding a place for the person in the community outreach and help the person come back in when ready.

Length of stay is individualised. Typically, it is a year. Staff gauge they are ready if all the supports are in place. They assist client to get Section 8 housing.

As part of the transition out, as well as helping the person find housing, assistance is given to helping the person live alone. There is a small kitchen upstairs and in the weeks before moving

out, staff help the person with shopping and cooking for him/her self. They step up community outreach. It is the hope that by then the person has a year's sobriety and an AA sponsor.

The combined focus means that, when a person moves out of Gemini House, the case manager follows him/her into the community or the person is passed on to a less intensive team. There is a lot of decision making and consultation with the client before passing the person on to another team. There are arrangements made for ongoing psychiatric treatment and for involvement in a recovery process related to substance use. There is an available safe and affordable housing alternative and an adequate vocational service plan that provides for productive daily structure.

Associates of Gemini House: Service is also given to 6 or 7 people in the community who need help with medication management, coming AA meetings and may, at some time need to be at Gemini House.

Drug Addiction

The house goes to AA meetings mainly. Once people are engaged, they may want to try NA groups. Preferably, staff get a sponsor from AA who will help them get to groups. Encourage people to look at different AA groups and find ones that are open to people with Dual Diagnosis. In the Manchester area, there is now a network in AA that knows the house and most in the house have AA sponsors. Staff try to find groups that have not yet made a commitment to have a month's meeting at the house.

Buddy System. When someone comes in, he/she has a buddy for the first 30 days. During that period, if the person wants to go out, a buddy must go also. After that, the person can go alone. If someone has relapse, he/she may have a buddy for 1-2 weeks.

Peer Support. Community meetings are run by members. House leader is appointed for a week. Meetings are 15-20 minutes. A resident is monitor for a night. Meetings plan for:

- the evening's AA meeting
- who is on the buddy system
- the celebration of sobriety days and birthdays

CAMBRIDGE AND MANCHESTER NH, WESTBRIDGE

WestBridge is a private, non profit agency. It works intensively with a small group of clients who can private pay, offering 10 hours case management a week.

To address a range of needs of clients with dual diagnosis, the agency offers the following five ancillary rehabilitation services:

- **Residential Services**: Supervised residential services that accept clients with dual diagnosis, including supported housing (ie outreach for housing purposes to clients living independently), and residential programs with on-site residential staff.

- **Supported Employment**: Vocational program that stresses competitive employment in community settings and provides ongoing support. Staff act as job coach, encourage, provide transport intervene/facilitate with the employer if the client signs a release.

- **Family Psychoeducation**: A collaborative relationship between the treatment team and family (or significant others) that includes basic education about SMI and its management; social support and empathy, interventions targeted to reducing tension and stress in the family as well as improving functioning in all family members.

- **Illness Management:** Systematic provision of necessary knowledge and skills through psychoeducation, behaviour tailoring coping skills training and a cognitive behavioural approach to help clients learn to manage their illness, find their own goals for recovery and make informed decisions about their treatment.

- **Assertive Community Treatment (ACT) or Intensive Case Management (ICM):** A multi-disciplinary team, (client to clinician ration of 15-1 or lower) providing 24 hour care at least 50% of the time in the community.

WestBridge is a relatively new agency. It is building its client load at present and further developing its teams in Cambridge Mass and Manchester NH. Its work is based on Evidence-Based practice and it has close links with Dartmouth-New Hampshire Psychiatric Research Centre. Its Medical Adviser is Dr Robert Drake and its Medical Director is Dr Douglas Noordsy, who, in 2001, was awarded the Exemplary Psychiatrist Award by NAMI.

MONTPELIER VT, WASHINGTON COUNTY MENTAL HEALTH SERVICES

Washington County Mental Health Services is an agency which serves mainly rural Washington County in central Vermont. The buildings where agency services are provided are in Montpelier, the state capital, a town of about 8,000 people and in Barre, which has a population of 11,000 people. The other 20 towns and villages in the county are quite small. People travel to receive services by private transportation, and in some cases by agency vans and support workers.

One of the programs of the agency is Community Rehabilitation and Treatment which serves people with long-term serious mental illness, often involving institutionalisation, providing case management, counselling, psychiatric services, vocational services, day treatment, rehabilitation services, (teaching psychosocial skills in a community setting), and support services: offering help with transportation, shopping, meal preparation, and community needs. There are 400 people in this program.

Hiring consumers as direct service staff

Since the first consumers were hired in 1994, approximately 30 consumers and ex-consumers of the agency have been hired to fill a variety of jobs. Most are part-time and few are full time. Most of the jobs are competitive, sometimes publicly advertised. Consumers and ex-consumers work as co-workers of the other staff at the agency.

Dual Diagnosis Program

Dual Diagnosis treatment has been in place since 1996. A visit from the Dartmouth research group then prompted the setting up of a group. It is an open ended group of about 4-7 people which meets each Monday. This is a welcoming group, in that it accepts new members. It uses a *double trouble* format. The focus is on management of both mental illness and substance abuse. There is a cognitive behavioural approach and the States of Recovery model is used.

A second group, which meets on Thursdays, began in 1998 and people are still attending. It is a tools and skills group, actively looking at relapse prevention. People stay in the group as long as they need to.

A pre-contemplative group began in 2002. It is for people who don't recognise they have a problem. May order a pizza and talk about drugs and alcohol. People are symptomatic and actively psychotic.

A Residential Dual Diagnosis community is being set up at 7 St Paul Street. A coordinator has been hired and the first residents are moving in. 24 hour staff concentrate on teaching the eight clients the skills needed to live independently or semi-independently. The dual diagnosis treatment segment is in the planning stage.

Additional interesting programs at Washington County will be looked at under Rural Services.

BURLINGTON: THE HOWARD CENTER FOR HUMAN SERVICES

Co-occurring Disorders Treatment Program

This offers comprehensive, integrated mental health and substance abuse services to individuals with both psychiatric and substance abuse disorders who have ongoing involvement with the criminal justice system.

The project works collaboratively with consumers, families and other community agencies to provide full integrated treatment, continuity of care and care givers through time and setting, to a vulnerable population in order to actively minimise the risk of relapse, recurrence of mental illness and re-arrest or incarceration.

At the core of this program is a multidisciplinary team and assertive case management. The team provides active and ongoing treatment to 30-40 individuals. The program is designed to engage clients, accommodate various levels of severity and disability, and at different phases of treatment. The team is made up of professionals with combined mental health and substance abuse treatment expertise and who have extensive experience working with individuals involved in the criminal justice system operate the program.

The case manager and treatment team focuses on providing acute and on-going treatment for each client. Each team member is familiar with each client served, assuring timely and consistent treatment. Services are provided on a long-term basis, with continuity of caregivers over time. The integrated team approach provides the majority of services, with minimal referral to outside providers. These services are available 24 hours a day, 7 days a week. Services are

comprehensive and individualised, and are adjusted according to the changing needs of the client. This occurs through ongoing evaluation and individual-directed treatment planning.

To treat core clinical issues, the following services are integrated into the individualised and tailored treatment plans of clients:

- Integrated group treatment and outreach
- Group/individual case management
- Overall focus on consumer stability
- Cognitive distortion/errors and problem solving training
- Relapse prevention work
- Basic social skills and affect regulation training
- Consultation with significant others
- Stress reduction and mediation training
- Medication management
- Medical advice
- Motivational interviewing

Through Howard Center and community services, clients are provided with:

- Safe, affordable and adequate housing
- Vocational rehabilitation and employment support
- Access to self-help programs
- Primary and psychiatric health care
- HIV and STD education
- Rapid access to more intensive levels of care when needed

Principles underlying the Co-occurring Disorders Program

- Dual diagnosis is an expectation not an exception.
- When mental illness and substance disorder coexist, both diagnoses should be considered primary.

- A substance disorder or psychiatric disorder should be considered "secondary" only if it resolves when the comorbid is at baseline.
- Both mental illness and substance dependence are examples of primary, chronic, biologic mental illnesses which fit into a disease and recovery model of treatment.
- There is no one type of dual diagnosis program. For each patient, the proper treatment intervention depends on the phase of recovery and the level of acuity, severity, disability and motivation for treatment for each disease.
- Addiction treatment in psychiatric populations is basically similar to addiction treatment in non-psychiatric populations.
- Addiction treatment.

Other programs offered at Howard Centre, including supported housing services will be discussed later.

CHICAGO

THRESHOLDS: ROWAN TREES

This is an intensive residential program to treat people with intractable Misa problems

This is a 45 bed residential treatment program for people with dual diagnosis of serious mental illness (schizophrenia, bi-polar disorder or severe depression) and severe substance abuse problems. It is a transitional living setting with length of stay determined by the member's treatment needs. The proposed length of stay is two years.

Programming consists of a treatment designed to lead the members towards abstinence from drugs and alcohol, a healthier lifestyle, and effective management of their mental illness. Secondary outcomes include successful involvement in vocational and educational training as well as the acquisition of independent living skills.

A four tier level system is incorporated to tie progress to privilege. As members progress through the levels, they earn more responsibility including managing their own money and medications as well as the opportunity to look at vocational or educational placement. There are specified responsibilities associated with each level and privileges earned as a result of successfully fulfilling these. One agreed aspect of the program is that a member does not leave the facility without an accompanying staff member for the first month.

A graduation ceremony is held for all members who have successfully completed the program.

The program has been operating for four years. It has had 30 graduates, relatively low, but it measures items such as decreased hospitalisation, relapses and job placements to see that the program has made improvements in clients' lives.

Residents have their own room, including a kitchenette. Some communal meals are provided for those who want them. Otherwise, residents are helped to do their own budgeting, shopping and cooking.

Individual treatment plans are worked out with clients. Program is loosely based on the 12 step model. Residents are required to do group programs in both areas: mental illness and substance abuse.

Such programs, such as *good chemistry*, deal with the interaction of the two conditions. People wishing to use this program need training and accreditation.

The response to relapses is not punitive. Clients are involved in discussion of the relapse with caseworker and coordinator. There is an *anchor* system 1-4, that allows analysis of the severity of relapse. There is an immediate termination of treatment if anyone uses alcohol or drugs on the premises.

There are 45 accommodation units available, six being wheelchair accessible. With two floors for men and one for women, this allows for 30 men and 15 women.

There are 18 full time and five part-time staff. These include a psychiatrist (5 hours per week). Nurses are available from other Threshold facilities. There are six MISA specialists, who do case management and group therapy. There are two Team Leaders who supervise the MISA specialists and also carry caseloads and facilitate groups. There is one Program Director to oversee all clinical and administration needs. There are three case aid positions that do transporting, job coaching, vocational crew coordination, and social activity coordination. There is one cook/vocational crew leader who coordinates breakfast and lunch five days a week. There are five front desk clerks and two for overnight shifts. There are part-time staff at weekends.

The program is funded by grants from the Office of Mental Health (residential and psychosocial rehabilitation grants). Funding comes also from Illinois Department of Housing Services, from Housing Urban Development and from a Chicago City grant.

The building, then derelict, was bought and rehabbed by Thresholds. Chicago Housing Authority subsidises clients' rent, charging one third of their income and paying the rest to Thresholds. If clients have no income, there is no charge for rent. Thresholds owns, operates and maintains the building.

GRAIS APARTMENTS

This is a supported living facility where both internal and community based programs are utilised.

