

**Connecticut Co-Occurring State Incentive Grant (COSIG)
YEAR ONE EVALUATION
September 2005 to August 2006**

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INTRODUCTION

Purpose of Program Evaluation

The Connecticut Department of Mental Health and Addiction Services (DMHAS) contracted the Yale University Program for Recovery and Community Health (PRCH) to conduct an evaluation of the co-occurring infrastructure and services enhancements being implemented through the COSIG awarded to Connecticut in 2005. The project includes the pilot implementation of evidence-based integrated treatment models for people with co-occurring disorders at two CT program sites: Morris Foundation in Waterbury for people in quadrant III with less severe mental disorder / more severe substance use disorders and the Hispanic Clinic of the CT Mental Health Center (CMHC) in New Haven, for people in quadrant II with more severe mental illness / less severe substance use disorders.

Background

According to the Surgeon General: “Forty-one to 65% of individuals with a lifetime substance use disorder also have a lifetime history of at least one mental disorder, and about 51% of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder” (U.S. DHHS, 1999b). People who have both disorders are significantly more at risk for other problems, such as increased vulnerability to relapse, re-hospitalization, suicidal behavior, violence, incarceration, inability to manage finances, unstable housing and homelessness, noncompliance with medications and other treatments, increased vulnerability to HIV, lower satisfaction with familial relationships, and higher service utilization and costs (Drake et al., 1998). Within this broader context, sub-groups also have specific needs and issues related to Co-Occurring Disorders (CODs) and treatment that are summarized below.

Women with CODs. Women differ in how their disorders may present, the mixture of problems, their response to medication and non-somatic treatments, and even the illnesses they are likely to develop. According to national surveys, women with CODs are more likely than men to have affective disorders, while men are more likely to have antisocial disorders. Women are also more likely to suffer from three or more disorders simultaneously (Zweben, 1996). Compared to men, women with CODs are more likely to have stressful life situations (e.g., single parenthood), have poorer job skills, and suffer from serious health problems. Treatment for women with CODs needs to take into account the prevalence of trauma (see below).

Trauma and CODs. There is extensive literature documenting high co-morbidity between exposure to psychological trauma, post-traumatic stress disorder (PTSD), and substance use disorders (Breslau et al., 1991; Cottler et al., 1992; Deering et al., 1996; Kessler et al., 1995;

Stewart, 1996) in the general population. Clearly, trauma exposure, the development of PTSD, and substance use are likely to be intertwined, to produce substantial psychosocial impairment (Brown & Anderson, 1991; Goff et al., 1991; Rose et al., 1991; Stewart et al., 1998, 1999), and to interfere with treatment recruitment and retention (Brown et al., 1998) and treatment outcome (Palacios, 1999) unless addressed systematically through an integrated treatment approach.

CODs Among Criminal Justice Populations. Compared to others in the criminal justice system, people with mental illnesses are more likely to be using drugs or alcohol when they commit a crime (Ditton, 1999). Estimates of the rates of severe mental and substance use disorders in jail and prison populations range from 3% to 16% (Peters & Hills, 1993; Teplin, 1990; Steadman et al., 1987). According to the U.S. Department of Justice nearly 284,000 prisoners—16% of state prisoners and local jail inmates and 7% of Federal inmates—had a mental illness (Ditton, 1999). Among detainees with mental disorders, 72% also had a co-occurring substance use disorder.

Homeless Populations with CODs. Although the root causes of homelessness are still debated, it is clear that a large proportion of the homeless population is made up of people with substance use disorders, many with co-morbid psychiatric illnesses (Baum & Burnes, 1993; Baumohl & Heubner, 1991; Oakley & Dennis, 1996; Phelan & Link, 1999; Willenbring et al., 1990).

CODs Among Racially/Ethnically Diverse Populations. Race, culture, ethnicity, and sexuality are associated with variations in prevalence, diagnoses, and treatment of substance use and mental disorders, and must be considered in treating CODs. As the Surgeon General's report, *Mental Health, Culture, Race, and Ethnicity* notes, "Culture determines how individuals describe symptoms and assign meaning to them, whether they are willing or reluctant to seek treatment, and how they confront the stigma associated with both disorders" (U.S. DHHS, 2001b).

For the above-described reasons, there is a growing need for implementing treatment interventions that target individuals with co-occurring disorders. It is understood that persons with psychiatric disorders can either be affected by each individual disorder acting independently or from the interaction between the two (e.g., an episode of mania may trigger a relapse into drug abuse or cocaine abuse may exacerbate symptoms of schizophrenia). Evidence-based integrated treatment models have proven to be effective in the treatment of people affected by co-occurring mental and substance use disorders as these approaches target both disorders simultaneously.

Evidence-based integrated treatment models combine mental health and substance use disorders treatment at the level of the clinical intervention. Integrated treatment programs mean that the same clinician(s), working in one setting, provide appropriate mental health and substance use disorder interventions in a coordinated fashion, whereby the provider agency takes responsibility for combining the treatment interventions into one coherent package (Drake et al, 1998; Drake et al, 2001). Integrated treatment programs can take place in either the mental health or addiction treatment systems, requiring only that treatment and other services for both conditions are delivered by appropriately trained staff and occur within the same setting. High prevalence rates for CODs, low treatment rates (Kessler et al., 1996; Regier et al., 1990), and the under-diagnosis of substance use disorders also highlight the need for better detection and screening strategies. According to Lehman (1996) the absence of assessment of CODs presents the major barrier to effective prevention. Thus a "no wrong door" approach—in which assessment occurs wherever an individual with COD presents him or herself—becomes critical. Moreover, screening and assessment practices serve little value unless they are implemented uniformly across mental health and addiction treatment systems.

