An Evaluation Framework for Measuring Outcomes of Dually Diagnosed Homeless Individuals in Flexible and Integrated Treatment Programs

by Richard Meldrum

Homeless individuals who are dually diagnosed have generally received poor services in treatment programs. Either the programs do not integrate mental health treatment with substance abuse treatment or the integrated programs have been too rigid to address complex dual diagnosis issues. Recently, flexible and integrated treatment programs have started to crop up to address this service gap. However, these programs often lack comprehensive evaluation data. Drawing on research with a stages of change, integrated treatment program, I explore potential ways to evaluate the short- and long-term outcomes of similar programs. The development and implementation of a comprehensive evaluation strategy is an important step to assessing the value of flexible and integrated dual diagnosis treatment programs.

Traditionally, dually diagnosed homeless (DDH) individuals have been treated either in mental health clinics or substance abuse treatment centers. These alternatives often result in high client dropout rates since they ignore the second diagnosis (Blankertz and White, 1990). When treatment is integrated, most programs employ a strict abstinence policy for substance abuse and require mental health medication compliance. Because recent research shows mixed results of these programs, some developers have switched to more flexible program goals (Carey, 1996). In contrast to the traditional treatment programs, the flexible programs do not necessarily demand abstinence or medication compliance. However, this transition has made client and program evaluation difficult. Therefore, I propose an evaluation strategy based on the analysis of an integrated DDH program that imbeds a flexible stage of change model within a continuum of housing structure. Before turning to my evaluation strategy, however, I provide a brief definition and description of the DDH population.

DEFINITION AND DESCRIPTION OF DDH POPULATION

The program discussed throughout this article categorizes people as dually diagnosed if they have a serious mental illness (e.g., schizophrenia, delusional disorders, schizoaffective disorders, mood disorders, borderline personality disorders, etc.) and a co-occurring substance disorder (e.g., abuse of alcohol, opiates, cocaine, etc.).[1] This definition is consistent with the literature referenced throughout this article.

Since the late 1980s the co-occurrence of mental illness and substance abuse has hovered around 17 percent within the homeless population (Burt, 1989; Tessler and Dennis, 1989; Burt, 1999). In general, program developers have only recently recognized dually diagnosed individuals as a significant subpopulation of the homeless community (McHugo et al., 1995). The consequence of this oversight has been demonstrated through the lack of services targeted directly at DDH individuals. Accordingly, members of this community often fall through the cracks of service provisions aimed at mental illness or substance abuse rather than both diagnoses. When DDH individuals are treated in only one system the second diagnosis is often ignored, resulting in a high dropout rate (Blankertz and White, 1990).

Although poor services remain a problem, this trend has begun to change through increased understanding and research into the composition of this group. Specifically, researchers and program developers are beginning to understand this group's extremely heterogeneous nature. Indeed, the MISA population differs not only in terms of demographics but also in severity of their mental illnesses and addictions (Carey, 1996; Drake, Osher, and Wallach, 1991). Complicating matters further, DDH individuals have higher incidences of general medical illness, legal problems, and skills deficits among their many other difficulties (Carey, 1996; Drake et al., 1991; Fischer, 1990). Most likely, these complications are the result of their severe substance abuse and mental illness impairments.

DESCRIPTION OF THE ROBESON CENTER

Opened in late 2000, the Robeson Center (Robeson) offers housing, treatment, and case management supports to DDH adults.[2] In order to serve its residents, the center provides services to accomplish two goals: to facilitate participants' development of the necessary skills to manage their multiple disorders and to obtain and maintain permanent autonomous living. To meet these goals, Robeson administration mirrors its residents' stabilization stages using a

continuum of housing and treatment program. In this manner, Robeson represents a new kind of agency that links housing and treatment geared toward DDH individuals.