Thresholds Grais Apartments MISA residential program serving individuals who have chronic and persistent mental illness, co-occurring substance abuse/addiction problems and histories of homelessness. The program is designed to reduce unnecessary admission to psychiatric hospitals, compounding problems associated with alcohol and drug abuse/addiction, homelessness. Thresholds Grais Apartments works collaboratively with the following providers to provide continuity of care for people with MISA problems:

Chicago-Read Mental Health Centre

Northtown Mental Health Centre

Community Counselling Centres of Chicago

Thresholds Bridge Programs which provide assertive outreach and case management into the community

Thresholds Mobile Assessment Unit which makes contact with homeless people and assists them to obtain treatment and find housing.

Thresholds Day Programs

Building Description: It is a 44 unit residence, formerly derelict and fully rehabbed. Each unit is fully furnished and equipped with a refrigerator, stove, kitchen sink, and cookware, a bed, chest of drawers, table and chair and linens.

Services Description: Grais Apartments clinical staff to resident ratio is about 1:6. The clinical team uses an assertive community team approach to delivering services which assures immediate response to the critical needs of residents and/or needs of family, friend, neighbours or community members. It has proven effective in preventing the emergence of problems.

Clinical staff give special attention to helping members address their MISA issues. Upon admission, every member completes a personal recovery plan, which addresses everything the member has tried in the past to manage his or her MISA issues. Those practices that have worked in the past are included in the plan, as well as staff suggestions. Routine visits between staff and member monitor progress with the personal recovery plan and revisions are made as necessary. When relapses occur, member and staff meet to discuss factors that led to the relapse, issues are processed and a new plan is put into place that addresses the individual recovery goals of the member.

Residential support services provided by the clinical staff assist members in the development of skills necessary for functioning independently in their apartments. The team helps with money management. Other daily living skills include assistance with laundry, cleaning, cooking, grocery shopping and socialisation. Individual case management services also include linkage to community resources. These can include but are not limited to community mental health centers, addiction services and 12 step resources. Medical, dental and vision care, educational programs and social security. The program also offers vocational services aimed at helping members gain paid permanent employment.

The professional staff coordinates planned activities during the day, evenings and weekends. An average of 20 groups are offered every week. Groups cover MISA recovery topics which include relapse prevention, alcohol and drug education, medication education, stress management, physical fitness, smoking cessation, anger management, factors that lead to increased well being, self esteem and hygiene. In addition, the program offers weekly community meetings, a members council group, outside activity groups and weekly in-house socialisation groups.

Admission: Decisions for admission are made by the clinical team and program director. Each incoming member must have serious mental illness, serious substance abuse/addiction and homeless status or be in transition from temporary housing which place the person at risk of being homeless.

They must agree to the building rules:

- No physical violence.
- No threats of physical violence.
- No drug/alcohol use or possession while at Grais Apartments.
- No drug paraphernalia.
- No weapons.
- No stealing.
- No withholding information about violations of the above rules by other residents.

Those members who are actively using drugs and alcohol need to demonstrate they are willing to stop. They need to agree in writing that they will keep these rules. Drugs and alcohol testing will be used to monitor compliance.

Criteria for Refusing Admission

- History of violence is such that providing 1:1 services is deemed too dangerous.
- The member does not identify recovery as a goal and is not able or willing to take steps towards abstinence.
- Medical needs are such that the person cannot live in the community without 24 hour supervision.
- The member refuses the services offered by the program.

Grais Apartments has a long history of collaboration with the New Hampshire-Dartmouth Psychiatric Research Center and demonstrates fidelity to its best practice guidelines.

EAST VANCOUVER DUAL DIAGNOSIS PROGRAM

A direct service program began in 1996, at first as psychoeducation. In 1997, Pohsuan Zaide took over as coordinator. In 1996, there were 350 referrals, in 2001, there were 1,100. The docks area of Vancouver, is characterised by homelessness and drug use. The Dual Diagnosis program operates as a shop front service, right in the heart of the area of greatest need.

As a means to integration of mental health and drug and alcohol services, conferences are used as a means of awareness raising and a beginning of cross training. There is now integration in seven of the nine Area Healths.

The program at the Dual Diagnosis unit is based on the model outlined in *Changing for Good by Prochaska, Norcross and Diclemente* (17). It is outpatient intensive treatment, the main format being group therapy.

Groups run every day. Many are self referrals, attracted by word of mouth. If detox is needed, there are inpatient facilities. Pacifica treatment center has access to psychologists and psychiatrists. The Dual Diagnosis program tries to educate and support mental health teams, which often have caseloads of 60-90 clients. The initial staff was three clinicians, now it is four, with a half time addiction services worker.

The only regulation for admission to the groups is that the person is clean and sober on the day. People may be at different stages with their mental illness and drug and alcohol addiction.

Groups:

1. **Orientation Group: Motivation**

   8 - 25 members

   Input is short video tapes

   Discussion of personal issues

   Members attend when they like, as often as the like. They are there to decide when they are ready to change and what they want to do.

   Orientation groups are used as a method of screening clients. Many of the clients have come with a history of severe trauma and abuse. People with borderline personality disorder may come. They are given a chance behaviourally. Staff need to distinguish between those who are workable in groups and those who are unworkable. The greatest difficulty is with those who are extremely antisocial, have no conscience or empathy. If possible, these people are referred for one-to-one counselling.

2. **Early Recovery Group**

   Self care

   Warning signs

3. **Women in Recovery Group**

   One in five groups is now a woman's group.

4. **Schizophrenia Group**

In it all, the trick is to treat people like human beings.

Treatment

After people have been stabilised for three weeks, each person does a self-assessment and then is case-conferenced. A treatment plan is developed. The person is directed into specific groups. Community care providers are invited to co-facilitate. The aim is to move to a case-management model. For this, a team psychiatrist is needed.

People who have lived with dual diagnosis for many years, may present like someone with personality disorder. The team has found that, with some, once the addiction is addressed and treated, the personality disorder clears up. It is basically a problem of self regulation. The effects of severe trauma may look like schizophrenia. In diagnosing, there is a need to hold a trauma framework and not diagnose too fast.

The probability is that a person will come back repeatedly. Staff need to ask themselves what they are doing to help people come back? Everyone with dual diagnosis is ambivalent. Staff need to work with that and increase the probability people will return.

Process of Recovery

In the depths of dual diagnosis, people can't see any way out. At this point, it can be essential for staff to do their own recovery. They need to accept they cannot save everyone, that they need to have good self care and maintain boundaries. Exposure to peoples' pain and suffering can be psychically hazardous environment. The process becomes something close to spiritual counselling. The person may say: *I can't live well. I have no hope*. A therapist may say: *Let someone else believe in you. I can hold your hope for you*. Clients may be helped to access their wise mind, use rational/emotional techniques, get some clarity. The Buddhist emphasis on mindfulness can help. It can be important to be open to small moments and deep pleasures.

One client remarked : *I always felt I was damaged goods. Now I have a foothold on humanity.*

Supported Housing Component

Berman House is a 6 bedroom facility purchased by the Health Board. The best success is with an 18-24 month occupancy. There is a recreational therapist, group and individual programs and living skills training. So far, 18 people have gone through the program.

ACUTE MENTAL HEALTH SERVICES CONCURRENT DISORDERS DEMONSTRATION PROJECT

NANAIMO, VANCOUVER ISLAND, BC

Aims

To demonstrate the effectiveness of intensive case management of a client group characterised by:

- Serious mental illness
- Addiction
- Multiple service users, but not engaged in any treatment process

The assumption was that they would be difficult to engage.

Client Group

30 people were selected from 132 referred. Only 4 were referred by multiple agencies. They were selected according to a history of non-engagement. They had all been banned by every agency that had dealt with them. Many had police contacts/records, were mentally unstable, many worked in the sex industry, many had HIV/Aids, many had brain injury and cognitive deficits from drug and alcohol use. Most had a trauma history. Many of the women had toxic-severe personality disorder, had lethal self-harm behaviours, were emotionally detached, victims, IV drug users. Bi-polar disorder was often a default diagnosis.

Crucial Component

The team made a two year unconditional commitment to them. There were no conditions. Abstinence was not a condition. There were no judgements made. They would work with them to improve their quality of life.

Aims of the team included stabilising the client's mental illness, building relationships with the clients and harm reduction. Try to help the client function at the present moment.

Team Members

In this model, it is very senior staff who are doing the frontline work, professionals with 20 years' experience. Lori Mets has an MA in Social Work, specialising in adult forensic research. Norma Winsper is a psychiatric nurse.

Model of Care

Assertive Case Management is the model of care. Some people are seen daily.

Support Framework

Research was set up from the beginning. It is being done through Malaspino University at Nanaimo. A Steering Committee, made up of committed stakeholders, oversaw the operation and worked on system barriers. Each Agency involved provided one representative. There was a broad clinical perspective. They dealt with the Ministry, police, detox units, drug and alcohol services, mental health services, probation, corrective services.

Crisis Housing

This was crucial. A six bedroom house was set up, operated by a NGO and funded by multi agencies. Two beds are long-term, 2 short stay and 2 are crisis beds.

The greatest obstacle to progress was lack of housing. Without stable housing, recovery cannot begin. Maslow's hierarchy of needs always applies. Fix food, shelter, secure housing, then look at behaviour.

Serious Mental Illness v Personality Disorder

Clients with serious mental illness had a more linear progression and were active in wanting to be involved. If a choice of clients needed to be made, it was better to start with those in this category.

Clients with personality disorder were often opportunists, use a lot of time, create chaos, are crisis oriented. The approach has to be one of containment, safety, containing chaos, providing structure. Need to be more proactive than reactive. There is progress, but it is not linear. They will run their own road show, especially with addiction. They can be users and predators.

Once trust was established, there could be progress and people could move towards being as functional as was possible for them. There was an emphasis on containment, respect, role modelling.

The first year of the program was one of stabilisation, building relationships, harm reduction. The theme ended up being *From Chaos to Clarity*.

Conclusions

Assertive Case Management works with this level of client. The team has learned how to predict progress according to diagnosis. There are process themes during treatment and predictable behaviour.

Outcomes

Drug use is less, there is less harm. Clients are smarter about taking care of themselves. There are substantial changes in the amount of harm done.

Into Year Three

Clients are moving into a containment phase. They have tasted connection to community and find that addiction is interfering. They may reflect on changing this behaviour.

Teething Problems with Evaluation

There was a need to find functional assessment tools, the kind used by Occupational Therapists. There is a need for objective functionality and data Front-line workers may need to do some of the assessment. Problems occur in layers, awareness occurs in layers.

REGINA SK, WESTVIEW DUAL DIAGNOSIS PROGRAM: PHOENIX RESIDENTIAL SOCIETY

Management: Westview is managed by the Phoenix Residential Society, a charitable organisation which provides a combination of assertive community treatment and housing/community supports. The Society also provides vocational services, runs a small catering service, and cafeterias for two organisations, and an in-house janitorial service.

Organisation and Structure: The dual diagnosis program is located in an apartment building referred to as **Westview**. It provides supervised apartment services for up to 10 clients at a time and has been in operation since 1993. The program provides psychosocial rehabilitation services and has 24 hour on site staffing. Residents have access to all other programs and services provided by the Society. Funding comes from Ministry of Health grants, with some income from Social Services and apartment rentals.

Target Population: The program targets rehabilitation clients of the Regina Mental Health Clinic with diagnosis of mental illness and current drug and/or alcohol dependence. The presenting problems of this group include non-compliance and a lengthy period of maladjustment to community living.

