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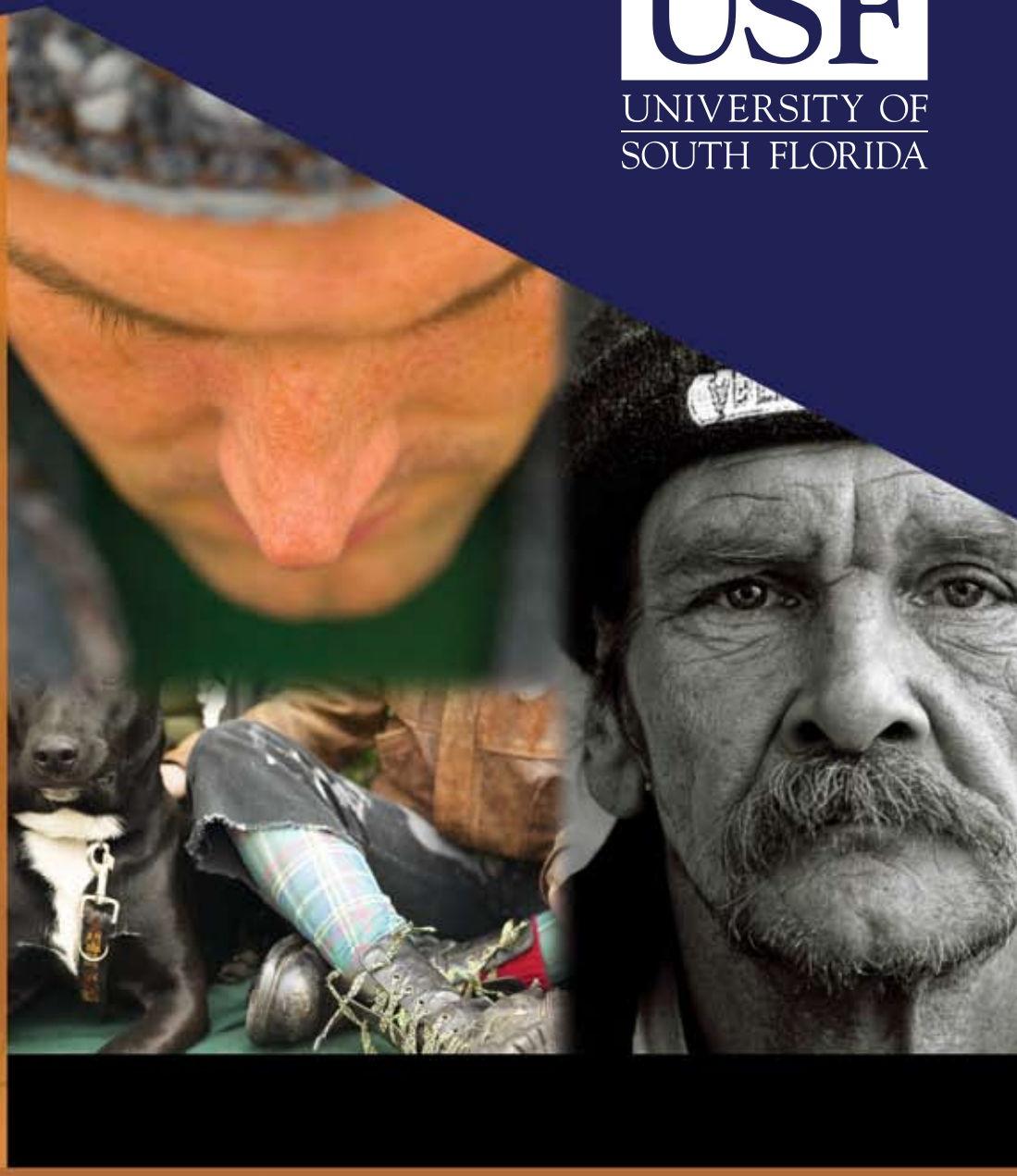

In any given week, the number of homeless persons with co-occurring mental health and substance use disorders has been estimated to range from 82,215 to 168,000…

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Evaluation of a Treatment Program for Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorder

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The University of South Florida

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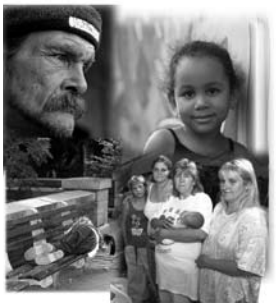
Comprised of three primary research departments, Mental Health Law & Policy, Child & Family Studies, and Aging & Mental Health and a number of specialized centers, the Institute conducts research and program evaluations, provides training and consultations, and offers a number of academic courses at the masters and doctoral levels.

INTRODUCTION

Overview

The considerable increase in literature on co-occurring mental illness and substance use in the past twenty years indicates a growing awareness of the prevalence of comorbid disorders. Epidemiological studies indicate a high risk of substance use disorders in the severely mentally ill compared to the general population (Drake, Bartels, Teague, Noorsdsy, & Clark, 1993). Individuals with co-occurring disorders (COD) meet criteria for both diagnoses of mental illness (such as mood or psychotic disorders) and substance use (such as abuse or dependence of alcohol). The combined symptoms of mental illness and substance use disorders place individuals at higher risk for unemployment, housing instability, and homelessness (Drake, Osher, & Wallach, 1991).

Homelessness affects over 3 million men, women, and children (National Law Center on Homelessness and Poverty, 2004).



An important factor when treating clients with a co-occurring disorder is the high risk of homelessness (Rothbard, Min, Kuno, & Wong, 2004). Homelessness is a major problem in the U.S. that affects over 3 million men, women, and children (National Law Center on Homelessness and Poverty, 2004). In any given week, the number of homeless persons with co-occurring mental health and substance disorders has been estimated to range from 82,215 to 168,000 (Rahav et al., 1995). This is a particularly difficult population to engage in services and their complex needs can overwhelm systems of care designed to treat only one type of disorder.

For decades, the typical method for treating clients with COD was to consecutively treat each presenting disorder, known as the serial treatment model. Complications very often arise when treating only one disorder at a time and can include overlooking symptoms or not recognizing both disorders as primary. That is, clinicians are often faced with the difficult task of separating symptoms of mental illness from those of substance abuse, which may mimic one another. For example, depressive symptoms developed during the withdrawal phase by an alcohol dependent client may be indicative of depression as a co-occurring disorder or simply side effects from the withdrawal of alcohol (Lehman, Myers, & Corty, 1989). The next most common yet ineffective service delivery model provides parallel treatment of both disorders in which the client goes to separate providers at separate treatment settings for treatment of each disorder separately. Though the client receives services for both disorders, there is typically minimal communication between providers. As a means of alleviating some of these common difficulties, significant research has identified the need to move toward an integrated system of treatment for co-occurring disorders (Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Minkoff, 1989).

Integration of Treatment Services

Because co-occurring conditions are so prevalent, an integrated mental health and substance abuse treatment service delivery model has the philosophy of viewing co-occurring disorders as the expectation rather than the exception (Minkoff & Cline, 2001). Integrated service delivery allows clients to receive

treatment for both disorders concurrently and services are delivered by the same multidisciplinary treatment team of clinicians at a single treatment facility. Of course, integration of both mental health and substance abuse treatment services also can create many challenges. For instance, difficulties may arise when engaging clinicians from both mental health and substance abuse fields to work together on a treatment program. Collaboration of the two fields is necessary for integration, yet tends to be impeded by differing beliefs and diverging treatment philosophies (Minkoff, 1989). For example, clinicians treating clients suffering from substance abuse may be wary of a treatment plan including prescribed psychotropic medications. Minkoff (1989; 1991) addressed such concerns in the development of the CCISC service delivery model for treating both mental health and substance abuse disorders.

CCISC Model

The Comprehensive, Continuous, Integrated, System of Care (CCISC) was developed based on the similarities between the mental health and substance disorders. The CCISC Model has been used in treatment programs across the country and is recognized by the Substance Abuse and Mental Health Service Administration (SAMHSA) as one of the best treatment models for individuals with COD (Minkoff & Cline, 2001). The CCISC model is built on eight evidence-based principles of service delivery for co-occurring disorders that provide a framework for developing clinical practice guidelines for treatment matching and can also be utilized to design a welcoming, accessible, integrated, continuous, and comprehensive system of care (Minkoff & Cline, 2001). The model has the following four basic characteristics:

The CCISC Model has been used in treatment programs across the county and is recognized by SAMHSA as one of the best treatment models for individuals with COD (Minkoff & Cline, 2001).

- **System Level Change:** All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders.
- **Efficient Use of Existing Resources:** The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services.
- **Incorporation of Best Practices:** The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of COD. This is based on the recognition that co-occurring disorders are not a single entity, but rather that individuals with COD have a wide range of disorders and needs in combination, and that best practice treatment involves integrating the provision of best practice treatment for each disorder at the level of the client.
- **Integrated Treatment Philosophy:** The CCISC model is based on implementation of principles of successful treatment intervention that are derived from research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers.

The rationale for system design is that dual diagnosis is an expectation in all settings that is associated with poor outcomes and high costs in multiple domains. Consequently, attention to COD must be a priority in all system activities and in the utilization of all system resources. Table one depicts the eight basic principles of the CCISC model:

Table One. Eight Principles of the CCISC Model

1. *Dual diagnosis is an expectation, not an exception*
2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level*
3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties*
4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting*
5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended*
6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change. Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al., 2001)*
7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements*
8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions*

Fortunately, even given the countless barriers to healthy functioning encountered by clients with COD, their needs for housing, employment, and symptom reduction can be met with evidence-based treatment.