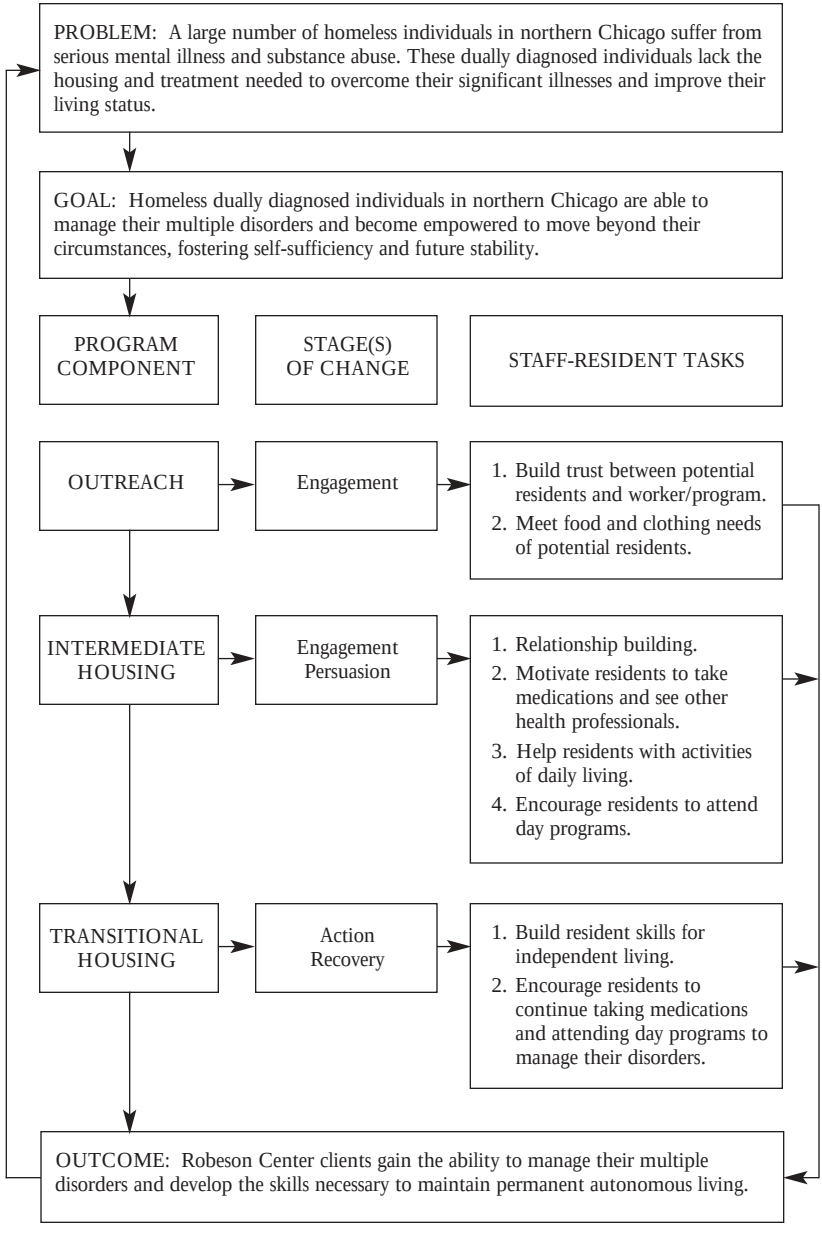
Robeson's services are rooted in a growing theoretical belief shared by a number of researchers. These researchers take into account the enormous complexities and vulnerabilities of the DDH population and, as a result, advocate for integrated and flexible treatment approaches (see Blankertz and White, 1990; Carey, 1996; Drake et al., 1991). This approach enables individuals to simultaneously progress through substance abuse and mental illness treatments in stages consistent with their level of diagnosis.

These flexible and integrated programs serve not only organizational needs but also may have an advantage over traditional programs. They meet organizational needs since many clinicians and administrators support integrating treatment within one system or setting. Indeed, this arrangement removes the burden of coordination between multiple agencies (Drake et al., 1991). Additionally, research finds that housing provisions may be the cornerstone of care for DDH individuals (Drake et al., 1991; Hopper, 1989). These housing provisions provide stability for potential residents during their struggle to gain control over their multiple problems.