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

Service Delivery Methods and Functions: The program is viewed as long-term with the goal of achieving abstinence. Residents coming into the program know this is the goal but also realise that relapse is part of the recovery process. They have access to a range of programs which promote effective skills for daily living and provide support for attaining health and sobriety. Addictions and psychiatric rehabilitation issues are addressed together. Services are delivered using individual and group formats.

Admission Process: Each resident is carefully assessed before admission into the program by an admissions committee comprising representatives from Phoenix Residential Society. Regina Mental Health Clinic and Saskatchewan Alcohol and Drug Services. An individual rehabilitation plan, agreed upon by the client, case manager and coordinator of the dual diagnosis program is drawn up.

Services Provided include:

- Financial: trusteeship, budgeting/money management, shopping, bill paying.
- Independent Living Skills: apartment maintenance, laundry, menu planning, grocery shopping, meal preparation, medication management, personal appearance, hygiene, relationships with others.
- Physical and Emotional Health: leisure, recreational activities, expending use of community resources, increasing social network, employment/educational resources, time management, planning daily activities, counselling, crisis management.

- Addiction Services: education, developing relapse prevention strategies, in-house recovery groups eg AA/NA.

Relationships to other Services: All referrals to this program from through the Regina Mental Health Clinic and the client must be under the care of a Regina psychiatrist. Because of the need for dual diagnosis services, Westview has opening some of its group programs to clients who are not residents of Westview.

Evaluation and Monitoring: In 1995, the program underwent external review of its practices and outcomes. Outcomes were that, in general, residents appeared to be in better physical health, to enjoy improved lifestyles and greater psychiatric stability. The length of sobriety ranged from four days to two years.

Relationship to Best Practice: An important element in Canadian best practice guidelines for clients with dual diagnosis is the concomitant delivery of addiction services with mental health services. Westview staff have training in both psychiatric rehabilitation and the treatment of addictions. Services offered to clients are individual and time unlimited. They are comprehensive in that they focus on the entire person and attempt to meet all their psychosocial, medical, housing and financial needs.

BOSTON: VINFEN CORPORATION

VINFEN is a private, non-profit human services organisation that provides an array of programs and services to help people with disabilities live independently and with pride. Vinfen supports men, women, and children, as well as their families at almost 200 program sites in Massachusetts.

Vinfen supports thousands of people each year in acute care, residential, respite, day, work and crisis intervention programs and services. Consumers include people with psychiatric and developmental disabilities, behavioural health issues and other health-related conditions.

Dual Diagnosis Programs: Vinfen runs these on 12 sites. Mostly, the model is a group home one, for 8-10 people, who remain in the program from 12 - 24 months.

Key Learning: In residential programs where services, eg groups, are offered in-house, it can be important, after 12 months, to take them out for these programs, otherwise, the clients become stale. The house remains a residential community. But the services are separated out.

Winston Road

A dual diagnosis group home, founded in the early 1990s. There are eight residents: six men and two women. There are also 70 supported housing beds in the area. Clients have to be homeless and have a dual diagnosis. They can stay as long as they need. In-house programs were run for two years, then the programs were moved out. Double Trouble groups are led by clients. In the beginning, clients could not be left without staff. Then clients learned living skills, self assessment and risk assessment skills.

Harbour Inn

This is on Long Island in Boston Harbour, a secure island, owned by the State. It is an eight bed dual diagnosis forensic program. It is the first step out of a State Hospital. The clients have all been responsible for serious crimes, including murder and sex crimes. 80% of these are isolated incidents, 20% of clients are psychopaths. Groups are run five days a week. Clients are supervised by staff for a month. After a risk assessment meeting, some go to day programs. Some would stay in-house for years, closely monitored. In general, clients stay for three to six months. Then they are referred to a department of Mental Health housing option. They are referred according to the level of support needed.

The Department of Mental Health has a recently opened 20 bed forensic unit for sex offenders and murders.

Jackson House at Lawrence Mass

This is a high intensity dual diagnosis residential program for 8 people. It is the first step from Harbour Inn. It is a damp house: no active drug/alcohol use is permitted on premises but relapse is tolerated, in fact it is viewed as an integral part of the recovery process. All clients of Jackson House must voice a desire to be clean and sober, agree to random toxic screens and participate in treatment-focused programs offered.

The program is highly structured, with a focus on skill development. Both disorders are addressed as primary co-occurring disorders. It is a client centred approach, also utilising harm reduction philosophy, helping clients find their own paths to sobriety and recovery.

The in-house program operates on Monday, Tuesday, Thursday and Friday from 9am to 2pm. There is evening programming daily, with at least four hours of it on Wednesday evenings, Saturdays and Sundays. Jackson House programs consist of both didactic and experiential groups. The groups are a mix of traditional substance abuse programming as well as psychosocial rehabilitation skill development groups. DBT (Dialectical Behaviour Therapy) skill modules are used, as are health and wellness topics. Staff are trained in behavioural techniques and skill development is emphasised over traditional feeling based therapy. Graduates are encouraged to return to the program to provide peer support and peer education.

All clients are encouraged to seek out individual therapy. Until this can happen, substance abuse counsellors on staff provide insight oriented therapy until linkages with community providers are established.

All clients are expected to participate in day, evening and weekend programs. Each client has an individual program structure and treatment plan that he/she participate din developing. All clients are expected to attend daily self-help meetings in the community. These are AA, NA and DRA (Dual Recovery Anonymous). Staff provide transportation and attend meetings with clients.

Collaborative relationships have been set up with community resources such as the local clubhouse, the educational/vocational program and day treatment programs offered at the local

mental health centre. This also provides crisis/emergency services. Links have been established with the local emergency rooms and the Lawrence Police Department.

The basic tenets of the Jackson House program are respect, responsibility and recovery. Vinfen has a zero rejection policy and takes the most difficult people.

This facility is staffed 24 hours, by two staff members. If there is a very difficult resident, extra staff can be moved in from other programs. Staff tend to be long term.

This is a voluntary, but secure program, with treatment for acute and chronic conditions. It has been running for six years.

I sat in on a group facilitated initially by a staff member, but then continued by the group itself. They were discussing triggers for relapse. Someone had noticed how watching a fellow resident rolling cigarettes provoked cravings for their drug of choice.

About 20 people have gone through the program in the six years of its history.

Despite government pressure for people to move on, Vinfen tries to allow people to recover at their own rate. There is a housing readiness group to help people prepare to move out. About 35% of clients who move out into their own apartments fail, due to isolation and desperation. Even with flexible support, they still fail.

Dorchester Bay Recovery Center, Boston

Also conducted by Vinfen, the center is attached to eight supported housing apartments. There is a 14 bed house at 31 Fessended Street. This is in a very depressed area. Eight beds are for 24 hour care and six are for more independent living. The clients have dual diagnosis and come from a wide range of cultural backgrounds. Staff are hired who match these backgrounds.

Groups at the center are all male. They run four days a week, from 10am to 3pm, with breaks for coffee and lunch. Women's groups are held off site. Groups may be related to issues about addiction, anger management (18) or wellness recovery. This uses a resource developed by Mary Ellen Copeland called Wellness Recovery Action Plan (WRAP) for Dual Diagnosis (19). The staff is made up of volunteers, under the guidance of a visiting psychiatrist. Attendance at the groups range from 18 months to 12 years. There are many social outings. These allow staff to assess aspects of socialisation that have been missed, eg over-friendliness to children.

Elliot Square, Roxbury, Boston

This was, until recently, a very depressed area. It is now becoming gentrified and Vinfen owns 40-50 of the 160 residences in the immediate area. Many of the residents had dual diagnosis. In order to provide resources, a social worker and psychologist were hired to work with the day program and also support residents in 11 group homes and one supported housing development.

The Elliot Square day program, which had been running for six years, has two social workers and two substance abuse counsellors who run groups. An average of 20-25 clients come each day.

Courses are run from Monday to Thursday, and the goal is to have evening groups as well. Strong peer support is the ballast of the program. Randy Rice is the program co-ordinator.

Clients must be in the contemplative stage of recovery. Clients may leave the program and start using drugs again, and later be accepted back into the program. If a group agrees, a client who is intoxicated may be allowed to join a group. For some people, it takes 4-5 years to start recovery. The center works with the legal system. Clients can come here while on probation. There is a high component of spirituality, as it has been found that clients with spiritual base do better in recovery.

Timetable:

8am Clients can come in and have coffee and bagels, just hang out. There is no clinical agenda.

10-1045am Check-in: How are you going? What have you been doing? What issues are you struggling with?

Monday:

11am Peer group run by consumer: Mental illness: Historical/religious labelling.

12 noon Lunch.

1pm Moore discussion.

Tuesday:

11am Recovery from drugs: videos, workbooks. AA theory. Groups run by staff members.

1pm Double Trouble group. This is a group open to anyone with a dual diagnosis and run by themselves. Script is provided by Double Trouble Recovery.

Wednesday:

11am A woman counsellor leads a group on mental illness and the physical impact of drugs.

1pm Psychodynamic approach: terminology and understanding of mental illness, behavioural background. Learning listening skills.

Thursday:

11am Social work group. Modelled on AA. One of the 12 steps taken and discussed.

1pm Stress and relaxation.

Saturday:

Drop-in for movies and popcorn. Some people start here.

There is a summer program of camping and sailing.

Effectiveness: This program has been very successful. Members interact non-judgementally. Clients rarely have to go into detox because the staff see them often enough to catch problems early. If clients are symptomatic, this can often be handled in the group.

Treatment Planning: The client staff and program directors come up with a treatment plan for three to six months, based on what the client wants to do. Harm reduction is used, eg, the client may move towards controlled drinking.

A self-assessment workbook, (20) developed by professionals involved with the center, is used in the initial stages of recovery. It can be used individually or in groups. It assists clients to develop their own program of recovery.

There is a strong emphasis on peer support, peer education and peer run groups.

Double Trouble in Recovery: (21) these are consumer run groups. Vinfen places great value on these strategies.

Peer Educators Project: (22) trains consumers to facilitate self help groups.

BIRMINGHAM, UK, COMPASS PROGRAM

The North Birmingham Mental Health NHS Trust (NBMHT) provides Mental Health and Substance Misuse Services to a catchment population of about 580,000. The primary aim of the Combined Psychosis and Substance Use (COMPASS) program is to provide a program of care within the NBMHT for clients with co-occurring severe mental health and alcohol/drug problems. The COMPASS program is a specialist multidisciplinary team supporting existing mainstream Mental Health and Substance Misuse Services to provide integrated treatment.

The role of the program is to:

- Encourage closer liaison between mainstream Mental Health and Substance Misuse Services.
- Provision of a consultation-liaison service to all community and inpatient Mental Health and Substance Misuse Services.
- Train clinicians in mainstream Mental Health and Substance Misuse Services to use an integrated treatment approach to address co-occurring severe mental health and alcohol/drug problems.

- Provide within Assertive Outreach Teams (AOTs) intensive clinical input and support through co-working, attendance at team meetings and provision of supervision to facilitate the delivery of integrated treatment.

- Develop working partnerships with Social Services, Criminal Justice Services and non-statutory Agencies within Birmingham.

- Evaluate effective treatment approaches for this client group.

- To serve as a regional and national resource.

Prevalence: A prevalence study was conducted by the COMPASS program (23)(Graham et al 2001) in community based Mental Health and Substance Misuse services across NBMHT. The main findings were:

- There are 1369 service users with severe mental health problems in Mental Health and Substance Misuse Services. Of these, 24% (324) had used alcohol and/or drugs to an impaired level o ver the last 12 months.