SCOPE AND METHODOLOGY

In order to assess the three goals of CT's COSIG award (i.e., 1) statewide implementation of standardized mental health and substance use screening measures, 2) pilot implementation of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) model at Morris Foundation, and the Dame la Mano project, which is a cultural adaptation of the Integrated Dual Disorder Treatment (IDDT) model at the Hispanic Clinic, 3) increased MIS capacity at the state level to identify, track and report outcomes for people with COD), we developed a program evaluation. to assess three basic aspects: fidelity of Motivational Intervention, program effectiveness, and process of implementation.

The program at Hispanic Clinic is an ambulatory program providing services that encompasses all of the clients' needs (i.e., treatment, case management, and vocational services). The program at Morris Foundation is a treatment program that also provides intensive outpatient (IOP) services and outreach.

Before implementing the Pilot programs at the two sites, the evaluators performed twelve focus groups and an individual interview with consumers at the Hispanic Clinic in New Haven and at Morris Foundation in Waterbury during the months of February and May of 2006. In addition, a focus group was performed with peer specialists working at the emergency room of the Yale-New Haven Hospital; this last group was included because we wanted to have feedback from stakeholders that are at different stages in their recovery process. Focus group participants were referred by their clinicians. The groups included people with psychiatric disorders only and with CODs. Lists of questions were presented to stakeholders from Morris Foundation, Hispanic Clinic, and Yale-New Haven Hospital peer staff. These focus groups were audiotaped and transcribed. Questions were selected using our previous experience conducting focus groups with consumers from the Connecticut Centers of Excellence initiative. These open-ended questions were aimed at eliciting stakeholder narratives regarding access and appropriateness of treatments (please refer to Appendix A and B for list of questions addressed at the Hispanic Clinic, Yale-New Haven Hospital, and Morris Foundation). Focus group participants provided feedback regarding perceived barriers to treatment, needed services, perceived community challenges, and effectiveness of programs. These data were analyzed utilizing a process referred to as coding, which consists of assigning labels in order to organize, retrieve, and interpret the data. Codes can be conceptualized as a way of reducing data, similar to performing content analyses (Coffey & Atkinson, 1996). Using this analytical procedure, we reduced data obtained to relevant concepts addressing questions asked as the way is done in grounded theory (Strauss & Corbin, 1990).

To evaluate fidelity of implementation of Motivational Intervention (MI), we selected an instrument, namely the "Therapist Checklist," which is widely used in addiction treatment trials at the Division of Substance Abuse at Yale University. Clinicians have been asked to complete this instrument immediately after each therapy session for the first three sessions with clients. Case managers, vocational rehabilitation specialists, and engagement specialists complete this instrument following each session for the first two sessions with clients.

To evaluate process of implementation, we performed interviews with COSIG program site coordinators and COSIG staff at the pilot sites. In order to gather information on this area, we

have also interviewed stakeholders including COSIG supervisors, site coordinators, Hispanic Clinic and Morris Foundation directors on the process of staff hiring, training of staff, delivery of services, and referrals and recruitment of program participants.

In order to assess program effectiveness, we put together an evaluation packet, which included measures of substance use, psychiatric symptomatology, coping skills, readiness to change, and satisfaction with services. COSIG evaluators received feedback from the steering committee regarding suitability of instruments selected. Attention was given to issues regarding participants' burden of completing instruments (e.g., number of items on an instrument, relevance of selected instrument). In our overall outcome evaluation, we are gathering information on the different domains as stipulated in the Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMS). Please refer to Table 1 on the next page for the instruments' relevance to NOMS outcome domains. Please see Appendix C, which describes the instruments and their psychometric properties.

In order to evaluate participants' longitudinal changes, we are assessing them at baseline before initiation of COSIG treatment, at six months, and at twelve months follow-up. Additionally, participants will serve as their own controls: hospitalization rates and adherence to treatment during COSIG intervention will be compared to adherence and hospitalization rates one year prior to COSIG intervention (for those participants that had prior treatment). Participants' satisfaction with treatment is being assessed at sessions two and six in order to evaluate participants' perception of their therapeutic alliance with clinicians.

Finally, as part of our evaluation we are also assessing the state's implementation of standardized mental health and substance use measures and current capacity to collect data related to Performance Partnership Grant (PPG) measures. Please see Tables 2 and 3 in the next section.

Table 1.
National Outcome Measures (NOMs) as Assessed by COSIG Evaluation Instruments

Domain	Outcome	Measures		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
Abstinence	Abstinence from Drug/ Alcohol Use	Not Applicable	Assess by <i>Time Line Follow Back And Leeds Dependence Questionnaire</i>	
	Decreased Mental Illness Symptomatology	Assess by <i>Brief Symptom Inventory</i>	Not Applicable	
Employment / Education	Increased/Retained Employment or Return to Stay in School	Assess by <i>Interview / Demographics</i>	Assess by <i>Interview / Demographics</i>	
Crime and Criminal Justice	Decrease Criminal Justice Involvement	Assess by <i>Interview with Clinicians</i>	Assess by <i>Interview with Clinicians</i>	
Stability in Housing	Increased Stability in Housing	Assess by <i>Interview / Demographics</i>	Assess by <i>Interview / Demographics</i>	