The following is a review of the literature on treatment of clients with COD describing the use of the integrated treatment approach in meeting some of the basic needs such as housing and employment as well as decreasing symptoms of mental illness and substance use.

Stable Housing

Housing instability is of particular concern for clients with COD. In fact, Drake and Wallach (1989) found that only 16% of a sample of chronically mentally ill clients had difficulties maintaining stable housing compared to 52.5% of clients with COD. In a study conducted by Bebout and colleague (1997), homeless adults received a combination of supportive housing and integrated treatment services for COD based on Minkoff's CCISC model. The program was successful in that clients were able to secure housing after receiving integrated treatment and the housing provided was permanent, affordable, and safe. Additionally, clients' overall quality of life was improved due to living in new conditions. The results of this study provide evidence for the utility of Minkoff's CCISC model in transitioning homeless clients with COD to stable housing. Another study by Drake et al. (1997) compared an integrated treatment approach to parallel treatment in which services were segregated. Homeless individuals with COD in the integrated program showed a greater increase in stable housing compared to those in the parallel treatment program.

Employment

The CCISC model emphasizes vocational, supported employment, and integrated employment in the community as clients with COD move toward self-sufficiency and independence (Minkoff & Cline, 2001). For homeless clients with COD, obtaining employment may be even more difficult as limited access to resources may result in poor hygiene or other obstacles. Leal and colleagues (1999) reported that clients spending greater lengths of time without a home are less likely to be employed. Although unemployment is an obvious barrier to healthy functioning, the Access to Community Care and Effective Services and Support (ACCESS) program has shown promise in utilizing vocational training with homeless individuals suffering from COD (Cook, Pickett-Schenk, Grey, Banghart, Rosenheck, & Randolph, 2001). Vocational training and assistance significantly predicted employment at twelve-month follow-up, even after controlling for client characteristics. Although homelessness may be associated with a greater number of challenges for clients with COD, programs including vocational training and placement may help to meet the employment needs of this population.

Mental Health Symptomatology

Symptoms of anxiety or depression may decrease the likelihood that one will set goals or feel capable of reaching them. Psychotic symptoms are likely to render an individual incapable of performing daily tasks. Utilization of an integrated model such as the CCISC in treating mental health symptoms for homeless individuals with COD is supported by the literature. In one study,

James and colleagues (2004) randomized clients with COD to either a six-week integrated program or a one-hour educational session on drug use and mental illness combined with routine community services. The integrated treatment group showed significantly greater improvement in mental health symptoms compared to the control group as measured by the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) at three-month follow-up. In another study, homeless males participating in an integrated program were more likely to reduce anxiety as well as scores on the BPRS compared to those in programs lacking integration of services (Nuttbrock, Rahav, Rivera, Ng-Mak, & Link, 1998).

Substance Use

Use of substances can negatively impact many aspects of life, often resulting in legal, occupational, and physical ramifications. For homeless individuals with COD, substance use has a detrimental effect on mental health functioning as well. Therefore, an effective treatment model for homeless individuals with co-occurring mental health and substance use disorders must target use of substances. Research supports the effectiveness of the CCISC model for treating substance use in homeless individuals with COD. In a quasi-experimental study, treatment based on an integrated model similar to the CCISC was compared to a primarily substance abuse treatment program using a therapeutic community model (Blankertz & Cnaan, 1994). Homeless clients with COD in the integrated program were more likely to be successfully discharged than those in the therapeutic community. Successful discharge included meeting objective (urinalysis) and subjective (self-report) measures of abstinence from substances for at least three months past completion of the program. This provides evidence that an integrated treatment model is more effective in treating substance use among individuals with COD as compared to a model focused primarily on substance use for individuals with COD.

Current Study

Although past research clearly supports the use of the CCISC Model for homeless clients with COD, there are limitations to the current body of literature. First, variation in client characteristics has been lacking in previous literature. For example, many studies have reported findings based on samples composed of entirely males or veterans (Drake, Mueser, Brunett, & McHugo, 2004). Second, while housing, employment, mental health and substance use have each been individually assessed as outcome variables in previous integrated treatment research, this combination of outcomes has not been assessed with regard to a homeless residentially treated sample of clients with COD.

The present study was designed to address these limitations by assessing the effectiveness of the CCISC model for a diverse sample of homeless individuals diagnosed with COD. Clients composed of both male and female clients of various age groups, were hypothesized to report increased housing and employment as well as decreased mental health symptoms and substance use one year after treatment entry.

METHOD

Participants

Data were gathered from 96 clients receiving services at the Keystone residential program. Individuals were eligible to receive services if they were homeless or at risk of being homeless, had co-occurring substance use and mental health disorders, and could perform daily living activities with supervision. Individuals were excluded from treatment at Keystone if they were convicted of a sex offense or had a history of criminal violence.

ACTS Pinellas Domiciliary is a residential treatment program in a quiet, secluded setting.

Additionally, 8-10 Keystone staff participated annually in a focus group setting intended to assess the fidelity to the CCISC model. This fidelity measure was administered to Keystone staff (i.e., included both ACTS and Directions for Mental Health described below) within a focus group setting that consisted of program administrators, managers, clinicians, and support staff. These fidelity evaluations were administered once per year for the three years of the project.

Procedure

Immediately upon being admitted to the Keystone program, clients meeting inclusion criteria were invited to take part in the study. After explaining the study and obtaining informed consent, participants completed a baseline interview that lasted approximately forty-five minutes to one hour. These initial interviews served as the baseline, and participants were interviewed again at 6 and 12 months following the baseline interview. Interviews were conducted in a private room to help ensure confidentiality, and participants were paid $20 for each follow-up interview.

Measures

Administrative Data

Information was collected on each client's primary mental health and substance diagnosis through the agency's management information system (MIS).

Government Performance and Results Act (GPRA)

The GPRA includes items addressing demographics such as age, gender, race, ethnicity, and education as well as outcomes like housing, employment, criminal justice involvement, and substance use.

Residential Follow-Back Calendar (New Hampshire Dartmouth Psychiatric Research Center; 1995)

This measure examines clients' current and previous 6-month living arrangements. Each response was classified into one of the following four categories: 1) literal homelessness, 2) institutional residence (i.e., jail or residential treatment program), 3) temporary housing (i.e., living with friend), or 4) permanent housing. Literal homelessness was defined as not having a

regular place to live and could include living on the street or in a car, abandoned building, or train or bus station. The specific time periods that were compared to assess residential status changes were: 1) one month prior to entering the Keystone program, 2) current status at the 6-month follow-up interview, and 3) current status at the 12-month follow-up interview.

Brief Symptom Inventory (BSI; Derogatis, 1982)

The Brief Symptom Inventory is a 53-item abbreviated form of the Symptom Checklist-90 (SCL-90) that was designed to assess common psychological symptoms. It has been shown useful as a measure of improvement occurring in response to inpatient and outpatient psychiatric treatment of males and females (Allen, Coyne, & Huntoon, 1998; Boulet & Boss, 1991; Piersma, Reaume, & Boes, 1994). Each item on the checklist represents a problem. Respondents are asked to indicate the extent to which each of the 53 problems has distressed them over the past 7 days using a 5-point Likert scale response format, ranging from (0) *not at all* to (4) *extremely*. The measure taps the following nine primary symptom dimensions: depression, interpersonal sensitivity, anxiety, phobic anxiety, paranoid ideation, somatization, obsessive-compulsive, hostility, and psychoticism. The BSI also provides a measure of overall mental health functioning called the Global Severity Index, which had a Cronbach's alpha of .98 in this study, indicating good internal consistency.

Treatment Satisfaction

This measure was developed by the Evaluation staff and was used to assess satisfaction with the Keystone program in three areas: quality of the overall program, quality of specific program components, and open-ended questions. Agreement with the program statements was rated on a five-point scale ranging from (1) *very satisfied* to (5) *very dissatisfied*. Agreement with the specific program components statements was rated on a five-point scale ranging from (1) *strongly agree* to (5) *strongly disagree* administered at 6- and 12-month follow-up.

Comorbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS; Minkoff & Cline, 2001)

This measure was used to assess fidelity to the CCISC model in 14 domains that address program competencies in multiple areas reflecting standards for co-occurring mental health and substance use disorders. It is completed in a focus group setting. Through discussion participants reached consensus on each item and provided one consensus response for each item that was rated using a 5-point Likert scale ranging from 1 (*rarely*) to 5 (*consistently*).

Analyses

All analyses were conducted with SPSS 14.0. Simple descriptive statistics were used to describe the sample's demographics and housing situation. Internal consistency of the Brief Symptom Inventory global scale was assessed by computing Cronbach's alphas. For continuous variables, two tailed univariate repeated measures analyses of variance were used to evaluate significant change

over the baseline and two follow-up periods, with effect sizes computed to gauge the magnitude of the effects. McNemar Chi Square tests (Siegal & Castellan, 1998) were used to examine change from baseline to 6-month follow-up on categorical variables and they also were computed to examine change occurring on categorical variables from baseline to 12-month follow-up. Trends over time in fidelity to the CCISC model were examined from year to year with annual administration, scoring, and review of the COMPASS.