In concordance with the literature, Robeson has developed three program components that form a continuum of program components: outreach, intermediate housing, and transitional housing (figure 1). These components attempt to provide the necessary flexibility for dually diagnosed individuals to progress at a pace consistent with their diagnoses. Furthermore, Blankertz and White (1990) imply that the individual characteristics of MISA individuals (e.g., acceptance of restrictive environments, desire for self-determination, tolerance of high expectations, willingness to strive for abstinence, etc.) may determine how much structured housing they prefer or need in order to address their mental illness and substance abuse issues.

Consequently, this housing structure necessitates an equally flexible treatment philosophy since a strict one would fail to differentiate the beneficial aspects of each housing component. Therefore, Robeson administration employs the philosophy that change occurs through a series of stages (Stellon, 2001; Osher and Kofoed, 1989; Prochaska and DiClemente, 1986; Prochaska and Prochaska, 1999). Specifically, Osher and Kofoed (1989) note that MISA individuals generally pass through four stages on their way to recovery: engagement, persuasion, active treatment, and relapse prevention. Initially, clients become engaged in the treatment relationship (figure 2). During the persuasion stage, clinicians work to motivate their clients' desire to change their self-

FIGURE 1: ROBESON CENTER LOGIC MODEL



destructive behavior. Clinicians may, for example, persuade a resident that substance abuse is a problem with high personal costs and that greater health and happiness can be attained by decreasing her substance use. After clinicians have persuaded substance abusers to reduce substance use, active treatment strategies can help them develop the necessary skills and supports to eventually achieve abstinence. Finally, after achieving stable abstinence, they can be assisted to maintain whatever resources and behavioral changes are needed to prevent relapse. These stages of change serve as the foundation for Robeson's housing components.

FIGURE 2: STAGES BY PROCESS OF CHANGE

STAGES OF CHANGE

	Engagement	*Persuasion*	*Active Treatment*	*Relapse Prevention*
Process	Build trust and relationship with MISA individual	Individual is willing to discuss his problem behavior(s)	Individual is actively involved in treatment	Individual is in treatment and has maintained at least 6 months of abstinence

DESCRIPTION OF PROGRAM COMPONENTS

Outreach: Engagement

The essential function of Robeson's outreach is to initiate the process of engagement with potential residents. To fulfill this function, Robeson clinicians provide outreach services to the streets and local social service agencies several times a week. In the agencies, outreach workers often meet with individuals who were referred by the agency's staff. However, street outreach is focused entirely on providing individuals with services and items that they specifically request. For example, a Robeson worker related a story about an individual who was obviously mentally ill but requested only clothing. Since the worker was attempting to gain the individual's trust, he provided clothing without attempting to address the mental health issue. The worker's example highlights the outreach effort's engagement function. This engagement process involves gaining the trust of an individual and continues throughout the individual's interactions with the agency. Engagement is essential to establish an effective relationship between the workers and the individual (Blankertz and White, 1990). Depending on the DDH individual's level of engagement and willingness to pursue treatment, she may be accepted into the program.

Intermediate Housing: Engagement and Persuasion

The overall goals of the intermediate housing component are to continue building a trusting relationship with the resident, stabilize the resident's multiple problems, and begin working toward abstinence. When individuals officially enter the program, they come into the intermediate housing section. This section allows a resident an indefinite length of stay depending on the individual's progress, and housing is provided at no charge to him. However, Robeson requires its residents to adhere to specific expectations (e.g., no alcohol or illegal drugs on premises, no weapons or fighting on premises, no abusive or threatening language, must keep room, person, and clothes clean, etc.) to help ensure the safety and comfort of residents and staff. Since most residents may be eligible for either SSI or Medicaid, Robeson case managers also work with the residents to secure these entitlements.