**Table 1. Continuation
National Outcome Measures (NOMs) as Assessed by COSIG Evaluation Instruments**

Domain	Outcome	Measures		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
Access/Capacity	Increased Access to Services	Assess by <i>Interview with Clinicians</i>	Assess by <i>Interview with Clinicians</i>	
Retention	Increased Retention in treatment – Substance Abuse	Not Applicable	Assess by <i>URICA and Interview with Clinicians</i>	
	Reduced Utilization of Psychiatric Inpatient Beds – Mental Health	Assess by <i>Brief Cope and Interview with Clinicians</i>	Not Applicable	
Social Connectedness	Increased Social Supports/Social Connectedness	Assess by <i>Brief Cope and Interview with Clinicians</i>	Assess by <i>Brief Cope and Interview with Clinicians</i>	
Perception of Care	Client Perception of Care	Assess by <i>Therapeutic Collaboration Scale</i>	Assess by <i>Therapeutic Collaboration Scale</i>	
Cost Effectiveness	Cost Effectiveness (Average Cost)			
Use of Evidence-Based Practices	Use of Evidence-Based Practices	IDDT Treatment Implementation -0- Assessment of <i>fidelity to MET</i>	DDCAT Treatment Implementation -0- Assessment of <i>fidelity to MET</i>	

FINDINGS

Focus Groups Results

Focus groups were conducted in order to get consumers' feedback regarding the implementation of pilot treatments at the two pilot sites. We wanted to get stakeholders feedback about the importance of implementing treatments for people with co-occurring disorders. Six focus groups and one individual interview were performed with consumers from the Hispanic Clinic, six focus groups were conducted with consumers from Morris Foundation, and one focus group was conducted with peer staff from the Yale New Haven Hospital's emergency room. A grand total of 94 people participated in the focus groups, 33 from the Hispanic Clinic, 54 from Morris Foundation, and 7 from the Yale-New Haven Hospital.

Following are the major topics that emerged from stakeholders' responses to focus group questions discussed at the Hispanic Clinic and Yale-New Haven Hospital:

a. Challenges faced by people receiving treatment: Focus group participants stated that they would like more supports available including supported employment, childcare, supportive housing: "shelters close during the day and people don't know where to go." Additionally, they mentioned that they would welcome help with furniture and food (i.e., food pantry). Participants also showed their dissatisfaction with having to be placed on long waiting lists in order to receive services: "screen people who need services and cannot go to waiting lists." They suggested extended hours of services: "open till 7:00 pm., also on Saturday mornings." Another important preoccupation was their lack of English language proficiency. Regarding this issue, participants said that they would like to have English classes.

Focus group attendees would also like some assistance with transportation: "some people have to come to the clinic three times per week" and "sometimes people don't come to group not because they don't want to attend; it is lack of money." Participants expressed that they would benefit from having access to free legal services.

b. Development of a specific program for the treatment of substance use and mental health problems: Participants expressed that this type of program will help people who have both disorders: "focusing in only one problem is not good." They also spoke about the importance of training therapists who are going to provide specialized services to a different kind of client: "staff needs to be aware and understand alcohol and drug problems." Moreover, participants stated the added challenge of treating people with both disorders: "working with people with co-occurring disorders can be frustrating but it will aid people to recover."

Participants suggested showing movies about mental health and substance use issues as part of the activities to be performed in this type of program. They also stated that having sessions in a group format was a good idea. Moreover, they favored meeting twice a week.

c. Issues to be included in this kind of program: Participants suggested inviting guest speakers to talk about other important issues such as marriage, childcare, psychoeducation, and to invite family members to these presentations. They also recommended inviting a pastor or priest: “spirituality is important, however, understand that some people have different beliefs.”

Focus group participants also spoke about the importance of including social activities, such as gathering for potlucks once a month, celebrating birthdays, going on outings, and having physical exercise groups. They also suggested having snacks and drinks. Focus group participants recommended specialized therapy groups including Dialectic Behavioral Therapy classes, Wellness Recovery Action Plan (WRAP) trainings, and groups for people affected with post-traumatic stress disorders. Finally, participants mentioned that this kind of program would require more psychiatrists and well equipped therapists that are knowledgeable and have patience treating people with co-occurring disorders.

d. What helps to want to participate and stay in treatment: They spoke about the importance of receiving support from group members and having treatment in Spanish: “interpreters sometimes say something different than what you are saying.”

e. Greatest challenges affecting people who live in New Haven and need mental health or substance use treatment services: Focus group participants mentioned drug dealing and violence such as gang activity and shootouts, as the major problem affecting their community. Some also expressed that they felt police stereotyping. Moreover, others expressed their displeasure with the city of New Haven, which they experience as not welcoming: “there is stigma not only against people with mental illness or substance use disorders, but also against poor people.” They added “the system (i.e., social security office, SAGA) treats you like you are nothing, like you are three years old because you have a mental illness.” A participant commented: “People kick you when you are down, people then prefer to go back to drug use...the system basically kicks people down, you need a strong support or will to get up.”

Participants also talked about their problems with transportation: “cab drivers do not take people that are subsidized by the state (vouchers), they prefer cash,” and “buses running off time, or going too fast.”

f. Know program works for you: Participants said that the program works when people change their behavior. They also expressed that when the program works: “you feel better about yourself,” “you feel good,” and “you notice the change.”

Finally, participants mentioned that when the program works people see results and the presenting problem is resolved: “esteem level goes up, and you feel empowered” and “you feel more self confident, you want to contribute, and you want to be productive.”

Following are the major topics revealed by participants at Morris Foundation:

a. Strengths/ positive aspects about current treatment: Focus group participants stated that they like their relatively brief program (fifteen weeks long). They also welcome the opportunity to speak and learn social skills. Participants also expressed that hearing other people's experiences was beneficial: "people in the group help each other a lot and are supportive of each other."

Participants also shared their contentment with the physical appearance of their treatment program. Moreover, they also conveyed their satisfaction with the support they receive, which included help with clothes, basic needs, bus passes, money to put down for deposit when renting an apartment, and gift cards as rewards for being clean.

b. Aspects that need improvement: Participant stated that they would like coffee and bagels with cream cheese before they start groups: "it will make you feel welcome." They complained about the frequency and duration of groups (three hours four days per week). They mentioned that the extended hours create conflict with their jobs: "you can't work if you have to attend groups." Participants also declared their displeasure with the way urine samples are collected: "no privacy."