RESULTS

All 96 clients completed the baseline interview that consisted of the GPRA measure as well as several standardized measures (i.e., Residential Follow-Back Calendar, Brief Symptom Inventory). Additional information on these 96 clients was obtained from agency records, including the agency management information system (diagnostic information) and psychosocial interviews (drug use information). Seventy-six clients completed the 6-month follow-up GPRA interview and standardized measures, whereas 52 completed the 12-month follow-up GPRA interview and standardized measures. Forty-eight clients completed all three GPRA interviews, so analyses examining change are limited to these 48 participants.

Client Baseline Information

The majority of clients were male (66.7%), averaged 41 years of age, white (81.1%), and almost 68.7% had a high school education.

Demographic Information

Baseline demographic information is presented in Table Two. The majority of clients were male (66.7%). Clients averaged just over 41 years of age with most falling into the 35-44 (35.4%) or 45-54 (37.5%) year-old age group. The youngest client served was 20 years of age at intake, whereas the oldest was 73. The sample was predominantly Caucasian (81.1%), although African-Americans (14.7%), Asians (1.0%), American Indians (1.0%), and other races (1.0%) also were represented. Two participants (2.1%) declared their ethnicity to be Hispanic/Latino, while one reported being Central American (1.0%) and another was Puerto Rican (1.0%). With regard to education, the sample was rather well educated. Although clients most commonly had less than a high school education (n = 30; 31.3%), 29 clients (30.2%) earned a high school diploma. Twenty-seven clients (28.1%) attended some college but did not graduate, whereas 8 clients (8.3%) were college graduates. Most participants reported being unemployed and not looking for work at intake (78.1%), with 12 reporting disabled unemployment (12.5%) and one indicated being retired (1.0%). Only two clients (2.1%) reported any employment at baseline, and this was part-time work. Six clients (6.3%) reported that they were unemployed but were looking for work.

Table Two. GPRA Baseline Demographics

Clients (N = 96)		
	N	%
Gender		
Male	64	66.7%
Female	32	33.3%
Age		
18 – 24	5	5.2%
25 – 34	17	17.7%
35 – 44	34	35.4%
45 – 54	36	37.5%
55 – 64	3	3.1%
65+	1	1.0%
Race		
Caucasian	77	81.1%
African-American	14	14.7%
Asian	1	1.0%
American Indian	1	1.0%
Other	1	1.0%
Ethnicity		
Hispanic/Latino	2	2.1%
Central American	1	1.0%
Puerto Rican	1	1.0%
Years of Education		
Less than High School	30	31.3%
High School Diploma	29	30.2%
Voc Tech After High School	2	2.1%
Some College	27	28.1%
College Graduate	8	8.3%
Employment Status		
Unemployed, Not Looking for Work	75	78.1%
Unemployed, Disabled	12	12.5%
Unemployed, Looking for Work	6	6.3%
Unemployed, Retired	1	1.0%
Employed Part-Time	2	2.1%

Note: Frequencies may not add up to 96 due to missing data.

Primary Mental Health and Substance Use Disorders

Table Three presents clients' primary mental health and substance diagnoses that were entered into the agency's management information system at intake (baseline). Regarding mental health diagnoses, most clients (n = 82; 85.4%) were diagnosed with a mood disorder, with major depressive disorders being diagnosed more commonly than manic disorders. Bipolar disorders (n = 34; 35.8%) were commonly diagnosed, with fewer clients diagnosed with anxiety disorders (n = 7; 7.4%) or psychotic disorders (n = 5; 5.3%). One client (1.0%) was diagnosed with attention deficit hyperactivity disorder.

With regard to primary substance diagnoses, most clients were diagnosed with alcohol or drug dependence (n = 94; 97.9%) as opposed to abuse (n = 2; 2.1%). Most clients were diagnosed with alcohol dependence (n = 51; 53.1%), followed by dependencies on cocaine (n = 17; 17.7%), multiple drugs (n=14; 14.6%), opioids (n = 8; 8.3%), cannabis (n = 2; 2.1%), sedatives (n = 1; 1.0%), and unspecified drugs (n = 1; 1.0%). One client was diagnosed with barbiturate abuse (n = 1; 1.0%), and one was diagnosed with cocaine abuse (n = 1; 1.0%).

Table Three. Baseline Primary Mental Health and Substance Use Disorders

	Clients (N = 96)	
	N	%
Primary MH Diagnosis		
Mood Disorders	82	85.4%
Major Depressive Disorder, Recurrent	22	23.2%
Depressive Disorder, NOS	18	18.9%
Manic Disorder, Unspecified	5	5.3%
Major Depressive Disorder, Single Episode	1	1.1%
Mood Disorder, NOS	2	2.1%
Bipolar, Unspecified Most Recent	16	16.8%
Bipolar, Manic Most Recent	11	11.6%
Bipolar, Mixed Most Recent	6	6.3%
Bipolar, NOS	1	1.0%
Anxiety Disorders	7	7.4%
Post-Traumatic Stress Disorder, Prolonged	3	3.2%
Anxiety Disorder, NOS	3	3.2%
Generalized Anxiety Disorder	1	1.0%
Psychotic Disorders	5	5.3%
Schizoaffective, Unspecified	4	4.2%
Schizophrenia, Paranoid Type	1	1.1%
Attention Disorders	1	1.0%
ADD with Hyperactivity	1	1.0%
Primary SA Diagnosis		
Alcohol Dependence	51	53.1%
Cocaine Dependence	17	17.7%
Polysubstance Dependence	14	14.6%
Opioid Dependence	8	8.3%
Cannabis Dependence	2	2.1%
Sedative Dependence	1	1.0%
Unspecified Drug Dependence	1	1.0%
Barbituate Abuse	1	1.0%
Cocaine Abuse	1	1.0%

NOS = Not Otherwise Specified

Note. Percentages represent valid percents because there was some missing data.

Psychosocial Information

Information on clients' first age when/if they tried alcohol and various illicit drugs was obtained from their psychosocial assessments that were completed as a routine part of services provided by the treatment agency. The evaluators obtained this information by reviewing clients' records at the treatment agency. Although GPRA data indicate past-month drug use, information gleaned from the psychosocial assessments specifies which substances client self-report using in their lifetime. Figures One and Two present information on the percent of clients who first tried drugs when they were in the specified age groups.

The first major point to be made concerns lifetime use. Almost all clients (99%) reported trying alcohol in their lifetime and more than two thirds (69%) reported trying marijuana in their lifetime. For other illicit drugs, most participants reported trying cocaine (63%) or crack cocaine (56.2%) whereas the majority denied ever using heroin (74%), other opiates (75%), or methamphetamine (82%). The second point to be made by this information concerns the age of first use of specific drugs. The vast majority of alcohol and marijuana users first tried these drugs before age 21. Data indicate that first use of methamphetamine was also young. For clients reporting methamphetamine use, most indicated first using the drug between the ages of 17 and 18. Clients using cocaine or crack cocaine reported first trying these drugs in their 20s. Most clients using heroin reported first using the drug between the ages of 19 and 25, and those reporting use of other opiates indicated first trying these drugs between the ages of 21 and 25.

71% of clients reported trying alcohol and 53% of clients reported trying marijuana by the age of 16.