Aside from attending to residents' basic needs, Robeson workers also assess the residents' dual problems. Robeson's psychiatric staff examines the residents' level of mental illness in this stage and prescribes appropriate medications to stabilize the illnesses. Staff nurses then have the responsibility to offer medications as prescribed. Treatment integration in this stage consists mainly of workers encouraging residents to stabilize their mental health through taking medications and their substance abuse through reduced substance use. Utilizing these measures and appropriate group meetings (e.g., Alcohol/Narcotics Anonymous), Robeson believes that residents will become increasingly aware of their problem behaviors and more willing to change those behaviors.

Transitional Housing: Action and Recovery

As the worker-resident alliance strengthens and residents maintain abstinence along with mental health stability, they can move to the center's transitional housing program. Once residents move into this stage, Robeson expects them to attain the level of abstinence where occasional lapses, but not days of problematic use, may occur. In this stage residents must pay rent equal to a third of their income (if they have an income) and are limited to a maximum stay of 24 months. Additionally, Robeson workers assist them with further treatment and daily living skills that will enable residents to maintain permanent independent living and the ability to manage their disorders. Toward the end of a resident's stay, Robeson workers will help residents find independent housing and link them to other social services if needed.

EVALUATION QUESTIONS AND RECOMMENDATIONS

In order to understand the impact of Robeson's programming, its administrators must consider at least three key evaluative questions. First, where do the residents enter the program? As stated earlier, Robeson provides outreach to the shelters and the streets in northern Chicago. However, if the vast majority of the clients come from social service agency referrals, then direct street outreach might be unnecessary to attract program participants. Robeson will most likely receive more residents from referrals than from street outreach since the instability of the DDH population may detract from regular street contact (Drake et al., 1991). Furthermore, referred clients may be easier to engage since they have at least developed a relationship with a social service worker and demonstrated willingness to be assessed by Robeson workers.

Second, how long does it take and how much does it cost for one resident to progress through the program? The intermediate stage presents the greatest opportunity for residents to linger and costs to grow. The residents in this stage not only have the lowest expectations of Robeson residents, but they also do not pay rent. Without higher expectations, these residents could easily remain in the center for long periods of time. If this delay is occurring unnecessarily, then the administration may need to increase its expectations from residents.

Third, is the program effective at fulfilling its mission statement? This question is the fundamental question that Robeson needs to address. Its program developers have taken a nontraditional approach to treating DDH individuals and need to know if the program does what is proposed. If it is not fulfilling the mission to provide services that facilitate residents' development of the necessary life skills and ability to manage their multiple disorders, then the approach should be changed.

Since poor evaluations remain a major criticism of nonabstinence treatment programs, a comprehensive evaluation toolbox must be employed. Indeed, Ogborne and Birchmore-Timney (1999) note that harm reduction program proponents often make promises of greater cost-effectiveness and better outcomes, but they support their claim with rhetoric rather than evidence. For this reason, evaluation strategies are important not only to ensure quality treatment for those receiving it but also to establish or eliminate nonabstinence programs from the field. To answer the questions posed above, the following measures will be discussed as a set of recommended evaluation tools: Substance Abuse Treatment Scale, medication compliance, activities of daily living development, program participation, housing outcomes, addiction out-

comes, and mental illness outcomes. These evaluation measures cover the spectrum of intermediate and long-term outcomes as well as individual and programming performance levels.

First, the Substance Abuse Treatment Scale (SATS) serves as the foundation for the evaluation strategy. The SATS is the result of a New Hampshire Division of Mental Health (NHDMH) seminar that elaborated on the stages of change model discussed above (see appendix). The seminar participants expanded the model into eight stages with more explicit criteria. The NHDMH then applied the scale in community mental health centers to track the progress of clients who were dually diagnosed throughout a 3-year study. Researchers found that SATS was a useful tool to summarize and track the progress of clients with mental illness in substance abuse treatment (McHugo, et al., 1995).

The major strength of SATS for the Robeson Center lies in its fit with the program. Indeed, the measure not only fits with the program's philosophy but also with the client population. The expanded stages of change model in SATS would be easy to utilize with Robeson's preexisting methodology since they both build from the same general format. Additionally, the measure is the only one designed, developed, and standardized for dually diagnosed individuals.