Focus group participants suggested having more counselors that have been in recovery themselves: "empathy is not enough to help." They stated their preference for counselors that have been through addiction problems: "groups should be facilitated by people that have clean time not book smart" and "addiction is something you have to experience." They also recommended counselors to work in different places such as detoxification units and residential treatment facilities: "to learn what people go through."

Participants also wanted more assistance with the legal system: "difficult to find jobs because of legal records" and "losing jobs is difficult for someone with records." They also emphasized the importance of treating people with respect rather than of treating them as children or criminals: "because we are addicts that does not mean we aren't human beings" and "program needs to be more cooperative than judgmental."

Focus group attendees were also concerned about staff turnover: "you have to say your same story to five or six different counselors," transportation problems: "buses stop running at 6:00 p.m. and there is no Sunday service;" a perceived outdated curriculum: "update the curriculum; do something different," and confidentiality issues.

c. Program for people with co-occurring disorders: Participants stated that this kind of program is needed for people that have both problems. They expressed that people with co-occurring disorders would need to see a psychiatrist more often. Furthermore, participants mentioned that clinicians working in this type of program will need to be very well trained in both disorders and the provision of individual and group treatment. Participants also recommended that staff pay attention to medical problems and to have groups focused on skills building: "when you are from the streets, everything works backwards."

d. What help to start a new program and stay in program: Participants manifested that having someone to relate to would contribute staying in a program: “having the feeling that staff is doing something.”

They also said that they would stay in a program if they were assisted in moving forward. For instance, getting jobs when they are clean. They also perceived “as very important learning skills: “to occupy time that I used to use doing drugs.” They would welcome programs that focus on the positive: “we are too stuck on the problem, we don’t focus on the solution.”

Finally, they said that they would stay in a program that provides person centered treatment: “you get help with all aspect of your life such as transportation, information about how to recover, how to get a bus pass, housing, day care, and school.” They added “make it interesting.”

e. Challenges in the Waterbury community: Participants revealed that a major challenge was the lack of jobs, and the limited or non-existent recreational activities: “that can affect staying clean.” They expressed their concern about not being able to get jobs due to having criminal records. Additionally, they complained of harassment by police. They also stated their frustration with the way Waterbury is run: “streets are dirty, no programs for inner city kids, and schools are bad.” Finally, they perceived too many barriers to get needed services: “in order to get services you have to be actively using.”

f. Additional resources needed: Focus group participants stated that lack of transportation was a major problem. They would also like to have a Narcotics Anonymous group in house, and help with obtaining employment: “help with writing resumes.” Participants also suggested having computer workshops. They would welcome more funding: “in Connecticut, when they do away with a program it never returns.” Finally, they emphasized the importance of having an open door policy for people who seek recovery.

g. Know program works: Participants mentioned that they know that a program works when they are interested in coming back because they learned a skill: “you look forward to what you will get.” They also shared that an indicator of an effective program is a reduction in the urge to use drugs: “you don’t pick up” and “you stay clean.” They also conveyed that when a program works, they are engaged in positive activities: “you do not go back to jail, you make moves for the better, and you are not in the streets.” Finally, participants stated that they know a program works: “when you feel change within yourself and don’t feel beat down,” “when other people noticed a change in you,” and “when you feel different...it gives you hope.”

Pilot Treatment Recruitment Status

Morris Foundation:

Received 11 "permission to contact" forms:

- Four completed baseline assessments: three women and one man
- One has scheduled a baseline evaluation
- Two do not meet criteria (already receiving services for sometime)
- Four have their phones disconnected or not in service.

Hispanic Clinic:

Five people declined to sign "permission to contact" forms:

- Three not interested
- One "happy with current treatment modality"
- One attending another substance use disorders group

Received 22 "permission to contact" forms:

- Twelve completed baseline assessments: six men and six women
- One has scheduled a baseline evaluation
- Four do not meet criteria (abstinent for more than 4 years)
- Two have their phones disconnected, not in service, or not accepting phone calls
- Two pending contact (i.e., one hospitalized and we will meet with the other)
- One refused treatment (i.e., "not interested at this time").

Process of Referrals:

Recruitment into the research started in July 2006.

The recruitment goal of eight people per month for the research study has not yet been met at Morris Foundation. There are several factors that contribute to this:

1. The project is in its early stages. To date, we have not had enough exposure to examine why clients decline the study. This is being tracked.
2. The baseline assessment needs to be performed prior to the client receiving treatment. However, intensive treatment cannot and should not be withheld because of a timing factor. Research personnel are off premises. This issue is being worked on with Morris Foundation COSIG leadership and Dr. Luis Bedregal.
3. Parole clients are excluded at this time from the research. We are modifying our protocol in order to include people on parole.

At the Hispanic Clinic, we have been able to meet our goal of recruiting at least six people per month. However, we present with some problems regarding contacting and scheduling appointments as some participants that sign "permission to contact" forms have their phones no longer in service or disconnected. This issue has been presented at each COSIG site. Strategies to solve this issue have been discussed with COSIG project directors (e.g., counselors would alert research staff when research participants have appeared for treatment appointments).

Finally, another problem presented has been the fact that some prospective participants do not show for their already scheduled baseline assessments. We are contacting them and after discussing what prevented them from keeping up with their appointments, we are rescheduling their assessments to another convenient day and time.

Pilot treatment process of implementation

Staff Recruitment:

COSIG staff at Morris Foundation is composed of two clinicians, one of which is a COSIG site manager, and two engagement specialists. Staff recruitment is often difficult and can be particularly challenging when positions take on the definition of the program implementation. With that as a concern, the Pilot Directors at Morris Foundation, Inc. assumed the role of coordinating the project immediately. Positions for the endeavor were posted internally and advertised statewide. Candidates were interviewed and hired during the first phase of implementation.