Figure One. Age of First Use of Alcohol and Marijuana

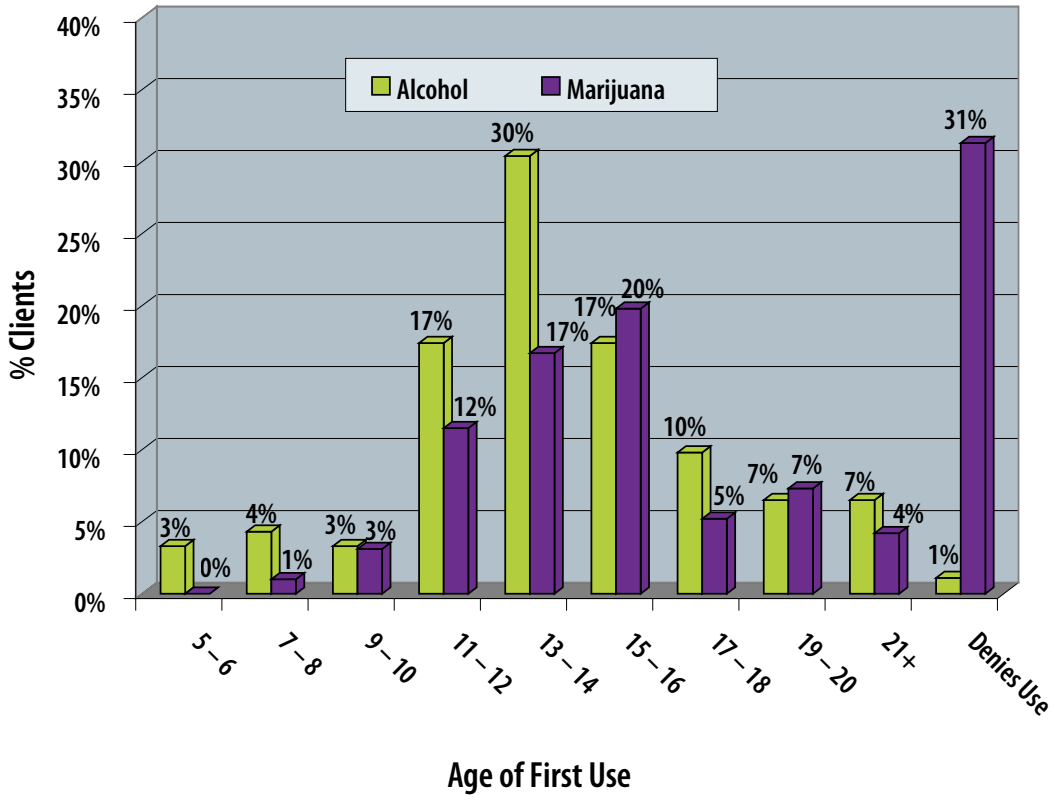
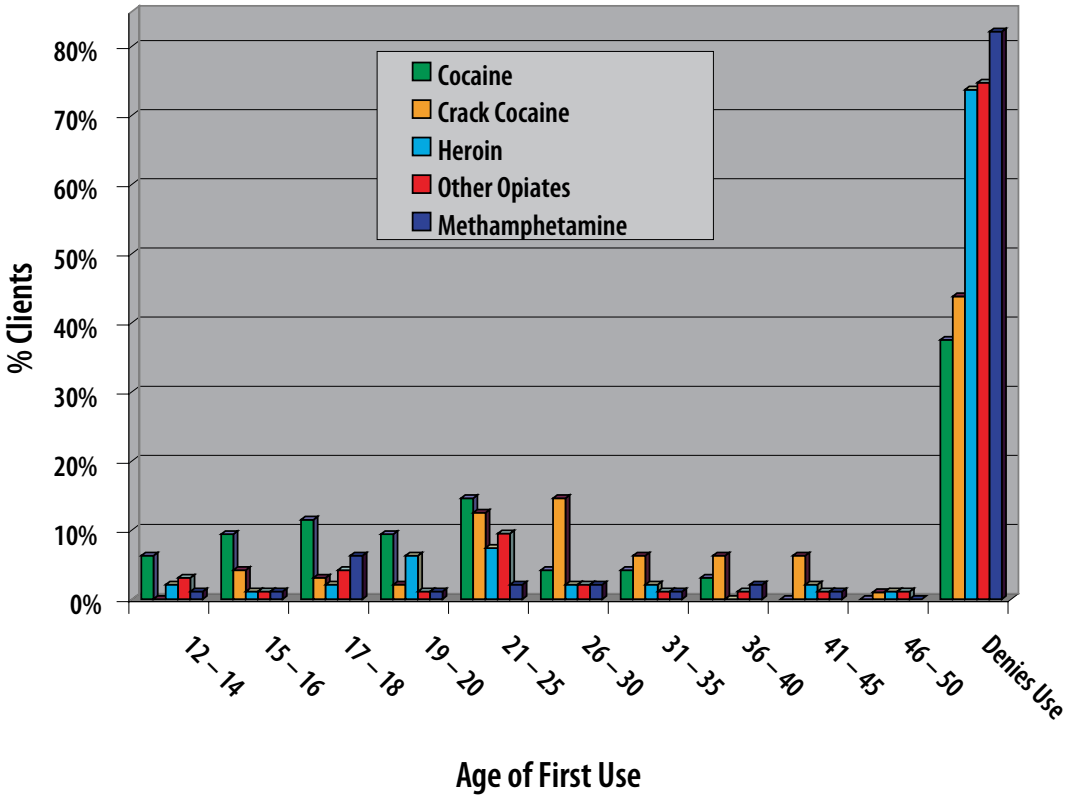


Figure Two. Age of First Use of Other Illicit Drugs



Alcohol and Drug Use

Table Four presents information on the mean number of days in the past month that clients reported using various substances. This information was collected during the intake/baseline GPRA. Data suggest that, on average, alcohol was the most frequently used drug, followed by cocaine/crack and marijuana. Table Five presents data on the percent of clients who abstained from various drugs as reported during the intake/baseline GPRA interview. Consistent with data on age of first use and diagnoses, this information suggests that during the month prior to intake, clients most commonly used alcohol and cocaine, with over 90% reporting abstention from marijuana, benzodiazepines, heroin, hallucinogens, and methamphetamine/other amphetamines in the month prior to the intake/baseline GPRA interview.

Table Four. GPRA Baseline Past Month Number Days of Drug Use, by Drug

	All Clients (N = 96)	
	Mean	SD
Any Alcohol	3.80	6.60
Alcohol, ≥5 Drinks	3.21	6.21
Alcohol, ≤4 Drinks	0.47	1.69
Any Illegal Drugs	3.08	6.67
Alcohol and Illegal Drugs	2.33	4.95
Cocaine/Crack	1.78	4.98
Marijuana	0.90	3.89
Benzodiazepines	0.65	3.78
Heroin	0.26	1.83
Hallucinogens	0.10	1.02
Methamphetamine or Other Amphetamines	0.05	0.51

Table Five. GPRA Baseline Past Month Abstinence Rates, by Drug

	All Clients (N = 96)
	% Abstinent
Alcohol	58.3%
Any Illegal Drugs	68.8%
Cocaine/Crack	77.1%
Marijuana	90.6%
Benzodiazepines	94.8%
Heroin	97.9%
Hallucinogens	99.0%
Methamphetamine or Other Amphetamines	99.0%

History of Homelessness

Table Six presents information on clients' histories of homelessness obtained using the Residential Follow-Back Measure during the baseline interview. Participants averaged just under 33 years of age when they first became homeless, ranging from 13 to 73. On average participants were homeless over five times in their lifetime, ranging from 1 to 50. Most participants (80%) were homeless anywhere from one to five times in their lifetime, although seven (7.4%) reported being homeless more than 20 times. One fifth reported being homeless for less than one month in their lifetime, although nearly 17% reported being homeless for at least 5 years.

Table Six. Baseline History of Homelessness

	All Clients (N = 96)	
	N	%
# Times Homeless in Lifetime	5.52	9.39
1 – 5	76	80.0%
6 – 10	6	6.3%
11 – 15	3	3.2%
16 – 20	3	3.2%
21 or more	7	7.4%
Total Amount of Time Homeless		
Less than 1 month	19	20.0%
1 to < 6 months	18	18.9%
6 to < 12 months	19	20.0%
12 to < 24 months	6	6.3%
24 to < 60 months	17	17.9%
60 months or more	16	16.8%

Note: Frequencies do not add up to 96 due to missing data.

Treatment Features

Length of Treatment

The mean length of stay was 137 days with a range from 22 to 382 days. As can be seen in Table Seven, the typical number of days most commonly ranged from 61 to 120 days. It is important to note that some clients relapsed, left the program and then came back to the Keystone program for additional treatment. The days for initial and subsequent treatment episodes during the grant period were counted in each client's total length of stay.

Table Seven. Number of Days in Treatment

	All Clients (N = 96)	
	N	%
30 days or less	5	5.2%
31 to 60 days	7	7.3%
61 to 90 days	18	18.8%
91 to 120 days	16	16.7%
121 to 150 days	12	12.5%
151 to 180 days	10	10.4%
181 to 210 days	13	13.5%
211 to 240 days	4	4.3%
241 to 270 days	6	6.1%
271 to 300 days	2	2.1%
301 to 330 days	1	1.0%
331 to 364 days	1	1.0%
365 or more days	1	1.0%

Successful Graduation

Ninety-three percent of clients (n = 89) successfully graduated from the Keystone treatment program. Some of the main reasons for not graduating from the program included never engaging in treatment, having positive urinalyses, and becoming incarcerated during treatment.

Treatment Satisfaction

Satisfaction data were obtained from participants in order to assess their experience with the Keystone program at both follow-up periods. Results from participants were overwhelmingly favorable (see Table Eight). The satisfaction measure was divided into several sections that will be described briefly below with corresponding table/figures to supplement the text.

Quality of Program

Participants were asked to rate their satisfaction with the quality of certain aspects of the program. As can be seen in Figure Three, the majority of participants were satisfied or very satisfied with the quality of the overall program at both 6-month and 12-month follow-up. Additionally, participants were asked to rate how helpful the program was with regard to their mental health and substance use issues. As can be seen in Figure Four, the vast majority of participants agreed or strongly agreed that the program was helpful in dealing with both their mental health and substance abuse issues. It is particularly noteworthy that even though most clients had graduated from the Keystone residential program at 12-month follow-up, they still rated their satisfaction high on most of the aspects of the program.

Table Eight. Participant Satisfaction Results

	6-Month Follow-up (N = 76)	12-Month Follow-up (N = 52)
How satisfied were you with[1]:		
Quality of the program	1.47 (0.86)	1.90 (1.23)
Quality of the treatment	1.63 (0.98)	1.81 (1.07)
Experience at ACTS	1.66 (1.01)	1.81 (1.10)
The Keystone program was[2]:		
Helpful in dealing with mental health issues	1.63 (0.91)	1.67 (0.99)
Helpful in dealing with substance abuse issues	1.83 (1.01)	1.94 (1.18)
Helpful to my overall well-being	1.53 (0.77)	1.77 (1.02)
Expect to use information gained from this program	1.52 (0.74)	1.75 (0.93)
Staff members treated me with respect	1.72 (0.99)	1.82 (0.97)
Recommend this program to other people	1.57 (0.79)	1.71 (0.96)

1. Response scale: 1=Very Satisfied, 2=Satisfied, 3=Neutral, 4=Dissatisfied, 5=Very Dissatisfied
2. Response scale: 1=Strongly Agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly Disagree