On the other hand, SATS's primary weakness lies in the realm of its newness. Robeson clinicians would need training to learn to use the measure effectively. However, McHugo et al. (1995) note that with "modest training and reasonable familiarity with their clients, clinicians can use SATS consistently and meaningfully" (p. 766). This training could progress more quickly for Robeson clinicians given their familiarity with the basic stages of change model.

The programming benefits that SATS offers lies in resident tracking. From the initial program overview, a potential logjam could easily occur in the intermediate housing stage without proper evaluation. Given the combination of free rent and low expectations, residents could linger unnecessarily in this program element, increasing costs and preventing the agency from helping other people. Applying SATS every 6 months, as NHDMH recommends, would allow Robeson workers to maintain an individual's residency in the appropriate setting. Therefore, SATS enables administrators to understand how long residents take to move through the program and how effective the program is in the intermediate time frame.

The second measure, medication compliance, is a very straightforward measure. Since residents are encouraged, but not absolutely required, to take medications that control their mental illnesses, an understanding of how many

people actually comply with these requests is important. Indeed, if residents are consistently taking their medications, then they are exhibiting more control over their mental illness. Thus, this measure indicates a resident's progression through the stages of change (Stellon, 2001).

Third, activities of daily living (ADLs) and program participation are good resident measures since they can indicate a level of engagement and progression toward independence. When residents first enter Robeson, workers identify the expectation that they will keep their clothes, their room, and themselves clean (Stellon, 2001). Additionally, residents are expected and encouraged to attend day programs at a sister agency. These programs range from traditional 12-step programs to educational seminars on nutrition. As the resident progresses through the housing components, Robeson workers expect residents to complete more ADLs and participate in more day programs. Therefore, monitoring residents' compliance indicates how well they meet program expectations and how capable they are of independent living.

Finally, in order to determine the program's effectiveness, Robeson must track individual housing outcomes, rehabilitation outcomes, and mental illness control after residents leave the program. The program's mission statement claims that "upon successful completion…the participant will have developed the skills necessary to obtain and maintain permanent autonomous living and the ability to manage their multiple disorders" (Stellon, 2001). Thus, these measures assess the program's ability to accomplish that end. However, Robeson evaluators may have difficulty tracking former program participants after they leave the program. This dilemma might be alleviated by offering former residents assistance (e.g., groceries, counseling, etc.) that would tie them to the organization long enough to track their outcome status and smooth their transition.

CONCLUSIONS

The specific aim of this analysis is to suggest an evaluation strategy for program and participant outcomes using the Robeson Center as a model. This proposed strategy provides a means to test flexible program structures that do not necessarily demand abstinence or medication compliance from DDH individuals. Although this article is not intended as an endorsement for a particular program structure, the rise in flexible treatment programs demands an appropriate evaluation toolbox. Thus, the creation of such an evaluation strategy is an important step in properly understanding the effectiveness of these programs. ■

APPENDIX

SUBSTANCE ABUSE TREATMENT SCALE (SATS)[3]

Instructions: *This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last 6 months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.*

1. PREENGAGEMENT: The person (not client) does not have contact with a case manager, mental health counselor, or substance abuse counselor.

2. ENGAGEMENT: The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.

3. EARLY PERSUASION: The client has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. LATE PERSUASION: The client is engaged in a relationship with case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.

5. EARLY ACTIVE TREATMENT: The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least 1 month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

6. LATE ACTIVE TREATMENT: The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than 6 months.

7. RELAPSE PREVENTION: The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least 6 months. Occasional lapses, not days of problematic use, are allowed.

8. IN REMISSION OR RECOVERY: The client has had no problems related to substance use for over a year and is no longer in any type of substance abuse treatment.

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FOOTNOTES

[1] The term "mentally ill substance abuser", or MISA, will be used interchangeably with the term "dually diagnosed" following the field's general trend.

[2] The name of this agency has been changed to protect confidentiality.

[3] This scale measures an individual's progress through the stages of change for substance abuse treatment.

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