COSIG staff at the Hispanic Clinic is composed of two clinicians, one vocational rehabilitation specialist, and one case manager. Although recruitment of bilingual/ bicultural staff is very challenging, the leadership at the Hispanic Clinic was able to assemble the COSIG staff team thanks to the connections developed through the Yale University psychology internship and the in house social work training. The COSIG staff at the Hispanic Clinic is also complete.

Staff Trainings:

The program at Morris Foundation is an outpatient treatment program that also provides intensive services (IOP) and outreach. Morris Foundation COSIG staff received Dual Diagnosis Capability in Addiction Treatment (DDCAT) training: they received a DDCAT assessment (1/2 day), two days of training (basic and advanced), and follow-up consultation over several months by Mark McGovern of Dartmouth Medical School (conference calls and one day in person). They also attended two, half-day trainings at the Hispanic Clinic on motivational interviewing by Forrest Foster of Dartmouth's Evidence Based Practices Center. The COSIG clinician and engagement specialist traveled to Waterville Valley, NH for a CSAT forum on opiate addiction and adolescents. The COSIG clinician has also taken additional gambling specific trainings and receives on-going supervision from Walter Miller from DMHAS. Morris Foundation is still working on developing their implementation plan for co-occurring enhanced services.

The program at Hispanic Clinic is an ambulatory program providing services that encompasses all of the clients' needs (i.e., treatment, case management, and vocational services). Hispanic Clinic COSIG staff received 2 1/2 days of training in the provision of the Integrated Dual Disorder Treatment (IDDT). Forrest Foster, who has continued to meet with the Hispanic Clinic COSIG program directors, Luis Añez and Manuel Paris, delivered the trainings. Additionally, Hispanic Clinic and Morris Foundation staff received training in motivational interviewing by Forrest Foster. Hispanic Clinic COSIG staff had three in person consultations and several telephone consultations with Ismael Santiago-Lamb, senior clinician at the Capitol Region

Mental Health Center (CRMHC). These consultations centered on the implementation of the IDDT model for Latinos, which was successfully adapted and implemented at CRMHC. This treatment model was named the Dame la Mano project. Hispanic Clinic is replicating this model in New Haven. Forrest Foster of Dartmouth's Evidence Based Practices Center meets every month with Hispanic Clinic leadership, and every three months Ismael Santiago-Lamb joins this meeting. Hispanic Clinic has developed an implementation plan based on the IDDT fidelity scale.

In addition, COSIG staff and other staff from both pilot sites attended a 2 1/2 day training on Trauma Recovery and Empowerment (TREM) adapted for Latinas, which was funded in part by the COSIG and took place in the month of June of this year. Both pilot sites also received a one-hour training by Julienne Giard, COSIG project manager, on the use of standardized mental health and substance use screening measures. Topics covered included: differences between screening and assessment, benefits of screening, and an introduction to the instruments being piloted. They also participated in follow-up calls regarding the screening pilot and received summary reports regarding their complete screens (i.e., percentage scoring for co-occurring disorders, mental health disorders only, substance use disorders only, and duration of administration of screens).

Delivery of Services

As expected, participants receiving COSIG pilot services, present with multiple case management needs (i.e., housing, food, clothing, transportation, referrals to receive other health services) and often require crisis-type interventions. The Hispanic Clinic's team approach is being successful in meeting most of the COSIG clients' needs. The same is true with Morris Foundation, which is utilizing its engagement specialists for case management specific issues as an adjunct to clinical services. Participants have been adherent to their appointments and we are already beginning to see improvements. In future reports, we will be able to provide anecdotal information and data about these perceived changes.

Statewide Implementation of Standardized Mental Health and Substance Use Screening Measures and Use of Outcome Data

One of the three main goals of the COSIG is to implement standardized mental health and substance use screening instruments. DMHAS has implemented a comprehensive statewide pilot and the results and recommendations from that are forthcoming.

The third main goal of the CT COSIG is to increase formal tracking of COD measures. DMHAS has begun to formally track statewide data regarding co-occurring disorder measures: (a) percentage of treatment programs that screen for CODs using standardized screenings: 30 of 175 agencies (17%) are participating in the screening pilot; The Advanced Behavioral Health (ABH)¹ survey reports that the vast majority of agencies screen, but not necessarily with standardized measures for CODs; (b) percentage of treatment programs that assess for CODs: according to the ABH agency self-report survey, 80% of MH clients are assessed for CODs and 83% of SA clients are assessed for CODs; (c) percentage of treatments that provide collaborative, consultative, and integrated models of care: ABH self report survey showed that treatment programs provide 28% collaborative, 20% consultative, and 44% integrated models of care. Finally, the state is in the process of formally tracking percentage of clients who experience reduced impairment following treatment (please refer to Tables 2 and 3). There is a discrepancy in percentage of people reported as having a co-occurring disorder according to screening pilot (48%) and according to diagnoses in MIS (16%). We plan to investigate this discrepancy. Although the state is in its beginning stages, it could be anticipated that these data will be tracked more accurately during the coming years.