Figure Three. Participant Satisfaction with the Quality of the Program

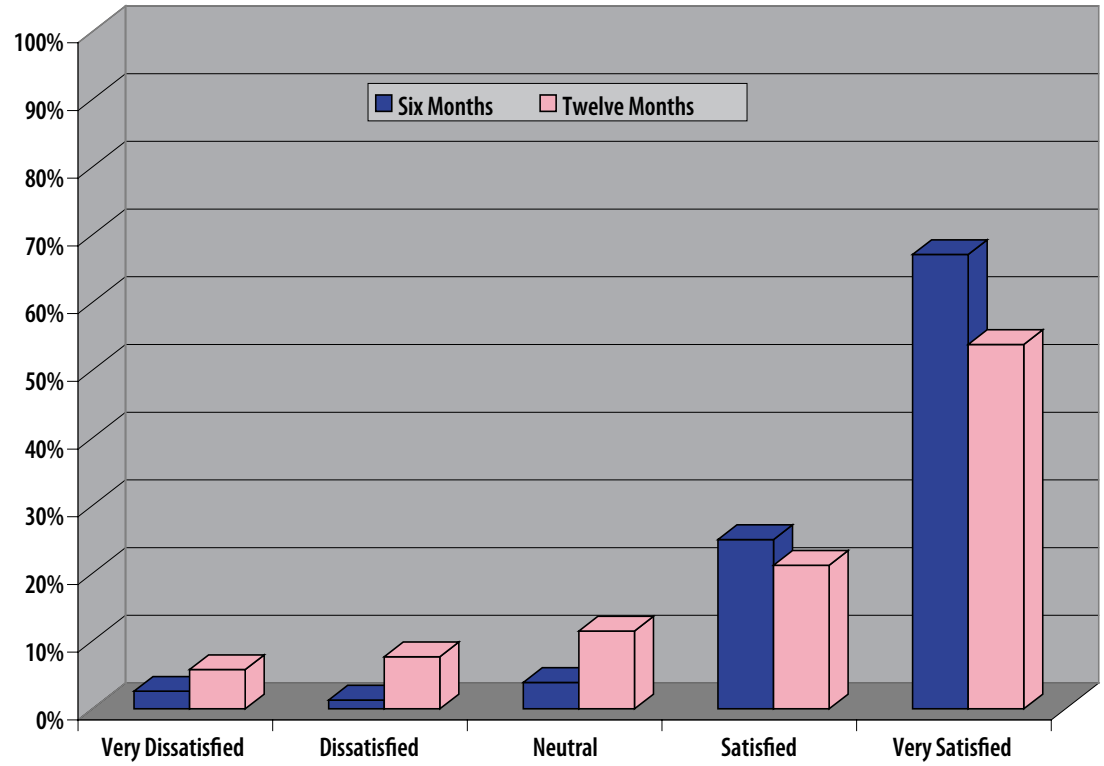
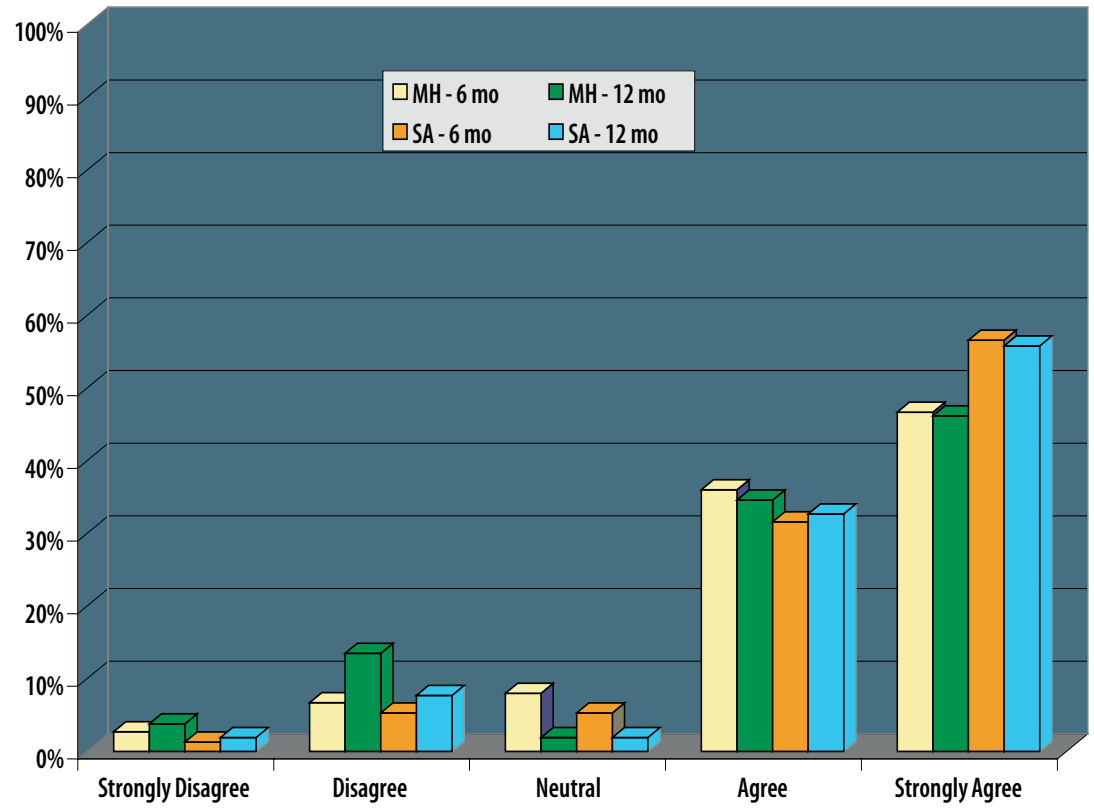


Figure Four. Program was Helpful in Dealing with Mental Health and Substance Abuse Issues



Open-Ended Questions

Most respondents reported very favorable comments about their experience with the Keystone treatment program. The majority completing a 6-month or 12-month follow-up responded to the two open-ended questions designed to elicit the program's strengths and weaknesses. The questions read, "What services did you find most helpful?" and "What services did you find least helpful?" The most commonly cited strength of the program was the case management and individual counseling. Approximately 55% of participants identified case management and/or the quality of the counseling as their most positive experience with the Keystone program. Some of the favorable comments included:

"Sharing with other people got me to do a lot of thinking about my drug use."

"Discussing matters with the case managers was very helpful."

"The one-on-one counseling sessions required that I be very honest with myself."

Group interaction and support also was commonly identified as a strength of the program, with 30% of participants claiming their favorite aspect of treatment to be the small group sessions. The mental health services and medication management were noted by 15% of participants as the best aspect of their treatment. Other strengths of the program included other program staff and AA groups.

Areas that participants identified as least helpful in the program had little to do with the treatment program and centered around issues of residential living. The most commonly noted weakness was the need for more clarification of the policies and procedures at the facility. Pettiness between clients was cited as the next most commonly noted. One participant complained that "The drama between clients was sometimes unbearable." Staff turnover and length of treatment also cited as weaknesses.

Client Follow-Up Outcomes

The following tables and figures provide information on change over time as measured by the GPRA and standardized assessment measures. Forty-eight clients completed the baseline, 6-month, and 12-month interviews, so these results are limited to examining change within this group of 48 clients.

GPRA Outcomes

Table Nine describes outcomes for key areas assessed by the GPRA measure. With regard to criminal justice outcomes, there was no significant change over time in the average number of past month arrests or in the proportion of clients arrested in the past month. The lack of significance should be qualified by the high rate of referrals from corrections settings. Many clients were incarcerated in the month prior to entering the treatment program, and thus the initial baseline average number of past month arrests is very low.

With regard to change in average days of past month substance use, significant change over time was detected for drinking 5 or more alcoholic

drinks, $F(2,36) = 3.48$, $p = .042$, and cocaine use, $F(2,45) = 4.85$, $p = .012$. Clients reported a significantly greater number of past month days of cocaine use at intake than they did at the 12-month follow-up period. Although other differences did not attain statistical significance, it should be noted that there was a consistent trend in which the means decreased over time for every illicit drug except marijuana and for two of the three alcohol measures. Chi square tests comparing the percent of participants using each drug over the past month revealed significant reductions in past-month use of any illegal drugs and use of cocaine from baseline to 12-month follow-up. Although not statistically significant, there was a consistent downward trend in the percent of clients reporting use of most drugs examined over time.

With regard to housing, statistically significant McNemar Chi Square tests indicated that a significantly greater proportion of clients were housed at 12-month follow-up compared to baseline with a steady increase in rates of housing observed over the three time periods. Employment data also indicate statistically significant increases in the percent of clients reporting any form of employment at both follow-up periods as compared to baseline/intake.

Mental Health Symptomatology

The statistical significance of change over time in mental health symptomatology as measured by the Brief Symptom Inventory was evaluated using a series of univariate repeated measures analyses of variance. These results and the corresponding means are contained in Table Nine. Results indicated significant change over time for the Global Severity Index as well as every BSI subscale except Hostility, though it should be pointed out that clients scores lowest in Hostility at both the baseline and 12-month follow-up. Figure Five graphically depicts clients' average BSI scores over time.