- The Assertive Outreach Teams had the largest percentage of clients with combined problems but there are a substantial number of these clients across all Mental Health and Substance Misuse teams.

Training and Support Needs of Staff in NBMHT Services

A Training and Support Needs Survey was conducted by the COMPASS program, (24) (Maslin et al 2001). 136 questionnaires were completed by a wide range of professionals across services (108) from Mental Health and 28 from Substance Misuse Services).

Development of COMPASS Program Intervention

Research and program development in USA, especially at New Hampshire-Dartmouth Research Center, in the team led by Dr Robert Drake, has shown that integrated treatment for clients, with co-occurring problems has shown positive benefits (25) (Drake et al 1998). In this model, mental health and substance use treatments are provided concurrently by the same personnel.
It was found that there was a need to tailor treatment to the context of the UK and evaluate whether it is effective (26) (Johnson 1998) (27) (Ley et al 1999).

Program Design

An integrated psychosocial treatment approach (28) (Graham 2003) (Cognitive-Behavioural Integrated Treatment or C-BIT) has been developed by the COMPASS program specifically for combined problem clients. This attempts to help them make positive changes in their drug and/or alcohol use which will lead to improvements in mental health and social functioning. The intervention consists of:

- Screening and assessment.

- Engagement and building motivation to change.
- Negotiating some behaviour change.
- Early relapse prevention of alcohol/drug use.
- Relapse prevention and management of psychosis and alcohol/drug use.
- Skills building.
- Working with families/social network members.

The intervention combines elements of integrated approaches with a particular cognitive and behavioural focus. The treatment draws from Cognitive Therapy, Motivational Interviewing and Relapse Prevention. The aim is two-fold: First to encourage clients to become aware of and modify beliefs about alcohol/drug use that maintain problematic use. Secondly, to learn skills to understand and manage the interaction between their substance use, their psychosis and the use of medication. Building vocational skills and a social network supportive of change are important parts of treatment.

The effectiveness of this integrated treatment approach is currently being evaluated. One stage in this evaluation is summed up in (29) (Copello et al 2001).

One of the practical learnings of the program, explained during my visit, by Michael Preece, registered nurse, was the crucial importance of *Assertive Outreach Teams*. The *Kingston/Erdington team* is comprised of four nurses, two social workers, support workers, .5 psychologist and .5 psychiatrist. They have a protected caseload of 60. It is a 24 hour team, with a full day shift, a lighter evening shift and half the team on call at night.

In setting up team, exit strategies have to be set in place from the beginning. Otherwise, clients do well with the intensive contact, but regress if moved to mainstream community services. The result can be a clogging up of the system, with few openings for new clients.

Clients of this team have severe, enduring mental illness, are hard to engage, forensic, self harming and often homeless.

In-patient support services: There are 161 inpatient beds in nine different localities. There are 2 x 15 bed intensive care, long stay units. This caters for a population of 520,000. **There is a move away from wards in general hospitals and from the medical model.**

Dr Hermine Graham, following a visit to New Hampshire-Dartmouth Psychiatric Research Center, set up the COMPASS program and helped develop the Best Practice Guidelines for Dual Diagnosis for the NHS in the UK.

SOUTH ESSEX MENTAL HEALTH AND COMMUNITY CARE

Dual Diagnosis Program: the Roche Unit, Southend/Rochford

The aims of the service are:

- To raise the profile of dual diagnosis issues in the Southend area.
- To create stronger links between all agencies in order to meet the needs of the client group and stop them falling through the net of care.
- To provide specialist treatment interventions to clients with co-existing severe and enduring mental health problems and substance misuse.
- To incorporate harm minimisation and assertive outreach interventions within overall service framework.

The overall approach is detailed in *Dual Diagnosis Protocols* (30) (South Essex Mental Health Community Care 2001) a handbook of the service which details:

- Prevalence UK studies indicate a range of 22%-37% among clients with severe mental illness.
- Definition.
- Structure of team/services.
- Aims/objectives including referral process.
- Assessment.
- Interventions including harm reduction.
- Specialist service provision, including sports initiative.

Group Homes: Supported Housing

There are two group homes that are part of the program. At present, four men live in each. This meets the need of this client group to begin to build social networks and have stable housing.

Team Composition

Marie Henderson leads a team of four members, 5.5 if ancillary members are included, which has a caseload of 64 clients. An assertive team approach is taken. Members are rostered to work at weekends. A consultant psychiatrist and a GP are .5. Many of the clients are high maintenance and require frequent contact.

Recently, an Assertive Outreach Team has been set up to provide social supports for clients, such assistance with cooking, cleaning, hygiene, budgeting, grocery shopping, leisure planning, recreational activities.

MONTREAL, QC, CENTRE DOLLARD CORMIER

Interviews with Line Boudreau, Henriette Beauvilliers, Violaine Lallemond and inspection of the large, modern facility, yielded the following.

This public program, with services free to residents of Montreal, provides an integrated and continuous network of addiction services. From 2001 to 2002, there were 6,000 clients. There were 3,400 new clients in 2002. The clinic works mainly on an outpatient basis, and can work with people for four years or more, if desired. General services provided include:

- Reception, Assessment, Orientation
- Clinical Group Activities
- Services for friends and relatives
- Emergency crisis beds/shelter
- Emergency Addiction Service is available 24 hours a day, 7 days a week.
- Detoxification
- Admission
- Withdrawal services 10 bed unit
- Recovery services 18 bed unit.
- Social Rehabilitation. This is open to clients enrolled and participating in the centre's programs. It provides support to clients for rehabilitation in their own apartment (max one year).
- Intermediary and Family-Type Resources: This is designed to meet accommodation requests. For clients with drug/alcohol addiction. AIDS, homelessness and/or social dysfunction. Short, medium or long term service ongoing supervision.
- Adult Inpatient Clinic: An 18 bed clinic for clients 22-54 who are participating in one of the Centre's programs. They can come here after detox to learn living skills and reorient to independent life. They are assisted with hygiene, nutrition, keeping their room clean, daily organisation and with legal problems. They can stay for a maximum of three months. The goals are to help them get an apartment, get a job or start an educational program. Open 24 hours a day, 7 days a week.
- Youth Inpatient Clinic: This is a 9 bed facility, open to clients 21 or younger, participating in the Youth Program. It is for youth who want to distance themselves from their living environment: the streets or their family, and examine their drug/alcohol use. The stay is about one month. Open 24 hours a day, 7 days a week and supported by programming.
- Community Services: links and services to other organisations dealing with drug and alcohol issues.

- Youth programs
  - Outpatient services
  - Inpatient services
  - Educational services
  - Community Outreach: street work
  - Parent services
- Excessive Gambling Program
- 55 and older program
- Homeless program. Clinical work adopts a harm reduction approach.
- Specialised Adult program: rehabilitation activities for:
  - Clients with less severe problems and more stable living conditions
  - Clients subject to judicial control, with a profile of ongoing criminality
  - Clients with a dual diagnosis of mental illness and drug and alcohol addiction.

CLINIQUE CORMIER LAFONTAINE

Danielle Duhamel, psychologist, described the work of the clinic.

Founded in 2001, this is third line comorbidity services for drug and alcohol addiction and mental health issues. It provides assessment, intervention, consultation and training services and does research. Services are provided in collaboration with Hospital Louis-H. Lafontaine. This clinic is part of the public hospital system, funded by the Ministry of Health and Social Services.

There is an integrated approach to dual diagnosis. Clients may be referred by clinicians or the community mental health team. First line workers are those doing street outreach, second line are those at Centre Dollard Cormier. The best referrals are of people who have reached a certain stage of recovery and have become blocked by some unknown factor. It must be problems with both mental health and addiction. The specialist team is made up of people employed by both mental health and drug and alcohol addiction services. It is a really integrated approach. The team is made up of a Medical Director, a psychiatrist, a social worker, a psychologist, a nurse and an educator. A researcher works with them.

The first step is psychiatric assessment. Sometimes, at this point, the client is sent back to the referring physician with questions answered.

So far, there are two treatment programs:

- for serious mental illness and addiction issues;

- for personality disorders and addictions.

Smart Recovery Groups

This takes a cognitive behavioural approach, rather than a 12 Step approach. Can have on-line meetings at www.smartrecovery.ws

CLINIQUE JEUNES ADULTES

This is also part of the public system. The clinic offers specialised psychosocial treatment and rehabilitation services for young adults suffering from schizophrenia. The services offered are medication, individual follow up, group follow up (social skills), family intervention (parents' group), assessment and referral regarding housing options.

70-80% of the clients have a dual diagnosis of schizophrenia and substance abuse. The schizophrenia must be seen as the primary diagnosis.

Clients are referred by another clinic of Hopital Louis-H. Lafontaine.

The team is multidisciplinary, comprising:

- Occupational Therapist
- Psychologist/Vocational Counsellor
- Psychiatric Nurse
- Psychiatrist, one full time and one part time
- ACT (Assertive Community Treatment) workers

Clients are assessed for readaption needs in the community. Is the need mainly occupational therapy, social work oriented or psychological?

Each team member follows his/her own case load of 30-40 clients. They can be seen for five years from the time of initial referral, then they are referred to another clinic at Louis H. Clients are seen twice a month. Clients tend to bond to the clinic and the team works well together. The small physical size of the clinic fosters this.

OT, Stephane Rivard, usually runs groups on social skills. Integrated Psychology Therapy, a Swiss model, is used. There are six modules, and clients treat it like a course:

- Cognitive
- Perception/Assessment/Evaluation

- Communication
- Social
- Emotional
- Problem Solving

Five to six people are in each group. The groups may run for two to four months. When the group is ready, it is taken out into the community to practice the skills.

Manual skills such as leather work, carpentry, pottery and craft are also taught.

The Social Worker sees parents, and has run a parents' group for eight to ten years. Focuses on resources for living. There are group homes for six to nine people and family houses and two supervised apartments, one of which has a meal provided each day for residents. Some are run by the hospital, some by a community group or a partnership of both. Some have 24 hour supervision and some have weekday drop in services.

Psychologist Ginette Comptois runs psychotherapy groups. She now has 50 clients and can see them only once a month. 50% of her clients are working and studying either full or part time.

Special High School for young people with schizophrenia

Often young people with schizophrenia leave secondary school after the age of 16. A special high school has been set up by the government for 30 patients, 15 from Clinique Jeunes Adultes and 15 from Louis H. Community organisations, the government and the clinic set up the school, which is funded by the government. At this school, they learn French and Maths. They collaborate with other high schools for other subjects. It helps young people finish high school and feel the same as others. There is vocational and educational readjustment. For patients with cognitive deficits, Special Education teachers work with them.

SECTION 4

DUAL DIAGNOSIS PROGRAMS FOR INDIGENOUS YOUTH

REGINA: RANCH EHRLO SOCIETY

Ranch Ehrlo is located at Pilot Butte, a short distance from Regina. A cluster of buildings is spread around an area, with green fields on every side, and, since this is the prairies, the view stretches to the horizon. This physical sense of openness to the environment may be essential to the wellbeing of its young clients, of whom 9 out of 10 are First Nation.

Founded in 1966 by Dr Geoff Pawson, as a non-profit corporation, The Ranch Ehrlo Society is a residential treatment centre for children and youth with social and emotional problems. Staff provide education, treatment and c are for these young people. The agency operates educational

programs, group homes and independent living facilities in Regina and the campus or "ranch" at Pilot Butte and at the Buckland Centre near Prince Albert.