**Table 2.
COD Measures as in the original COSIG Grant Application**

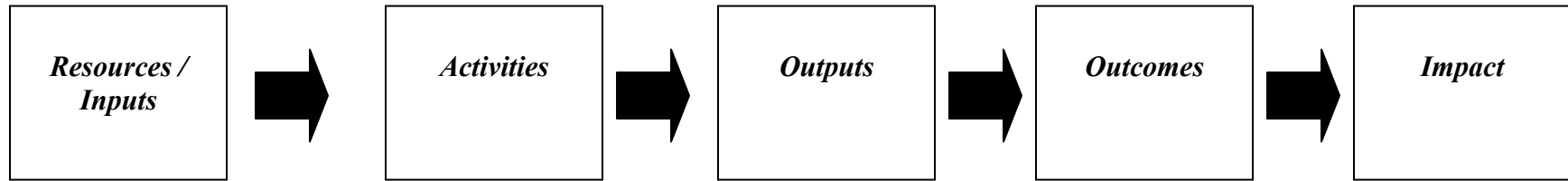
Table 4. PPG Measures	Current	Year 1	Year 2	Year 3	Year 4	Year 5
Percentage of clients with symptoms of a corresponding COD problem	25%	35%	45%	55%	65%	65%
Percent of treatment programs that screen for CODs	This information is not currently being formally tracked within the DMHAS MIS	25%	45%	65%	85%	100%
Percent of treatment programs that assess for COD		20%	40%	60%	80%	100%
Percent of treatment programs that provide treatment through 1) collaborative, 2) consultative and 3) integrated models of care		1) 15%	20%	25%	30%	35%
		2) 15%	20%	25%	30%	35%
	3) 10%	15%	20%	25%	30%	
Percentage of clients who experience reduced impairment following TX		30%	40%	50%	60%	70%

¹ ABH conducted a statewide survey of programs for DMHAS in 2005 regarding co-occurring disorders and how programs are currently serving this population (e.g., screening, assessment, types of treatment models).

Table 3.
Current COD Measures as of October 23, 2006

COD Measure	Year 1	Year 2	Year 3	Year 4	Year 5
Percentage of clients with symptoms of a corresponding COD problem	currently in the screening pilot it is 48%; according to diagnoses in our MIS 16% have COD (concerned about accuracy of this figure)	Per statewide screening July 07	Per statewide screening July 07	Per statewide screening July 07	Per statewide screening July 07
Percent of treatment programs that screen for CODs [using standardized screens]	27 of 175 agencies are in the screening pilot and 3 methadone maintenance agencies screen for CODs per contract changes 4-5 years ago; total 30 of 175 agencies (17%); do not have data on “programs” (as opposed to “agencies”)	100%	100%	100%	100%
Percent of treatment programs that assess for COD	Per the July 05 ABH agency self- report survey, <ul style="list-style-type: none"> ▪ 80% of MH clients are assessed for COD; 83% of SA clients are assessed for COD; ▪ 96% have a written policy requiring assessment of MH clients whose screening suggests the existence of a COD & 17% have a written policy requiring all MH clients be assessed for the presence of a COD; ▪ 94% have a written policy requiring assessment of SA clients whose screening suggests the existence of a COD and 31% have a written policy requiring all SA clients be assessed for COD. [Note: These data do not directly answer the stated question] 	TBD by annual self report survey of programs	TBD by annual self report survey of programs	TBD by annual self report survey of programs	TBD by annual self report survey of programs
Percent of treatment programs that provide treatment through 1) collaborative, 2) consultative and 3) integrated models of care	Per the July 05 ABH agency self report survey, 28% Collaborative; 20% Consultative; 44% Integrated	TBD by annual survey of programs	TBD by annual survey of programs	TBD by annual survey of programs	TBD by annual survey of programs
Percentage of clients who experience reduced impairment following TX	Not tracked	TBD by QMI outcome data	TBD by QMI outcome data	TBD by QMI outcome data	TBD by QMI outcome data

COSIG Logic Model:

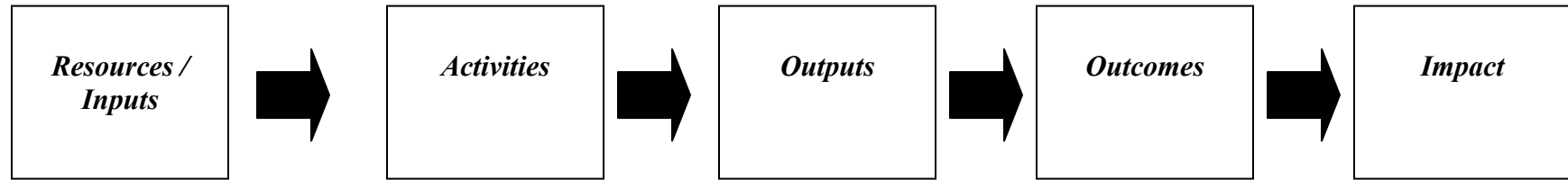


Planned Work

Intended Results

Consumers	Clinicians' training	IDDT Intervention	COD clients' reduction of Symptoms	Statewide capability to treat people with CODs
Clinicians	COD academic training	DDCAT Intervention	COD clients' increase functioning	Workforce training in CODs
Case managers	Pilot intervention at MF	COD Screen	Increase COD participants' adherence to treatment	Reduction in social indicators related to CODs
Engagement specialists	Pilot intervention at HC	COSIG Steering Committee meetings	Decrease COD participants' hospitalization rates	Improve health status of people with CODs
COSIG budget	Develop COD enhanced/capable agencies	COD treatment at Hispanic Clinic	Increase COD participants' community integration	
IDDT trainers	Screening Pilot	COD treatment at Morris Foundation		
	Outcome Data Analyses			

COSIG Logic Model. Continuation



Planned Work

DDCAT
trainers

Steering
committee,
including
Commissioner
as COSIG
Project
Director, and
two workgroups
(Screening and
Workforce
Development)

Project manager
Evaluators
COCE - TA
Analysts

Intended Results

Increase State
capacity to
track 100%
COD measures

Increase
clinicians'
expertise in
treating CODs

DISCUSSION / RECOMMENDATIONS

We believe that the overall COSIG goals for this year have been met.

Pilot implementation of standardized screening instruments (i.e., Modified MINI, MHSF-III, SSI-AOD, and CAGE –AID) occurred in 27 statewide mental health and/or addiction treatment agencies. Completing these instruments took an average of 11 minutes. Overall, 48% reported positive for CODs.