Table Nine. GPRA Outcomes: Baseline. 6-Month, and 12-Month Follow-Up Change Data

	Baseline (N = 48)	6-Month (N = 48)	12-Month (N = 48)	Significance[1]
Criminal Justice				
# Arrests, Past 30 Days (Mean, SD)	0.04 (0.20)	0.09 (0.35)	0.04 (0.21)	NS
% with ≥1Arrest, Past 30 Days	4.2%	8.2%	4.2%	NS, NS
Substance Use				
% Using Past Month				
Alcohol	33.3%	16.7%	19.1%	NS, NS
Any Illegal Drugs	31.3%	14.6%	6.4%	NS, $p = .004$
Cocaine	25.0%	10.4%	4.3%	NS, $p = .006$
Marijuana	6.3%	8.3%	4.3%	NS, NS
Benzodiazepines	4.2%	0.0%[2]	0.0%[2]	See Footnote 2
Hallucinogens	2.1%	0.0%[2]	0.0%[2]	See Footnote 2
Average Days Used, Past Month				
Any Alcohol (Mean, SD)	3.85 (7.05)	1.30 (3.49)	1.11 (3.40)	NS
Alcohol ≥5 Drinks	2.37 (6.06)	0.47 (2.31)	0.74 (3.49)	$p = .042$
Alcohol ≤4 Drinks	0.63 (1.88)	0.50 (1.83)	0.42 (1.45)	NS
Any Illegal Drug Use	3.34 (7.19)	1.36 (4.58)	0.72 (3.32)	NS
Cocaine (Mean, SD)	2.36 (6.37)[a]	1.32 (4.59)[ab]	0.19 (0.92)[b]	$p = .012$
Marijuana (Mean, SD)	0.87 (4.58)	0.11 (0.38)	0.55 (3.13)	NS
Benzodiazepines (Mean, SD)	0.51 (3.09)	0.00 (0.00)	0.00 (0.00)	NS
Hallucinogens (Mean, SD)	0.21 (1.46)	0.00 (0.00)	0.00 (0.00)	NS
Mental Health Consequences of Drug Use[3]				
Stress from Drug or Alcohol Use	2.98 (1.37)[a]	2.24 (1.66)[b]	3.05 (1.88)[a]	$p = .018$
Gave Up / Reduced Activities	2.55 (1.42)	1.39 (1.82)	3.03 (1.94)	NS
Emotional Problems	2.78 (1.31)	2.35 (1.76)	3.28 (1.89)	NS
Housing				
% Housed	12%	24.4%	45.2%	NS, $p = .031$
Employment				
% Employed Part-Time	2.1%	2.1%	8.5%	NS, NS
% Employed Full-Time	0.0%	20.8%	19.1%	See Footnote 2
% with Any Employment	2.1%	22.9%	27.7%	$p = .002$, p = .002

1. Significance of continuous variables (means) was evaluated by univariate repeated measures analyses of variance using baseline and both follow-up scores. Significance of categorical variables (percents) was evaluated using McNemar chi square tests first comparing baseline and 6-month percents and then comparing the baseline and 12-month percents.
2. No statistical tests could be computed because there was zero variability at one or more times.
3. Response scale ranges from 1 (*not at all*) to 4 (*extremely*).

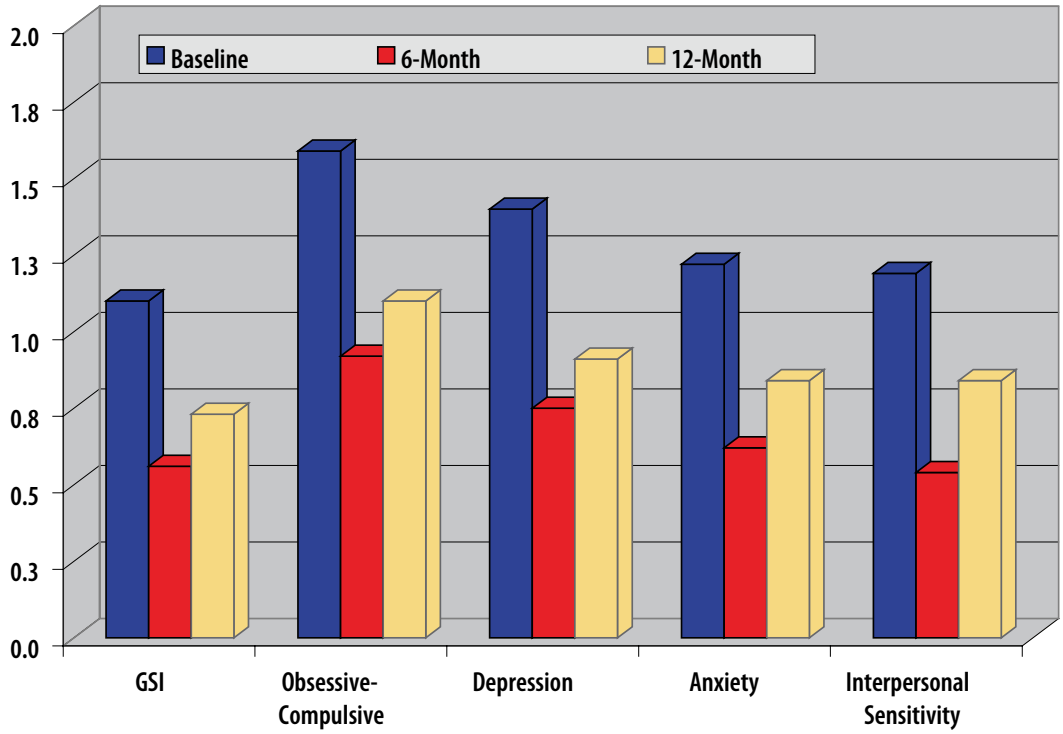
Notes. Means within the same row not sharing a common subscript are significantly different from one another ($p < .05$). NS means not significant.

Table Ten. Mean Brief Symptom Inventory Raw Scores Over Time

	Baseline (N = 48)	6-Month (N = 48)	12-Month (N = 48)	Significance, F(2,46)
Global Severity Index	1.10	0.56	0.73	18.94, $p < .001$, $\eta^2 = .45$
Somatization	0.67	0.22	0.41	10.53, $p < .001$, $\eta^2 = .31$
Depression	1.40	0.75	0.91	11.36, $p < .001$, $\eta^2 = .33$
Anxiety	1.22	0.62	0.84	10.81, $p < .001$, $\eta^2 = .32$
Psychoticism	1.18	0.66	0.80	10.40, $p < .001$, $\eta^2 = .31$
Obsessive-Compulsive	1.59	0.92	1.10	13.67, $p < .001$, $\eta^2 = .37$
Hostility	0.61	0.40	0.36	NS
Phobic Anxiety	0.67	0.35	0.53	7.74, $p < .001$, $\eta^2 = .25$
Interpersonal Sensitivity	1.19	0.54	0.84	9.54, $p < .001$, $\eta^2 = .29$
Paranoid Ideation	1.16	0.53	0.79	11.64, $p < .001$, $\eta^2 = .34$

Note. Significance was evaluated by univariate repeated measures analyses of variance using baseline and both follow-up scores.

Figure Five. Mean Brief Symptom Inventory Raw Scores Over Time



Fidelity Results

As can be seen in Table Eleven, the specific areas in which the Evaluators used the COMPASS to examine the fidelity of the Keystone program to the CCISC model included: (1) Program philosophy, (2) Management structure, (3) Access to care, (4) Identification of co-occurring disorders, (5) Assessment and diagnosis, (6) Treatment planning, (7) Treatment content and programming, (8) Integrated treatment relationships, (9) Treatment program policies, (10) Psychopharmacology, (11) Discharge planning, (12) Integrated external care management, (13) Staff competency and training, and (14) Specific competencies such as trauma, gender, age, cultural and family competencies.

Based on the COMPASS results over a three year period, it is evident that the Keystone program made incremental program change and systemic improvements across the organization. The creation of a "welcoming" policy for person with co-occurring substance abuse and mental health disorders for a first step in quality improvement. The identification of dual disorders, and improvement in treatment planning for individuals with both disorders is reflected in the COMPASS results and through chart reviews. The COMPASS also tracked a marked improvement of "integrated" treatment relationships with its partner agency and subcontractor, Directions for Mental Health. The evaluators observed a slight "over-rating" of staff competencies in year Two which was recognized by the Keystone staff and several areas of specific training, such as trauma and employment, were added to the program to enhance the overall competency of the program. In conclusion, the Keystone staff sustained a three year effort to use the CCISC fidelity tools that had a positive impact on the entire ACTS agency.

Table Eleven. COMPASS Fidelity Results

COMPASS Domain	Percent of Maximum Points Obtained		
	2003	**2004**	**2005**
Program philosophy	80.0%	92.0%	100.0%
Management structure	62.5%	75.0%	82.5%
Access to care	88.0%	92.0%	88.0%
Identification of co-occurring disorders	60.0%	92.0%	100.0%
Assessment and diagnosis	86.7%	76.7%	77.1%
Treatment planning	100.0%	56.0%	80.0%
Treatment content and programming	89.1%	80.0%	100.0%
Integrated treatment relationships	77.5%	62.5%	80.0%
Treatment program policies	55.0%	85.0%	80.0%
Psychopharmacology	71.4%	86.7%	100.0%
Discharge planning	60.0%	60.0%	80.0%
Integrated external care management	40.0%	87.5%	60.0%
Staff competency and training	0.0%	86.7%	80.0%
Specific competencies	31.1%	60.0%	83.3%

Note. Interviews conducted 9/19/2003, 9/17/2004, and 10/14/2005.

DISCUSSION

The implementation of the Keystone program is a prime example of systemic change and quality improvement within a program and with the community at large. The Agency for Community Treatment Services (ACTS) successfully 'transformed" a traditional substance abuse residential treatment facility to a "co-occurring capable" mental health and substance abuse program, whose boundaries and aftercare services spread throughout this multi-county community. This was evidenced by ACTS' collaboration with Directions for Mental Health (subcontractor) who provided both on-site and aftercare mental health case management. Other provider agencies were brought into the process from the beginning with "open-door' invitations to training and consultation provided by the grant with Dr. Kenneth Minkoff and the evaluation team at USF-Florida Mental Health Institute.