Agency programs take a "holistic" approach to the care and treatment of the individual, addressing the social, psychological and physical well being of people within a culturally sensitive environment, that recognises the right of all people to follow a spiritual path of their choosing. Major treatment components include residential treatment, casework and educational services, cultural programs and recreational activities.

During its history, Ranch Ehrlo has helped more than 3,500 young people address problems associated with poverty, violence, abuse, drugs and racism. The current annual figure is 120 male and female residents and up to 20 day students.

The most troubled young people from all parts of Canada are referred here.

There are four residences at the main campus, nine group homes and two independent living programs in Regina, and three residences in Prince Albert. Young people ranging in age from 8 to 18+ with an average age of 15, can stay for a few months up to several years at Ranch Ehrlo, depending on the problems being addressed. There are also some developmentally delayed clients, aged 50 or more. There is a small group of severely disabled clients who are unable to communicate easily. Referrals come from the Saskatchewan Department of Social Services, the Department of Child Welfare, the Department of Mental Health, the Department of Indian Affairs, various Bands and Tribal Councils. There are referrals from Manitoba, Alberta, Yukon, North West Territories, Nova Scotia and Nunavit.

The four residential units on campus are stabilisation and assessment units with the following specialisations;

- Rorison House for clients with substance use and behavioural/mental health problems.
- Jewison House for clients with sexually intrusive behaviours.
- Appleton and Mitchell Houses for clients with conduct disorders, and also for younger clients, aged from 9 – 11.

Also on the campus are a large, modern educational facility and an administration block.

Families who wish to visit can stay, free of charge, in the McNamara Family Home, on the campus. Families are encouraged to be involved in their child's treatment programs. Families are brought down from remote areas to be involved. Staff also travel to home regions to meet with families and communities. There are letters and emails sent. A family camp is held regularly. This communication intensifies as discharge nears. It is essential that children experience consistency at home, enhancing and building on that which they have experienced during treatment.

Education is an important component of services offered here. Individualised schooling is available at the K-12 Schaller School. The Agency also has a teacher and a teacher's assistant at local high schools and rents classrooms as a home base and for withdrawal or coaching. As soon

as possible, young people are integrated into mainstream schooling. For youth 17-24, there is a Supportive Employment Program, which provides training in skills needed for work placement.

Ranch Ehrlo promotes a therapeutic environment, characterised by support, safety and trust. My overwhelming impression was of a place where young people are loved and respected. This was demonstrated by Geoff Pawson himself and by every staff member I met. At midday, I shared lunch with the group of young people at the dual diagnosis facility, Rorison House. Next to me sat a delightful young girl from Nunavit, I commented on her attractive eye shadow and we talked easily. It emerged later that she had only been at Ranch Ehrlo a short time. She would have been considered the most troubled young person in her community. Already, the atmosphere of safety, love and respect was transforming her.

Children often come from chaotic environments where there is no safety, stability or reliability. The simple matter of three meals a day at set times provides security, and children stop hoarding food.

Staff are hired carefully and work on a mentored basis for some time, to ensure their approach harmonises with the spirit of Ranch Ehrlo. There are Duke of Edinburgh awards programs and volunteer work opportunities. Thursday nights are culture nights, where they learn about different cultures. Elders facilitate sweat lodges. There is a Pow Wow Club where First Nation youngsters can learn more about their culture, pow wow dances and intricate costumes. Youngsters practice and perform for the public, sew their own outfits and take part in weekly sweetgrass ceremonies.

A key principle is to keep the young people active and interested. There is an activity program each afternoon. Clients are involved in planning and maximum variety is ensured. There are camping trips during vacation times.

Unit workers act in the place of parents. They promote good communication, working through issues and disputes. There are morning, afternoon-evening and night staff. Each house also has its own housekeeper who prepares meals. Staff share meals with the young clients.

Length of Stay: This is not short term treatment. Young people come with multiple problems, after 15 or so years of dysfunctional living. They may also have foetal alcohol syndrome and ADHD. They may stay 6 – 12 months or 12 – 24 months. Some, such as those with intrusive sexual behaviours, may stay 4 – 5 years. Some may never be able to return to their communities. If there is no family or community support, they may be helped to independent living and employment in Regina.

Funding: The multiple referring bodies pay on a fee for service basis. If a young person is referred by Client Welfare or Mental Health, the agreement is that that agency will pay for the treatment. Usually the child has a status that allows this to happen. This may be temporary or permanent Provincial wardship. The majority come in under parental agreement and parents can remove the children. Individual donors have supported the Society since the beginning and have assisted in funding the attractive modern buildings, including the education centre. Consequently, Appleton House, the most recent development, resembles a well designed modern home, where privacy, community and supervision co-exist with ease.

Specific Dual Diagnosis Program at Ranch Ehrlo

Rorison House is a residential treatment program designed to help children and adolescents who have problems related to the use or abuse of alcohol, prescription or non-prescription drugs, inhalants or other dependency inducing substances. Many of the residents have co-occurring substance abuse and behavioural or mood/anxiety disorders. Common dual diagnoses include substance use and conduct disorder, oppositional defiance disorder, depression and post-traumatic stress disorder.

Like all Ranch Ehrlo programs, treatment at Rorison House is based on a holistic approach. Assessments are comprehensive and designed to help staff understand the full context of the presenting problems. Interventions are designed to meet the social, emotional, cognitive, physical and educational needs of residents within a cultural context that celebrates spiritual and traditional differences.

Access to Services: Services are available to any child or adolescent with problems due to substance use or dependency. An intake committee reviews referrals. If substance use is identified as a primary issue and residential treatment an appropriate level of care, the young person is placed in Rorison House.

Service Elements: At Ranch Ehrlo, emphasis is placed on the importance of a safe, nurturing, predictable and stimulating environment where relationships between residents and caregivers can develop. Healthy activities, a positive environment and therapeutic relationships provide the foundation from which change is effected and pro-social behaviour maintained and the potential for relapse reduced. When relapse does occur, the resident is engaged in a problem solving process, with the emphasis on learning. Where the resident does not willingly participate in this process, supervision is increased to assist the resident back to sobriety, reduce the risk of further relapse and ensure all residents within the program remain safe. Relapse is viewed as party of the treatment program and treated as such.

Assessment: Prior to admission, an Initial Assessment and Service Plan is completed. The initial assessment provides a rating of the severity of the presenting issues or reasons for service, describes the resident's social history, educational profile, medical, psychiatric and psychological profiles and outlines the initial treatment goals, practitioner activities and indicators of success. On admission, the clinical caseworker completes a mental status examination, suicide risk assessment, a Child and Adolescent Functional Assessment Scale (CAFAS) and a Drug and Alcohol/Substance Abuse Screening Tool (DSAT-10).

After admission, the process of a Comprehensive Psychosocial Assessment is initiated and completed by the caseworker within 60 days. The youth completes several standardised assessments during this period, which include:

- Substance Abuse Subtle Screening Inventory (SASSI)
- Minnesota Multi-Phasic Personality Inventory – Adolescent (MMPI-A)
- Behavioural Assessment for Children (BASC)

- Wechsler Intelligence Test for Children Third Edition (WISC-111)

Other standardised and non-standardised assessment tools include:

- La Due Solvent/inhalent involvement scale
- Suicide risk assessment-living works model
- Children's depression index
- Conner's scale ADHD
- Anxiety scale MASC

Each resident meets with one of the Ranch Ehrlo consulting psychiatrists and may be referred for the following:

- CT Scan
- EEG
- Paediatric Consultation

All residents attend a series of medical appointments, including a full physical examination within two weeks of admission completed by a licensed physician with substance abuse training or experience. Optical and dental examinations are completed within one month of admission.

Information gained through the resident, the resident's family (if possible) and the above assessments is used by caseworkers to make a diagnosis using DSM-IV. This diagnosis guides the caseworker and residential team in developing an individualised treatment plan for the resident.

Service Elements: The service plan outlines treatment goals and relates them to reasons for service and desired outcomes. It also describes practitioner activities, client tasks and indicators of success. Attention is paid to the four cornerstones of the agency: work, education, recreation and therapy. Service plans are fully reviewed on a quarterly basis. During these reviews, goal attainment ratings are completed along with service plan compliance. In addition, severity ratings for reasons for service are completed to measure progress in regards to primary referral issues. Each resident is encouraged to participate in the development of his or her individual goals.

Treatment:

- Individual counselling to deal with issues such as family dysfunction, abuse, grief, neglect/abandonment, to set goals, relapse prevention plans and aftercare supports.
- Family involvement.

- Community based activities once detoxification and stabilisation have occurred. For example, hockey, ballet, music/voice lessons.
- AA, NA and Alateen.
- Treatment groups generic to all residents:
  - Daily Group
  - Social Development
  - Addiction Education
  - Intensive Therapy Process Group – exploring alcohol abuse, domestic violence and sexual abuse
- Therapeutic camp trips during school holidays and summer months. The therapeutic process is continued in a camp setting, including a yearly northern wilderness camp.

Outcomes:

As part of aftercare, caseworkers follow all former residents at two, four and six monthly intervals after they are discharged. Ideally, contact will be made with the former resident and regional work. Issues looked at include abstinence/sobriety, school or work placement, current residential setting and community resources used. If the former resident is in difficulty or needs assistance, the caseworker will arrange the necessary support through the Ranch or in collaboration with resources in the youth's home community.

CALGARY: WOODS HOMES

Eagle Moon Lodge and Lone Pipe Lodge

Eagle Moon Lodge and Lone Pipe Lodge serves the needs, on a fee-for-service basis, of First Nation youth from across Canada, aged from 10-17, with a history of suspected or known substance abuse as well as risk factors (FAS/FAE.ADHD etc) related to substance abuse concerns.

Eagle Moon Lodge is an eight bed residential treatment centre at the Bowness Centre of Wood's Homes. Lone Pipe Lodge is a six bed residence in North East Calgary.

The roots of the program go back to 1991, when the Canadian Centre was set up as an alternative for western youth to US treatment. It evolved into a national service with four distinct but interconnected programs: Detoxification, Engagement, Assessment and Solvent Abuse. The Solvent Abuse program received federal funding in 1993, as one of the six such programs across Canada, run by First Nations communities. Three are still running. The fee for service drug and alcohol treatment remained First Nations based and evolved into Eagle Moon Lodge in 1995. The Lone Pipe Lodge program was developed in 1999 as a way of extending the service to provide a

transitional program that allows young people to practice community and life skills before returning home.

Wood's Homes do not take first time referrals. They take extremely disturbed children who have been kicked out of services in the home Province. They exhibit violent, extreme behaviour. The mandate of this service is that children are never banned.

Eagle Moon Lodge is a stabilisation program. The more at risk clients stay there. Average stay is six months, but they may stay nine months.

Program:

- Detoxification
- Getting to know you
- **Medicine Wheel Pattern**
- Spring: new beginnings
- Summer: experience and learning
- Fall: self reflection
- Winter: going home, giving back to the community

The four directions and the cultural component draw on traditional teachings and rituals/practices delivered through First Nations staff and allow young people to move from a place of resistance to healing. The focus is on harm reduction and the realistic management of temptation, rather than abstinence.