Recruitment of people with CODs into pilot treatments and the research component at the two sites has gained consistency. Over the two months of research recruitment (July – August), the goal of six new admissions into COSIG treatment at the Hispanic Clinic has been met. At Morris Foundation, this goal has not yet been met. However, initial problems that have prevented meeting recruitment goals are being addressed (e.g., COSIG evaluator going more often to the pilot sites, increased referrals by Morris Foundation clinicians, and addressing changes in recruitment protocol to include people on parole).

Implementation of Interventions at pilot sites has happened or is happening. As expected, COSIG clients at both pilot sites present with multiple needs that require significant case management. Needs include, but are not limited to, housing, medical, transportation, childcare, and food. Moreover, clients attend treatment on a crisis type basis. A high percentage of clients with CODs are also affected by medical conditions and a history of trauma. It has been difficult to initiate treatment interventions (IDDT or DDCAT), specifically at the Hispanic Clinic, before these needs are met. Therefore, COSIG staff has been implementing intensive case management. Community resources (e.g., jobs, shelters/housing, medical services) are mostly non-existent for this population. It would be of great benefit to the COSIG programs to have these types of community resources to alleviate COSIG clients' needs.

The State of Connecticut has begun to formally track COD measures. Although still in the initial stages, we anticipate that tracking of COD measures will increase statewide. There is an increased awareness among CT mental health and addiction treatment programs regarding the importance of collecting COD measures.

EVALUATION PLANS FOR YEAR TWO

Period 9/06 to 8/07

- Continue administration of baseline battery, post-treatment, and follow-ups at Hispanic Clinic and Morris Foundation
- Develop a logic model program evaluation that allows for examination of the processes (i.e., inputs, activities, outputs, and utility) of Hispanic Clinic and Morris Foundation pilots implementation
- Provide continued feedback to pilot project leaders, community stakeholders, and funding agency
- Implement participatory process to evaluate pilot implementation
- Track outcome progress at Hispanic Clinic and Morris Foundation
- Track outcome assessments at Hispanic Clinic and Morris Foundation
- Evaluation of fidelity of implementation of Motivational Intervention technique at Hispanic Clinic and Morris Foundation
- Provide continue feedback to pilot project leaders
- Modification and resubmission of IRB and HIC protocols and informed consent forms to include random audiotaping of sessions, and inclusion of people in parole status
- Application to NIH for a Certificate of Confidentiality
- Maintenance of a computerized tickler to track evaluation schedules (i.e., baseline, post-treatment, and follow-up) at Hispanic Clinic and Morris Foundation

Appendix A

Hispanic Clinic and Yale New Haven Hospital Focus Group Questionnaire

“Thank you for taking the time to meet with us today. We are beginning a study that aims to enhance the quality of the treatment programs available to people with co-occurring disorders, this refers to people with both a psychiatric illness and substance use disorders. As part of this project, providers, community leaders, and consumers will play an active role in the planning and implementation of the treatment program. The purpose of today’s meeting is to obtain your feedback and suggestions on how you believe community agencies can improve their services. We will ask you a series of specific questions where we invite you to openly share your opinions and talk about your experiences. Remember that there are no right or wrong answers and we expect different points of view. You should also know that all the information that we collect is confidential as to who provided it. We will not be asking any personal information, not even your names, and your answers will not in any way affect the services you receive here. Does anyone have any questions before we start?”

1. What do you think about the idea to develop a specific program for the treatment of substance use and mental health problems?
2. What do you think is important to include in this kind of program? What kinds of issues do we need to be aware of or understand?
3. When you hear about the start of a new treatment program, what helps to make you want to participate and stay in treatment?
4. What would you say are the greatest challenges affecting people who live in the New Haven community and need mental health or substance use treatment services?
5. How do you know that a program is working for you?

Appendix B

Morris Foundation Focus Group Questionnaire

“Thank you for taking the time to meet with us today. We are beginning a study that aims to enhance the quality of the treatment programs available to people with co-occurring disorders, this refers to people with both a psychiatric illness and substance use disorders. As part of this project, providers, community leaders, and consumers will play an active role in the planning and implementation of the treatment program. Since you all currently receive services at Morris Foundation, the purpose of today’s meeting is to obtain your feedback and suggestions on how you believe the agency can improve their services.

We will ask you a series of specific questions where we invite you to openly share your opinions and talk about your experiences. Remember that there are no right or wrong answers and we expect different points of view. You should also know that all the information that we collect is confidential as to who provided it. This means that we will not disclose who actually participated in this focus group and your answers will not in any way affect your current or future treatment at Morris Foundation. Does anyone have any questions before we start?”

- Let’s start by talking about the positive aspects of your program. What do you think are the strengths of your treatment program here at Morris Foundation?
- What aspects of your program would you like to see improved?
- What do you think about the idea to develop a specific program for the treatment of co-occurring disorders?
- What do you think is important to include in this kind of program? What kinds of issues do we need to be aware of or understand?
- When you hear about the start of a new treatment program, what helps to make you want to participate and stay in treatment?
- What would you say are the greatest challenges affecting people who live in the Waterbury community and need mental health or substance use treatment services?
- Tell us about the additional resources and supports that have improved your treatment program.
- How do you know that a program is working for you?