Housing Outcomes

Over the course of three years, the Keystone program reached out to persons who were homeless in a variety of settings. In the early stages of the grant, ACTS "reached-in" to a homeless population at the Pinellas County jail as a means of jail diversion and over time diversified referrals to Homeless Coalitions and direct street contacts. ACTS, through its own continuum of residential and supportive housing, had capacity to serve clients discharged from the Keystone program, but also accessed supportive housing through several mental health and substance abuse agencies in the Tampa Bay area. ACTS' long history of working with homeless populations was an asset to program implementation. Case managers were able to make new connections and to increase the number of referrals to ACTS transitional housing programs.

The decreases found in the percentage of clients in correctional facilities or homeless at both 6- and 12-month follow-up indicate initial success in housing of clients at Keystone. Both homelessness and incarceration are typically viewed as the worst housing situations. Jail may be preferable to the street as food and shelter are provided; however, a criminal record is likely to dissuade potential landlords from accepting a new tenant (Drake, Osher, & Wallach, 1991). Certainly, residing in a treatment facility, having temporary or permanent housing would be preferable to the street or a correctional facility. Although most would certainly agree that a treatment facility is superior compared to being homelessness or incarcerated, there is some debate regarding whether residing in a treatment facility is indicative of a client's engagement in therapy or indicative of his dependence on others for housing, food, or other needs (Mares, Kasprow, & Rosenheck, 2004; Tsemberis, Gulcur, & Nakae, 2004). That is, researchers tending toward the latter point to the effectiveness of Housing First programs in which clients are provided with independent living situations right from the initiation of treatment, rather than transitioning to greater independence after completion of residential treatment (Tsemberis et al., 2004).

Indeed, the focus on the last year of the grant has been on creating affordable, stable and independent housing opportunities for clients, and this is evident in the follow-up outcomes on housing stability.

Employment Outcomes

Employment also increased from baseline to 6- and 12-month follow-up although the percentage employed at baseline was particularly low (1.7%). The low level of employment at baseline was partially due to many clients being admitted to Keystone from jail, where employment is not available. Although most clients were still not employed at six-months, many had not completed the residential treatment at Keystone and were therefore not able to work. However, in the last year of the program, a vocational specialist was hired whose duties included assisting clients with locating jobs and educational opportunities. The addition of a full-time vocational counselor made it possible for all clients to have a thorough vocational assessment. Different testing instruments identified their specific interest areas and abilities and clients were assisted with job preparedness and counseling. The vocational specialist also assisted in job placement or referred to corresponding services in the community following discharge.

The goal of the program is not simply to treat and discharge clients but to assist clients in the road to greater independence in living. Given the improvements to the Keystone program and the educated nature of the clients in the sample, with the majority having received at least a high school education, an even greater increase in employment for Keystone clients is expected in the future.

Mental Health Outcomes

As expected, mental health symptoms decreased significantly from baseline to 6- and 12-month follow-up. The current study revealed scores on the subscale measuring depression were higher than most other subscales, consistent with the sample composition of primarily either Bipolar or a Major Depressive Disorder as primary mental health diagnoses. The decrease in symptoms of depression indicates an effective targeting of treatment to the presenting symptoms of the clientele.

Of course, symptoms decreased on subscales other than depression as well. In fact, all subscales except for hostility showed significant decreases at six-month follow-up. Prior to the present study, the Keystone program was primarily a substance abuse program. However, the integration of the program included hiring a mental health clinician to treat clients with COD in both group and individual formats. The decrease in symptoms of mental health indicates an effective integration of treatment targeting mental health symptoms and not only substance use. The Keystone program, following the integration of the CCISC Model, has been successful at reducing mental health symptoms in clients with COD.

Substance Use Outcomes

The decrease in substance use from baseline to 6-and 12-month follow-up occurred despite low initial levels. Low reported levels of use upon entry to the program were often due to clients previously having been incarcerated or in a detoxification unit where the environment limits the ability to acquire or use substances. It is important to not that the majority of clients were not using alcohol or drugs one year following intake. The low drug use is impressive considering the average length of stay was about four and one-half months so many clients has been living in the community over seven months.

Fidelity Results

The entire implementation process of the CSAT Treatment for Homeless Grant required community collaboration with numerous community agencies. One major advantage this community had was the recent success of the CMHS Community Action Grant for Service System Change for Persons with Co-Occurring Disorders. This CMHS grant built a foundation and culture of "co-occurring capability" within Hillsborough County. ACTS along with other community agencies, the State of Florida-DCF Substance Abuse and Mental Health Program Office, County, local Medicaid Office, Managed Care organizations and providers developed a Memorandum of Understanding to organize a Comprehensive, Continuous Integrated System of Care (CCISC) for persons with co-occurring disorders and utilized several tools developed by Dr. Kenneth Minkoff, including the COMPASS or Comorbidity Program Audit and Self Survey for Behavioral Health Services which was a key monitoring instrument in the Keystone program.

Based on the COMPASS results and identified needs of the staff; treatment planning, supportive housing and supported employment emerged as core areas of training and consultation. Dr. Kenneth Minkoff provided ongoing training to the Keystone staff on co-occurring disorders, treatment planning and the entire community was welcome to participate throughout the three year process. USF-FMHI provided training on supportive housing and in the third year of implementation another community agency, Boley Centers, provided on-site supported employment consultation and integrated services for clients.

Summary

In summary, ACTS, as the primary grantee, executed all of the planned activities in the grant, from an administrative function to clinical interventions. The Keystone program was a catalyst for moving the entire organization forward as a co-occurring capable and enhanced provider in the community. ACTS also had a dramatic impact on modeling for other agencies in the Suncoast service region of Florida and has been recognized at several state conferences as an agency with the capability of serving persons who are homeless with co-occurring disorders. This experience has led ACTS to expand its target

population to serving persons with forensic mental health and substance use histories. The State of Florida, DCF Substance Abuse and Mental Health Program Office, has provided the Keystone program with a sustainable funding base to continue services for person with multiple problems in the community rather than in institutional or homeless settings.

The major components of the CCISC Model as outlined by Minkoff and Cline (2001) are system-level change, efficient use of existing resources, incorporation of best practices, and integrated treatment philosophy. This study supports the effectiveness of the CCISC Model on a program level as well as a system level. The Keystone program has successfully transitioned from offering exclusively substance abuse treatment to serving clients with mental health and substance use needs as well as addressing vocational and employment concerns.

Additionally, several committees were formed during the course of the grant and included the following:

- **Dual Recovery Advisory Board** - formed under the guidance of a peer specialist from the community. The Board was composed of program administrators, case managers, current and former clients, family members, and a member of the evaluation team. Major topics were program improvement, continuum of care options, overcoming barriers during treatment and after discharge from the program, and housing and employment assistance. The main goals were to increase clients' active involvement and participation in the program, create a working partnership between staff and clients, and empower the client.
- **Resident Counsel Committee** - formed under the guidance of the Clinical Director and met on a weekly basis to discuss program efficacy, client validations, program rules and regulations, disciplinary consequences, and sanctions. The results of the meetings were communicated to all residents during a weekly community meeting.
- **Recovery Time Two (Rx2)** – created for individuals with co-occurring mental health and substance use disorders. Groups were held on a regular basis and open to individuals from other programs.

Program and Policy Considerations

Beyond program integration, the system of care has developed as multiple agencies have established relationships in order to transition clients from residential treatment to more independent living. Some issues to consider include the following:

- **Expand the CCICS model throughout the organization** – ACTS has made a major commitment to implementing the CCISC model. It would be wise to continue to use the COMPASS throughout the organization, especially as ACTS expands services for person who are homeless, outpatient detoxification, jail diversion programs and forensic mental health clients.
- **Improve integrated treatment relationships and discharge planning** – particularly with community mental health and substance abuse organizations that provide continuing care for Keystone clients after they leave the program.

- **Expand the on-site and off-site employment services with Boley Centers, Inc**. - consider implementing the Individual, Placement and Support (IPS) model of supported employment with this targeted co-occurring population.
- **Continue to develop supportive housing services throughout the community** - utilize best practices and non-linear methods to obtain housing.
- **Share the results of the Keystone program** – particularly with the State of Florida's DCF Substance Abuse and Mental Health Program Office, the local Homeless Coalitions in Hillsborough and Pinellas County, State DCF Office on Homeless, and the State Council on Homelessness.

REFERENCES

Allen, J, Coyne, L., & Huntoon, J. (1998). Trauma pervasively elevates Brief Symptom Inventory profiles in inpatient women. *Psychological Reports, 83(2)*, 499-513.

Bebout, R. R., Drake, R. E., Xie, H., McHugo, G. J., & Harris, M. (1997). Housing status among formerly homeless dually diagnosed adults. *Psychiatric Services, 48*, 936-941.

Blankertz, L. E., & Cnaan, R. A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. *Social Service Review, 68*, 536-560.

Boulet, J., & Boss, M. (1991). Reliability and Validity of the Brief Symptom Inventory. *Psychological Assessment, 3(3)*, 433-437.

Cook, J. A., Pickett-Schenk, S. A., Grey, D., Banghart, M., Rosenheck, R. A., & Randolph, F. (2001). Vocational outcomes among formerly homeless persons with severe mental illness in the ACCESS program. Psychiatric Services, 52, 1075-1080.