There is a strong spiritual component, with smudge or prayer a part of community life and attendance at sweat lodges, run on site at Eagle Moon by elders. At Lone Pipe, clients may go out to sweat lodges. There is a sacred room, set up according to the Medicine Wheel, and incorporating sacred objects.

Underlying philosophy: The text , *The Sacred Tree* (31) is an outcome of the Four Worlds Development Project began at a conference in Lethbridge, Alberta in 1982. Participants were native elders, spiritual leaders and professionals of various Native communities in North America. It incorporates important concepts, symbolic teachings of the *The Sacred Tree*, first principles, the gifts of the four directions, a summary chart and a code of ethics.

Values, Guiding Principles: These are based on the seven teachings of *The Sacred Tree*. All the principles are inter-connected and work together to support an ethical life. The teachings apply to everyone: youth, families and staff members. They rest on the understanding that people grow, learn and evolve over time and that an important goal in life is to achieve balance or moderation.

- Courage
- Love
- Honour
- Respect
- Wisdom
- Truth
- Humility

How the program works: Clients start off at Eagle Moon Lodge, usually for at least a month for stabilisation. Depending on progress, the young person will then move to Lone Pipe Lodge, which has a greater emphasis on moving towards independence. They stay there up to five months. The programs provide a continuum of comprehensive treatment and support services that gradually move each youth from an intensive and structured environment to a community setting, including the opportunity for the young person to be placed in the home of a caregiver. The final stage of treatment is a planned and supported transition to the young person's home community.

During his/her time in the program, he/she is assigned a coach who will act as an advocate or mentor. Treatment intervention draws upon cultural activities, group sessions, and individual and group relationships which promote trust and respect. The program provides the young person with 24 hour supervision and a detoxification program of between 1-5 days if the young person experiences a relapse. There is also psychological assessment, nursing services and individual and family counselling available as required. In aftercare, staff travel out to work in the communities and to follow up. They show communities what works with kids, how to build supports and enhance their natural resilience.

Cultural links: The programs utilise First Nation elders to promote a sense of pride and direction through cultural and spiritual teachings in the healing journey. They are also an essential resource in opening doors within the indigenous community. In the beginning, there was a lot of mistrust from aboriginal people. There can also be difficulties between different tribes. For First Nation staff, working on the programs brings up a lot of issues. The elders can calm situations that arise. Services are now offered to communities and word of mouth recommendations happen.

History: Wood's Homes were founded in 1914 as an orphanage. It has evolved, over 60 y ears into an adolescent treatment program. Its other programs include:

Exceptional Needs: This is a dual diagnosis program for children and youth with two diagnoses in DSM-IV. These may be mental illness/substance abuse, ADHD/Bi-polar/parent-child conflict.

Format: It is a 2-6 month residential treatment program. It has been found that clients need this long to work on behaviour issues. Children go home at weekends. Plans are made on Friday and debriefing is done with families on Sunday. There is a case conference every month to check on goals. Parents still take care of daily needs. There is a parent support group one night a week. Family involvement is crucial. Psychiatrists, psychologist and nurses are on staff and the program works closely with psychiatric services in the city. Family, individual and group therapy are used. There are client groups each night: anger management, social skills.

Referrals: Come from Calgary Child Welfare and Mental Health. Three beds are for Mental Health clients, five beds are fee for service from government departments Child Welfare/Wards of the Province. 22 families are on the waiting list.

Catalyst: This is a complex Mental Health National Program with six beds. It is for children and youth who have broken down family supports. Diagnosis often FAS or ADHD. They tend to be involved with more than one system and have been kicked out of their home communities. They enter the Stabilisation Program, then are referred to Exceptional Needs for 3-6 months. They are in the Catalyst Program for up to 12 months.

Stabilisation: This is short term crisis diffusion. Mental Health pays for five beds, two are for Child Welfare referrals and one is available for referrals from across Canada. Referrals come from the crisis team. Clients can come for 3-5 days. Parents must visit daily. Goals are set with the youth and family. A therapist does individual and family counselling. A referral is then made to community services in the local area. 307 families have been served in the past year. It is a free service for families.

A protected Safe House for the protection of children 13 to 18 who are involved in prostitution. This is a locked unit. Children are picked up by the police and face court within 72 hours. It is a 21 day program focusing on stabilisation, health care and minimal treatment.

SECTION 5

TREATMENT FOR PERSONALITY DISORDER

Manchester NH, The Mental Health Centre of Greater Manchester

As recognised by the American Psychiatric Association, with its Psychiatric Services Gold Achievement Award, in 1998, the Mental Health Centre of Greater Manchester has a clinically integrated approach to Dialectical Behaviour Therapy (32 and 33) for adults with borderline personality disorder and adolescents who display self-harming behaviours. Trauma treatment and cognitive therapy, related to need, are also used. DBT can be adapted for use with avoidance and dependence behaviours.

They are Intensive Outpatient programs. Both programs focus on helping clients to learn skills for handling feelings, dealing with other people and managing crisis without hospitalisation or losing support from family, friends or helping professionals.

This specialisation started at Manchester MHC in 1993.

When people with personality disorder are part of a mixed caseload, they take the bulk of time and energy and burn out case workers. At Manchester MHC, they are treated separately. Skilled therapists use short, sharp focused treatment, that doesn't go beyond a year. Treatment is solution focused.

Over the past 8 years that this approach has been used, there has been a great improvement in quality of life, hospitalisation has been reduced by 90%, Emergency Room use by 78% and 58% are working.

Montpelier, VT Washington County Mental Health Services

Personality Disorders Treatment: The dialectical behaviour therapy program provides treatment for individuals who are self harming, usually as a means of tension reduction. The aim of this program is to teach life skills and to coach, by individual therapy, towards healthier solutions. Admission to this program follows and in-depth diagnostic interview and orientation. A one year commitment to the treatment program is required.

Residential Treatment: A group home at 62 Barre Street, is called **Single Steps**. It is a community designed around Dialectical Behaviour Therapy principles. Its aim is to help women with borderline personality build lives worth living. An environment is developed where DBT skills are reinforced. There is a lot of role playing. The focus is on emotional regulation and stress tolerance, and building connections with community. Women have to do some meaningful activity each day. They may cut and go to emergency rooms because they are bored.

They have a client who was a serious cutter, had 117 stitches, and would ingest sharp objects. She was initially thought to be hopeless. Now, she has not cut for four months, is getting her high school diploma and singing in a choir, getting her driving license. She wanted to get out of hospital. She commented *How can you prevent someone from harming herself by watching her?* Now she co-leads a group in the house.

Several skills groups are fun in the house. The traditional skills class is run each Thursday morning. The DBT mentor runs a homework group on Tuesday nights to help out before the skills class. In class, groups work through the four DBT skills modules:

- Core Mindfulness
- Emotional Regulation
- Interpersonal Effectiveness
- Distress Tolerance

There is also an **Applications Group**, to help residents figure out what skills might help in a particular situation.

Staff:

- DBT therapist: helps the person identify why she is doing things that may be wrecking her life, like cutting or quitting jobs.

- Single Steps Counsellors: work with the person to build a life worth living: set up meaningful activities, create some structure, develop and maintain life skills

Service Coordinator/Case Manager: coordinates treatment at Washington County Mental Health.

Montreal, QC Clinique Cormier LaFontaine

Clients mainly have borderline, but some have narcissistic and anti-social personality disorders. The team working with them is made up of a psychiatrist, a psychologist and a social worker.

There is a two phase treatment: weekly groups and a meeting once a month where the client meets all the team together. An adapted version of **motivational interviewing** (34) is used: Motivate, don't confront or take charge. Stress the clients' responsibility for themselves. A therapeutic protocol is drawn up, so that a stable, written set of guidelines are given to clients. Limits are set.

There is a trend now in Montreal hospitals that they are willing to work with clients with personality disorder in special programs using motivational interviewing and dialectical behaviour therapy. Marsha Linehan has a clear therapeutic framework.

Robert Drake (New Hampshire-Dartmouth) has another scale of stages of change to deal with severely disabled populations. He suggests what to do at each stage. Stages are:

- Engagement

- Persuasion

- Active Treatment

- Relapse Prevention

Therapy is always integrated. Substance abuse is always linked to other symptoms.

SECTION 6

TRAUMA TREATMENT

Washington DC, National Capital Center for Trauma Recovery and Empowerment

Geoff McHugo from New Hampshire-Dartmouth Psychiatric Research Center also suggested I talk to Dr Maxine Harris at another location of Community Connections. SAMHSA has now

recognised that trauma is an almost universal component of dual diagnosis. It has recommended that trauma treatment be part of an integrated approach to the treatment of dual diagnosis.

Dr Harris has designed treatment approaches for a diverse range of people, from women to youth and children (35-42). Trauma must be addressed because, if people are suffering from post traumatic stress disorder, they simply do not hear the clinical approaches tried with them and cannot engage with them. Judith Herman (43) has also written in this area.

Roger Fallot, also from Community Connections, Washington DC has explored the role of spirituality and religion in recovery from mental illness (44).

SECTION 7

ASSISTING HOMELESS PEOPLE WHO HAVE DUAL DIAGNOSIS

Washington DC Community Connections

At the recommendation of Dr Robert Drake, I contacted Richard Bebaut to learn about his housing models for people with dual diagnosis who had been homeless. Richard is Clinical Housing and Research Director of Community Connections. He oversees 21 supervised group homes, each having six to eight people, supervising case management for the clients. The house managers supervise direct line services.

Community Connections runs a comprehensive housing program (45) (Bebaut 1999) serving formerly homeless and at-risk adults with serious and persistent mental illness. The program combines intensive case management, integrated dual-diagnosis treatment and other clinical services with a range of housing options, which are operated under the auspices of a single agency. For individuals with co-occurring substance uses disorder, housing responses are guided by a four stage model of treatment and recovery. This continuum approach has relevance for high risk populations, especially those in poor, urban settings where safety and harm reduction are high priority.

The Community Connections Continuum represents a comprehensive housing response that includes a wide range of options that are linked to one another and to mental health services within a single organisational structure. The range includes several different levels of staffing and support intensities. Both permanent and transitional housings are available. About 60% of the more than 360 adults who receive community based supports at Community Connections live in housing units that are owned or leased by the agency. Housing supports, property management, clinical and rehabilitative services are all situated under one umbrella. Housing and clinical supports are integrated in an attempt to assure continuous access to decent, affordable housing with flexible supports.

In previous research, the Washington DC Dual Diagnosis Project compared an integrated treatment approach implemented at Community Connections to a standard treatment control group, for homeless dually diagnosed adults in inner-city Washington. Compared to controls participants in the integrated treatment group experienced more days in stable housing, were

judged to have advanced to a later stage of treatment on the SATS (46) (McHugo et al 1995) and demonstrated greater decreases in alcohol use (47) (Drake et al 1997). The Washington project combined integrated mental health and substance abuse treatment with a housing continuum approach. One goal of the project was to help homeless persons with dual disorders attain permanent, high quality housing over time rather than merely to keep them off the streets.

Detailed analyses of the housing records for the integrated treatment group in the Washington DC project were reported separately (48) (Bebaut et al 1997). Housing status was assessed along with residential history, substance use, treatment stage (SATS), psychiatric symptoms, and quality of life at baseline and at 6, 12 and 18 month follow-ups. Most participants were successful absorbed into stable housing by study end and progress towards substance abuse recovery at the 6 and 12 month assessment points emerged as the only predictor of final housing status. Those with no detected use of illicit drugs during the 6 - 12 month period were almost three times as likely to achieve stable housing compared to those with known uses. The findings suggest that the continuum model, together with integrated dual diagnosis services, was helpful to formerly homeless persons with co-occurring substance disorders.