Appendix C

Description of Instruments

a. University of Rhode Island Change Assessment Scale (URICA; DiClemente & Hughes, 1990) - Client's motivation, or readiness for change, may be an important predictor of response to treatment (Prochaska, DiClemente, & Norcross, 1992). The 32-item URICA assesses the client's current position regarding readiness for change (e.g., pre-contemplation, contemplation). In a study performed by Dozois et al. (2004), internal reliability (Cronbach's alpha) of the URICA subscales were found to be .77, .80, .84, and .82, for the pre-contemplation, contemplation, action, and maintenance subscales, respectively. Scores on this instrument will provide information on stages of readiness for treatment and retention rates.

b. The Brief Symptom Inventory – The BSI is a reduced version of the 90-item Symptom Check List (Derogatis, 1983, 2000). The BSI is composed of 53 items that samples nine primary symptom dimensions. It is widely used and the symptom dimensions have demonstrated very good Cronbach's alpha reliability indices ranging from .71 to .85 (Kellelt et al. 1976). Following is a list of the BSI dimensions:

SOM – Somatization
 O-C – Obsessive-Compulsive
 I-S – Interpersonal Sensitivity
 DEP – Depression
 ANX – Anxiety
 HOS – Hostility
 PHOB – Phobic Anxiety
 PAR – Paranoid Ideation
 PSY – Psychoticism

This instrument will provide data regarding reduction of psychiatric symptomatology.

c. Timeline Follow Back - The Timeline Follow Back (TLFB) is a self-report instrument designed to evaluate estimates of past daily drinking. The TLFB can facilitate collecting information up to 12 months before assessment using memory aids to maximize recall. In a cross-cultural evaluation performed by Sobell et al. (2001), the TLFB achieved good psychometric properties, supporting its use with Swedish, Spanish, and English speaking populations of alcohol abusers. Data from this instrument will permit assess abstinence and substance use frequency.

d. Leeds Dependence Questionnaire (LDQ) - The LDQ is a brief 10-item instrument that assesses dependence to different substances (Raistrick et al., 1994). It demonstrated good internal reliability (Cronbach's alpha = .94) and test-retest reliability ($r = .95$). Ford (2003) found good reliability of the LDQ (Cronbach's alpha = .92) and good concurrent validity with the Dartmouth Assessment of Lifetime Inventory (DALI, $R^2 = .44$). Scores on this instrument will permit assessment of participants' severity of substance use.

e. The Brief COPE - Carver (1997) derived it as an alternative to the original COPE Inventory (Carver, Scheier, & Weintraub, 1989). The Brief COPE is a 24-item instrument used to assess individuals' preferred coping styles and strategies. Among the advantages of this abbreviated version are its reduced length, as well as its reliability in predicting outcomes across stressful situations (Meyer, 2001). Thus, the Brief COPE scales can be generally classified as assessing adaptive versus maladaptive coping styles, and emotion-focused versus problem-focused strategies. Furthermore, the Brief COPE scales achieved reliability scores (Cronbach's alpha) ranging from .50 to .90 (Carver, 1997). Scores on this instrument will provide information on coping skills, social connectedness, and treatment retention rates.

f. Therapeutic Collaboration Scale (TCS) – This scale is part of an assessment instrument named the Cultural Competency and Collaboration Scale (CCCS) developed by Larry Davidson and a team of collaborators (Davidson, 2002). The TCS has 14 items as compared to the 22-item CCCS. The TCS can be responded using a five point Likert-type scale ranging from 1 (*not at all*) to 5 (*very much*). Higher scores indicate good perceived therapeutic collaboration. The TCS assesses the degree to which participants experience the relationship with their therapists to be collaborative and meaningful. Being aware that clients' views about the therapeutic alliance and not the therapists' (Marziali, Marmar, & Krupnick, 1981) correlates highly with psychotherapy outcome. Psychometric properties of the Spanish version of the Therapeutic Collaboration Scale (TCS) showed substantial internal consistency reliability (Cronbach alpha = .94; Paris, Bedregal, Añez, Shahar, & Davidson, 2004). This instrument will provide information on the participants' perception of care.

Fidelity Evaluation

a. Therapist Checklists - The 27-item Therapist Checklists tap therapists' use of specific interventions (Carroll et al., 1994; Carroll, Nich & Rounsaville, 1998; Carroll et al., 2000). These checklists enhance treatment discriminability, and help estimate the overall level of treatment specific interventions provided to each participant in the study. The checklist is completed post session. Preliminary analyses of this technique in a previous cocaine psychotherapy study indicated acceptable agreement between therapist checklists and observer ratings (Carroll, Nich & Rounsaville, 1998). This assessment will provide valuable information on effectiveness of Motivational Interviewing.

b. Yale Adherence and Competency Scale (YACS) - To assure that the psychotherapy conditions under investigation are discriminated and delivered in a manner consistent with guidelines, random therapy sessions will be audiotaped and evaluated by raters who are trained to perform this work. The Yale Adherence and Competence Rating Scale consists of a series of items tapping key unique components of the therapy evaluated and comparison approach. For each item, raters are asked to rate the degree to which the therapist used that particular intervention in the session (adherence), as well as how skillfully the therapist implemented the intervention (skillfulness). For the most recent version of the rating scale (Carroll et al., 2000), the coefficient alpha for the treatment scales were in the .80 to .95 range, indicating a high degree of internal consistency, and the ICC's (intraclass correlation coefficient) for the adherence and competence

scales ranged from .75 to .90. It complements information from the Therapist Checklist as assessed by an outside rater.

Table 4. List and Schedule of Study Assessments

Domain/Measure	Baseline	Two Weeks	Six Weeks	Six Months	Twelve Months
a) Outcome					
1. Process of Change (URICA)	X			X	X
2. Brief Symptom Inventory	X			X	X
3. Time Line Follow Back	X			X	X
4. Leeds Dependence Questionnaire	X			X	X
5. Brief Coping Response Inventory	X			X	X
6. Therapeutic Collaboration Scale		X	X		
Domain/Measure					
	2/3 Weeks		Randomly		
b) Fidelity					
1. Therapist Checklist	X				
2. YACS			X		

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