New York Pathways to Housing

Dr Robert Drake also recommended I meet Sam Tsemberis at Pathways to Housing in Harlem. Sam started out with outreach to the street homeless in New York. He visited prisons, hospitals and shelters. He couldn't engage people with dual diagnosis. They were scared off by psychiatrists. He found that homeless people had different priorities to those of people who ran treatment programs.

He decided to let homeless people set the pace and goals. What they wanted was a place of their own, then they might go out to treatment.

The process was to engage the people and get them what they want. The choice continues. The people are spread around as much as possible, to normalise their housing. There must then be intensive services wrapped around this housing. Assertive Community Treatment (ACT) teams are an essential component. There is no prior demand that clients participate in treatment or sobriety. Clients are asked what support and help they want, and these are provided. Gradually, many realise they need help with their mental illness and addictions in order to sustain tenancy.

Pathways to Housing was the first program in the United States to offer homeless, street-dwelling men and women with dual (or more complex) diagnoses immediate access to independent apartments of their own. Street life, an early Pathways to Housing mission statement explains, renders people incapable of managing the most basic daily routines and affords little room to contemplate matters such as treatment or recovery. For this reason, the organisation provides people with an apartment *first,* so they may find a reprieve from the war zone that is homelessness. Assistance is provided every step of the way to help them move into and integrate into the community and to begin the journey through recovery and rehabilitation.

In most other programs serving homeless people who have dual diagnosis, clients move along a continuum of care, primarily living in congregate, supervised settings where they must earn their freedom and privileges and can graduate to independent supported housing based on their

demonstration to staff of their adherence to fixed set of rules, expectations and behaviours. In other programs, clients are rejected for housing and removed from housing for violating rules, not taking their medications, taking and selling drugs, being charged with a criminal offence. In the Pathways to Housing program, clients lose their housing the same way any tenant loses housing, by not paying their bills, running a drug den, acts of violence, creating disturbances intolerable to neighbours or other violations of a standard lease.

Pathways to Housing separates housing from treatment. It treats homelessness by providing people with individual apartments and then treats mental illness by individualised programs that seek out and actively work with clients as long as they need. They address their emotional, psychiatric, medical and human needs on a 24 hour, 7 days a week basis.

In a two year study comparing the outcomes of individuals receiving services-as-usual in the New York City mental health system, 84% of the Pathways to Housing clients remained housed as opposed to 60% of the city's clients. *Tsemberis, 1999.* In a follow up study, at five years, using a much larger sample of clients, 88% of Pathways to Housing clients remained housed compared to 47% of the city sample *Tsemberis and Eisenberg, 2000*. The most recent comparisons were made in a federally funded study using a randomised intent-to-treat longitudinal design. 225 homeless individuals were assigned to either Pathways to Housing (N=99) or to NYC programs serving the same population but using the treatment first method. (n-126). Results showed that after 12 months, 80% of the Pathways to Housing group were living in stable housing, compared to only 24% of the control group *(Shin, Tsemberis, Asmussen and Moran, under review)*

Program Costs

Total program costs include: the fair market value of the housing, and the local area salaries and costs required to staff and operate an Assertive Community Treatment Team. In New York, this is approximately $22,500 per person per year. This compares very favourably with any other alternative residential program widely used for this population:

- $65,000 for a community residence
- $40,000 for an SRO with services
- $27,000 for a cot in a public shelter
- $85,000 for a bed in a jail cell
- $175,000 for a bed in a State hospital

The program began in 1992 with 50 apartments. It now has 450 apartments.

The apartments are clustered around an ACT team within a 40-50 block radius.

Each team handles 70 people. Each team member has a protected caseload of 10. They can see clients every day or more than once a day if necessary.

Boston: Safe Haven Project

This project is in its early stages. It will involve collaboration between Vinfen, Boston University and Boston Medical Center. It will house 8 people and will have a clinic where there can be on-site detox. Dual Diagnosis homeless crisis intervention will work with the homeless outreach teams to get people off the streets. The aim will be to move clients into supported housing.

CONCLUSIONS

- There is an urgent need to change perceptions that Dual Diagnosis of mental illness and substance abuse is the exception rather than the rule. Research data and clinical experience in USA, Canada and UK indicate the reverse is true.

- The fact that all three countries have National documents regarding dual diagnosis indicates that they are taking the issue much more seriously than we are in Australia. There is a need for a Federal initiative to produce Best Practice Guidelines here.

- Canada has a National Program Inventory which enables any interested person to find out what services are available and to access them. There is an urgent need for such a document here. There are some quality dual diagnosis programs in NSW and other States. However, few know what they are, where they are and how to access them.

- The ultimate goal in bringing about effective treatment of people with dual diagnosis is system integration at State and Regional levels. This long-term process has begun in 15 US States and three Canadian Provinces. The required consultancy methodology and support is available through Zialogic, set up by Drs Ken Minkoff and Christie Cline.

- Integrated treatment for dual diagnosis has been established by research to be the most effective approach. Further evidence will come from the 55 site five year study currently underway, to be completed in mid 2005. A Toolkit for the delivery of integrated treatment has been developed by Dr Robert Drake and team at New Hampshire-Dartmouth Psychiatric Research Center. It will soon be available through SAMHSA. I have a copy for inspection.

- There are models of effective outpatient and residential dual diagnosis services from all three countries.

- The Assertive Community Treatment Team model of a multidisciplinary team, from diverse backgrounds, working from a holistic care, rather than medical model, with a protected caseload of 10 clients per team member, emerges as a crucial component of effective dual diagnosis treatment.

- The plight of the homeless who have dual diagnosis needs special consideration. There are effective programs such as those at Community Connections, Washington DC and Pathways to Housing in New York which are breaking the cycle of homelessness and promoting quality treatment of dual diagnosis.

- There are superb dual diagnosis residential programs in Canada for Indigenous youth who have dual diagnosis.

- Dialectical Behaviour Therapy, developed by Marsha Linehan, has been used effectively in USA and Canada for nine years. There are high quality out-patient and residential programs based on this approach. Study of these programs, ongoing contact and training could provide effective resources in a neglected area. It is, at present, not uncommon for crisis teams called to homeless hostels to say they cannot treat or are not responsible for people with personality disorders.

RECOMMENDATIONS

- That, at a Federal level, Best Practice Guidelines for the effective treatment of dual diagnosis be developed, distributed widely for consultation and discussion, then implemented. That in such development, overseas research be given intensive study and experts such as Dr Robert Drake and his team be consulted.

- That a National Inventory of Dual Diagnosis Programs be developed at Federal level, within which each State is examined separately. That the Canadian document be taken as a model of the detail required.

- That the need for system integration at State, Regional and Area Health levels be taken seriously. That a pilot program be undertaken in at least Area Health in NSW, using Zialogic Consultancy methods, over a period of at least three years, and incorporating rigorous evaluation, with a view to duplication across the State.

- That copies of the SAMHSA issued *Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit* be obtained and their use trialled in at least one Area Health, with ongoing evaluation. Ongoing consultation with the authors at New Hampshire Dartmouth Psychiatric Research Center is encouraged.

- That the models of out-patient and residential treatment identified in this report be examined by a committee with widespread experience in related areas. That appropriate models be used in clinical trials in NSW, over at least four years, with concurrent evaluation. That there be a commitment by State Government to ongoing funding so that there is lasting benefit to dually diagnosed people.

- That the plight of the homeless who have dual diagnosis and who are most at risk, be given priority. That models of care demonstrated by Community Connections and Pathways to Housing be considered, along with the need of some for residential treatment and living skills assistance.

- That Aboriginal elders be encouraged to visit Ranch Ehrlo in Pilot Butte, out of Regina SK, and Eagle Moon/Lone Pipe Lodge at Woods Homes in Calgary AB, with a view to designing their own, culturally appropriate dual diagnosis residential facilities for

Aboriginal youth. That the Alcohol Education and Rehabilitation Foundation be approached for funding these visits.

- That some members of the community based mental health teams and crisis teams be trained to use Dialectical Behaviour Therapy (DBT) to treat clients who have personality disorders. The treatment approach used at the Center for Mental Health at Greater Manchester NH could be a model (54, 55).

- That the setting up of residential facilities, based on DBT for people with personality disorder, be investigated and implemented. The model at Single Steps group home, part of Washington County Mental Health Services, Montpelier VT, could be studied.

DISSEMINATION OF THESE CONCLUSIONS:

I will communicate these findings to:

- The St Vincent de Paul State Advisory Committee for the care of People with Mental Illness

- The Coalition for Appropriate Supported Accommodation

- The Project Group for Pathways to Homelessness

- The NSW Cabinet Based Advisory Committee on Dual Diagnosis

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APPENDIX

1. DIRECT SERVICES TO THE HOMELESS

Montreal, Centre Dollard Cormier, Rue Ontario Est

Francine Cote has worked with the homeless since 1982.

The long-term homeless are always taken care of by the charities. There is a need for long term planning. Every winter, there has to be an emergency plan for those who won't go to the shelters. There is a high tolerance 400 bed shelter run by a charitable group that has minimal rule.

Dual Diagnosis: 85% of clients have a mental illness. The Centre Dollard Cormier at Ontario Est works with Clinique Cormier Lafontaine. The two workers have a harm reduction approach. Often after a client's period in detox, they provide whatever help the client needs. They administer welfare cheques, work as an advocate with landlords, deal with the legal and justice system, with lawyers and probation officers. The nurse may act as a go between with doctors. They try to ameliorate living conditions and help clients adjust to independent life.

Most clients want help to get an apartment, to pay rent and get food. Then they will try to lessen drugs use. The drug of choice in this area is cocaine.

Heroine users who are in treatment go to Le Cran for methadone. There is a proposal for a prescription heroin trial run by the Federal Government in 2004.

HIV/AIDS has changed things. Workers may accompany people to their deaths and bury them.

They work with prostitutes to help them protect themselves. Homeless women here who have mental illness may live with pimps.

People who want to live in makeshift shelters often have severe mental illness. Those who freeze to death stay outside to drink.

Clientele are white and French. First Nation people don't come to this service. Some live on the streets near Chinatown. They go to the Native Friendship Centre of Montreal, a day centre. The Federal Government pays for their detox. Some then return to their reserves.

There is a shortage of apartments and a two year waiting period for supported housing.

Services for Aged, Homeless People who may have Mental Illness

Encore Community Services, New York

History

Begun in 1977 as a service to the elderly poor of Manhatten it set up a meal room and leisure centre at the Actors' Chapel in the lower part of St Malachy's Church. These disadvantaged and isolated elderly people had not family support and lived in single room occupancy hotels and old-law tenements in west, mid-town Manhattan. Today, it has grown into a multi-purpose nonsectarian organisation that provides support services to 14,000 seniors annually. In 1995, it assumed sponsorship of a neighbouring senior centre. It began delivering an additional 50 meals to shut-ins and an additional 145 congregate meals on a daily basis. It also delivers 800 meals for Saturday and Sunday to the homebound, as part of the weekend meals program.

In 1998, Encore responded to the critical shortage of supported housing for elderly homeless people, many with mental illness, by developing the Encore 49 Residence, an 89 unit residential facility. The former Markwell Hotel, a dilapidated single room occupancy hotel, was transformed into a renovated facility for homeless elderly men and women. It is now a single room occupancy facility with 89 furnished rooms in a nine story elevator secure building.

Referrals come mainly from the Department of Homeless Services and community referrals.

Eligibility Criteria

- Homeless or at risk of homelessness, aged 55 or over.
- Interest in living independently within a supportive type of housing and a willingness to participate in activities and programs.
- Current proof of physical examination (within four months of application) and adherence to treatment plan.
- Evaluation by a psychiatrist and a willingness or resident to follow recommendations.
- No active substance or alcohol abuse and motivation to maintain sobriety.
- No violent, disruptive or socially aggressive behaviour which constitutes a danger to self or others.
- Compliance with *Guidelines for Living* the house rules of Encore 49.

Chicago, Deborah's Place

This facility operates on four sites in the city of Chicago. It is a service which cares for homeless women with varying levels of need.

- Overnight Shelter 1532N. Sedgewick Ave. This provides a bed for 30-35 women all year. It is open from 5pm to 8am. It has a harm reduction emphasis. Women cannot drink on site, but can come in drunk. Each woman is assigned a case manager. Women can leave belongings here in locked trunks at the base of beds which can be theirs as long as they need them. Some women have been coming here for 18 years. There are showers and a laundry and evening meal, TV, computers. A group meets in the evening. This model may change, as there are moves by the city and federal agencies to more permanent safe haven type shelters.

- Mara's Transitional Housing Program at 1456 W. Oakdale Ave. To come here, women must be 90 days clean and sober. It is a two year program for 30 women. Women have their own rooms, with a key. They pay 30% of their income as a program fee. This money is put aside for them and returned as a grant when they leave. Women must remain clean and sober, however, if they relapse, the room will be held for them while they go into detox. All are assigned chores and must do them and chores are rotated. They meet with a case manager once a month. They must do some voluntary work or go to a learning centre or the humanities class. The aim is to keep women moving in the direction of housing. Case workers start working on getting housing right from the start. However, low cost housing is scarce and SRO lists are closed. Marah's is a bridge back into the community. Cabrini Green, a huge, crime-ridden complex nearby, is being razed and tenants from there have swamped housing lists.

- Irene's Day Time Support Centre. This is a safe place for women. 30-35 women come here. Women come here to shower and rest. Overnight shelters may not be the best place to get eight hours sleep.

  Women Craft Inc operates on part of this site. This is a business venture which produces recycled paper products and hand made jewellery. The women do the paper making on site, using donated equipment and shredded paper.

- Teresa's Transitional Shelter. 10 women share the one big room. Maximum stay is four months. Women must be clean and sober. They must do chores and voluntary hours. The progression is to Marahs.

- Deborah's Place 11 Apartments on 1530 N. Sedgewick Ave,. 39 women have rooms with private or shared bathrooms, with on-site supportive services. This helps women move from homelessness to permanent housing.

- Rebecca Johnson Apartments on 2822 W. Jackson Bvd. These are newly renovated studio apartments that provide 90 women who have been homeless with homes of

their own. The building offers private bathrooms, kitchen and laundry facilities, 24 hour security, resident lounges, on-site management and supportive services staff.

- Education and Employment Services are offered at three Learning Centre sites where women can do computer classes, sewing, arts and crafts, reading groups and job readiness programs.

Humanities Program

Based on Earl Shorris' work (51) courses run at all buildings and at the learning centres. I sat in on one session of a four week seminar of the Odyssey Project on justice, crime and punishment. Women had read excerpts from Kant, *On Punishment* from *The Philosophy of Law,* John Stuart Mill from *Utilitariansim*, Camus from *Reflections on the Guillotine* and Susan Jacoby from *Wild Justice*. Amy Thomas Elder, from the School of Philosophy, led the discussion. Women contributed vigorously, many of their opinions coming from life experience, but blending reflections on the literature. Part of the process was to consider our ideals of justice and mercy, and to address how tensions between the two shape both human communities and human beings.

Shorris believes that exposure to the classics of philosophy and literature can lead to a re-enfranchisement for people who have lost a sense of their human dignity and worth. His process are being used widely now, in countries including USA, Mexico and now Australia.

2. RURAL SERVICES

A Rural Alternative Crisis Facility: The Home Intervention Program, Montpelier, Vermont

From 1992, this program became recognised as one able to divert very high risk persons, who otherwise would be admitted involuntarily to Vermont State Hospital, to voluntarily agree to medications, curfews and other intervention techniques that eventually reduce crisis and promote stabilisation.

In 1995, it took on its present identity as a non-hospital based community program accepting both adults and children at risk of hospitalisation. In late 1996, it moved to its present site in Barre, where it is a home in a residential neighbourhood. Divided into three living areas, a three bedroom unit, a single bed unit and a child's unit, it allows for a greater diversity of treatment options for as many as five consumers at a time. The average length of stay is six days for adults and four for children.

Goals: to meet the needs of people with a severe and persistent mental illness who are in crisis and unable to remain in a community setting. These people would be engaged in behaviour that was not acceptable to residential care home staff, group home staff, respite

providers or general hospital psychiatric units. This might involve a person being non-compliant with medication to assaulting staff or members of the community.

The goals of the program were:

- To create a new community setting, an environment willing to accept such people on a voluntary basis.

- To create a place where such people would find enough support to engage in care on a voluntary basis.

- To facilitate the use of natural supports and an individualised plan of care that would encourage use of the program by people who declined voluntary treatment. This would be possible only if the resident felt a sense of control over the intervention/treatment. To achieve this, staff needed to be willing to contract and re-contract with the resident as his/her situation changed.

Residents have single bedrooms, allowing private space for reduced stimulus, avoidance of close exposure to the crises of others and opportunity to rest. Residents cook their own meals, clean their own living area and see the same treatment providers they were seeing prior to the crisis.

Intensive staffing: At least three line staff (counsellors) are always on duty, including awake overnights, when the unit is full. Nurses are on site all but late at night, and one is always on call. An agency psychiatrist sees every patient individually each weekday, holding rounds with the line staff and the Director, a clinical psychiatric RN. Counsellors accompany residents on trips outside the facility. Counsellors provide direct emotional support and assistance to clients, distribute medications, process initial and discharge paperwork, assess suicide/homicide ideation levels, tally vital signs and work with clients to produce a collaborative, individualised treatment plan. The cook meals, with client help, and whatever else needs doing. Resident involvement in daily activities is strongly encouraged to help them maintain/relearn/improve needed skills for independent living on return home.

Staff are extremely varied in their backgrounds, education levels and skills. This diversity means that individuals care often able to help particular clients. Since this is a rural community, staff and clients often know each other from everyday life.

Basic precautions have been taken in the outfitting of the building to prevent self harm by clients. However, there are no seclusion rooms, no locked doors between residents and the outside and no mechanical restraints. Knives and chemicals are locked up and residents are searched for sharps on entry. The main security comes from the bond of respect formed by staff with residents and a combination of watchfulness and sensitivity. All staff are trained in NAPPI: Non-Abusive Psychological and Physical Intervention, defusing techniques and physical restraint.

There are three groups of clients: adult in-patients, children, who have their own unit, and adult outpatients.

There is collaboration with the local hospital psychiatric ward, with emergency room and with staff of the rural community mental health centre. Community involvement is encouraged. HI treatment plans focus on the resident's strengths and challenges in the community. Medication adjustment, housing, medical problems, attendance at community support groups are examples of focus areas.

As a consequence of this personal and individual focus many consumers choose to go to Home Intervention instead of to the psychiatric hospital. Clients are also referred there by the courts. (52) Williams, X., & Hartman, M., 2001).

3. SUPPORTED HOUSING MODELS FOR PEOPLE WITH MENTAL ILLNESS

Howard Center for Human Services, Burlington VT

Goal: To provide a safe and respectful environment in which people who have mental illness can work towards improved health and independence.

Method: The center serves adults in Chittenden County who have mental illness in a wide range of programs with varying levels of supervision and staffing.

Safe Haven is a seven bed shelter for people who are homeless and whose behaviour precludes other housing options. Residents do not need to leave during the day.

Services provided:

- Non intrusive, temporary housing.
- Supportive counselling with 24 hour staff (awake overnight) to help stabilise guests' mental, physical and emotional wellbeing.
- Connecting guests with community services and resources.

Arroway and Seventy Two are residential treatment programs, each designed for seven individuals who would benefit from a structured, supportive environment before moving to a less restrictive level of care.

Services provided:

- 24 hour staff (asleep overnight) who offer supportive counselling.
- Residents function as a co-operative group, sharing cooking and household chores.

- Staff assist residents to connect with economic, medical, psychosocial, and housing services.

- Residents and staff serve as part of an interdisciplinary team to develop individualised treatment plans.

Branches is a transitional housing facility, with six rooms, designed to promote interdependence and housing stability for adults who have been homeless

Services provided:

- Partial day and asleep overnight staff offer counselling to help stabilise tenants' mental, physical and emotional wellbeing so that the tenant can learn independent living and social skills.

- Tenants are responsible for their own shopping, cooking, budgeting and recreational activities with support form staff when needed.

Shelter Plus Care offers unlimited stay housing for six adults whose behaviour has resulted in their being chronically homeless.

Services provided:

- Part time day and asleep overnight staff offer support for tenants to live together cooperatively.

- Linking individuals with the appropriate services to address their economic, medical and psychosocial needs.

- Staff assist tenants to increase their quality of life by developing independent living and social skills.

Lakeview Community Care Home is a 17 bed program offering housing with nursing oversight for unlimited lengths of stay. Residents are adults who are not able to live on their own.

Services provided:

- 24 hour staff (awake overnight)

- Staff support residents to improve their quality of life by maintaining a healthy lifestyle.

- Staff supervise medications and involve residents in community activities. Staff cooks provide nutritional meals.

The Next Door is a therapeutic living program for eight individuals designed to transition from the hospital into the community and as a possible hospital diversion.

Services provided:

- 24 hour staff (awake overnight) provide intense counselling proactively and in times of crisis.
- A regular schedule of groups, house meetings, meals and residents' chores.
- Assisting residents to develop links and supports in the community that will sustain them in the community after discharge.

Monroe Place, Allen House and St Paul are supportive, independent living situations. Monroe Place and St Paul are apartment buildings with part-time staff services and community space. Allen House is a single room occupancy building with more extensive staff services.

Services provided:

- Staff supervision of medications when needed.
- Assistance with appointments.
- Tenants are responsible for their own shopping, cooking, budgeting and recreational activities with support from staff when needed.

4. HOUSING FOR PEOPLE RECOVERING FROM ADDICTION

Self-Run, Self-Supported Houses for more Effective Recovery from Alcohol and Drug Abuse

In a document with the above title, from the US Department of Health and Human Services, TAP Series No 5 (53), the Oxford House model is described in great detail and the process by which a group of consumers could go about setting up such a house is explained.

The first Oxford House began in Silver Springs, Maryland in 1975. These houses are often set up from revolving funds made available by States to recovering individuals for the establishment of recovery houses. Such houses:

- Utilise no paid staff;
- Operate democratically;
- Expel any residents who relapse into using alcohol or drugs; and
- Are financially self-supporting.

Details of the Oxford House movement can be obtained from:

National Clearing House for Alcohol and Drug Information (NCADI) (800) 729-6686 or (301) 468-2600

SAMHSA DHHS Publication No (SMA) 95-3070 *Self-Run, Self-Supported Houses for more Effective Recovery from Alcohol and Drug Addiction* TAP Series No. 5.