Derogatis, L. R. (1982). *Brief Symptom Inventory: Administration, Scoring, and Procedures Manual-II*. NCS Pearson Assessments, Inc. Minneapolis.

Drake, R. E., Bartels, S. J., Teague, G. B., Noordsy, D. L., & Clark, R. E. (1993). Treatment of substance abuse in severely mentally ill patients. *The Journal of Nervous and Mental Disease, 181*, 606-611.

Drake, R.E., Essock, S.M., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52(4)*, 469-476.

Drake, R. E., Mueser, K. T., Brunette, M. F., & McHugo, G. J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*, 360-374.

Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist, 46*, 1149-1158.

Drake, R. E., & Wallach, M. A. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry, 40,* 1041-1046.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *The Journal of Nervous and Mental Disease, 185*, 298-305.

James, W., Preston, N. J., Koh, G., Spencer, C., Kisely, S. R., & Castle, D. J. (2004). A group intervention which assists patients with dual diagnosis reduce their drug use: A randomized controlled trial. *Psychological Medicine, 34*, 983-990.

Leal, D., Galanter, M., Dermatis, H., & Westreich, L. (1999). Correlates of protracted homelessness in a sample of dually diagnosed psychiatric inpatients. *Journal of Substance Abuse Treatment, 16*, 143-147.

Lehman, A. F., Myers, C. P., & Corty, E. (1989). Assessment and classification of patients with psychiatric and substance abuse syndromes. *Hospital and Community Psychiatry, 40*, 1019-1024.

Mares, A.S., Kasprow, W.J., & Rosenheck, R.A. (2004). Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. *Mental Health Services Research, 6,* 199-211.

Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry, 40*, 1031-1036.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In K. Mindoff, & R. E. Drake (Eds.), New directions for mental health services, (pp. 13-27). San Francisco, CA: Jossey-Bass.

Minkoff, K & Cline, C. (2001). *New Mexico Co-occurring Disorders Program Competency Assessment Tool.* Santa Fe, NM.

Minkoff, K., & Cline, C. A. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America, 27*, 727-743.

NASMHPD/NASADAD (1998). *The new conceptual framework for co-occurring mental health and substance use disorders.* Washington, DC.

National Law Center on Homelessness and Poverty. (2004). *Out of Sight-Out of Mind? A Report on Anti-Homeless Laws, Litigation, and Alternatives in 50 United States Cities.* Washington, DC.

New Hampshire-Dartmouth Psychiatric Research Center (1995). *Residential Follow-Back Calendar, Version 6/1/95*. Lebanon, NH: Dartmouth Medical School.

Nuttbrock, L. A., Rahav, M., Rivera, J. J., Ng-Mak, D. S., & Link, B. G. (1998). Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community. *Psychiatric Services, 49*, 68-76.

Overall, J. E., & Gorham, D. R. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports, 10*, 799-812.

Piersma, H., Reaume, W., & Boes, J. (1994). The Brief Symptom Inventory (BSI) as an outcome measure for adult psychiatric inpatients. *Journal of Clinical Psychology, 50(4)*, 555-563.

Rahav, M., Rivera, J. J., Nuttbrock, L., Ng-Mak, D., Sturz, E., Link, B. et al. (1995). Characteristics and treatment of homeless, mentally ill chemical-abusing men. *Journal of Psychoactive Drugs, 21(1),* 93-103.

Rothbard, A. B., Min, S., Kuno, E., & Wong, Y. I. (2004). Long-term effectiveness of the ACCESS program in linking community mental health services to homeless persons with severe mental illness. *The Journal of Behavioral Health Sciences & Research, 31(4),* 441-449.

Siegal S, Castellan NJ. (1998) *Nonparametric Statistics for the Behavioral Sciences, 2nd. Ed.* New York, NY: McGraw-Hill, Inc.

Tsemberis, S., Gulcur, L., & Nakea, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94,* 651-656

Appendices

Appendix A

Informed Client Consent
Social and Behavioral Sciences
University of South Florida

Information for People Who Take Part in Research Studies

Researchers at the University of South Florida (USF) study many topics. For example, we want to learn about more effective treatment and services for homeless persons. To do this, we need the help of people who agree to take part in a research study.

Title of research study: Treatment for Homeless
Person in charge of study: Kathleen Moore
Study staff who can act on behalf of the person in charge: Scott Young, Susan Carrigan
Where the study will be done: Hillsborough and Pinellas Counties, Florida
Who is paying for it: Substance Abuse and Mental Health Services Administration

Should you take part in this study?
This form tells you about this research study. You can decide if you want to take part in it. You do not have to take part. Reading this form can help you decide.

Before you decide:

- Read this form.
- Talk about this study with the person in charge of the study or the person explaining the study. You can have someone with you when you talk about the study.
- Find out what the study is about.

You can ask questions:

- You may have questions this form does not answer. If you do, ask the person in charge of the study or study staff as you go along.
- You don't have to guess at things you don't understand. Ask the people doing the study to explain things in a way you can understand.

After you read this form, you can:

- Take your time to think about it.
- Have a friend or family member read it.
- Talk it over with someone you trust.

It's up to you. If you choose to be in the study, then you can sign the form. If you do not want to take part in this study, do not sign the form.

Why is this research being done?
The purpose of this study is to find out how treatment programs can better help people who are homeless or at risk of becoming homeless deal with their problems and receive the services they need.
Why are you being asked to take part?
We are asking you to take part in this study because you are homeless or at risk of becoming homeless and may have had some problems with alcohol and drugs and mental health issues.

How long will you be asked to stay in the study?
You will be asked to spend about 1 year in this study.

How often will you need to come for study visits?
A study visit is one you have with the person in charge of the study or study staff. You will need to come for 3 study visits in all. If you agree to participate, you will be asked to answer questions now, in six months, and again in one year. Most study visits will take about one hour of your time. At each visit, the person in charge of the study or staff will ask questions about your living situation, your life experiences, your use of alcohol and drugs, recent arrest, where you have lived recently, your feelings, and your treatment services.

What other choices do you have if you decide not to take part?
If you decide not to take part in this study, that is okay. By not participating, this will not affect your treatment in any way. You will still receive the same treatment services whether you consent or not to be in the study.

How do you get started?
If you decide to take part in this study, you will need to sign this consent form. A staff member will ask you some questions about your living situation, your life experiences, your use of alcohol and drugs, recent arrest, where you have lived recently, your feelings, and your treatment services.

What will happen during this study?
We will ask you some questions now, and then in 6 months and at 12 months. Each interview will take about an hour and you are free to answer or not answer any of the questions that will be asked to you.

Here is what you will need to do during this study
You will need to sit with a staff member for an hour and answer some questions about your living situation, your life experiences, your use of alcohol and drugs, recent arrest, where you have lived recently, your feelings, and your treatment services.

Will you be paid for taking part in this study?
We will pay you $20 at 6 month and then again at 12-month follow-up for your continued participation in this study.

What will it cost you to take part in this study?
It will not cost you anything to take part in the study.

What are the potential benefits if you take part in this study?
You will not directly benefit from participating in this study. However, by participating you may help services for people who are homeless and have treatment needs.
What are the risks if you take part in this study?
There is some risk to those who take part in this study. You will be asked personal questions, and that can make some people upset. However, you can refuse to answer questions and choose to stop the interview at any time. If you need to, the interview can be done at another time. You may choose to withdraw from the study at any time and there will be no penalty in regards to your treatment services.

What will we do to keep your study records private?
Federal law requires us to keep your study records private. Your records will be kept in a locked file at the University of South Florida. Only authorized persons will be able to read the information. Your name will not be identified in any reports. Code numbers will be used to protect the information. Your name will not appear with the personal information you provide. It will only be linked with the contact information you provide us. Your privacy and research records will be kept confidential to the extent of the law. There are exceptions.

Any evidence of child abuse or neglect obtained during an interview must be reported to the authorities. If you say that you plan to harm someone or yourself, research staff must tell people to help you. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them confidential. The only people who will be allowed to see these records are:

- The study staff.
- People who make sure that we are doing the study in the right way. They also make sure that we protect your rights and safety:
    a. The USF Institutional Review Board (IRB)
    b. The United States Department of Health and Human Services (DHHS)
- The agency who paid for this study is the Substance Abuse Mental Health Services Administration. They may look at the study records to make sure the study is done in the right way.

We may publish what we find out from this study. If we do, we will not use your name or anything else that would let people know who you are.

What happens if you decide not to take part in this study?
You should only take part if you are comfortable with participating in the study.

If you decide not to take part:

- You won't be in trouble or lose any rights you normally have.
- You will still get the same services you would normally have.
- You can still get your regular counseling services from your therapist.

What if you join the study and then later decide you want to stop?

If you decide you want to stop taking part in the study, tell the study staff as soon as you can.

- We will tell you how to stop safely. We will tell you if there are any dangers if you stop.
- If you decide to stop, you can still receive your regular services from your therapist.

Are there reasons we might take you out of the study later on?
Even if you want to stay in the study, there may be reasons we will need to take you out of it. You may be taken out of this study:

- If we find out it is not safe for you to stay in the study.
- The sponsor might stop the study.
- If you are not coming for your study visits when scheduled.

You can get the answers to your questions.
If you have any questions about this study, call Kathleen Moore at the University of South Florida at (813) 974-2295. If you have questions about your rights as a person who is taking part in a study, call USF Research Compliance at (813) 974-5638.

Consent to Take Part in this Research Study
It's up to you. You can decide if you want to take part in this study.

I freely give my consent to take part in this study. I understand that this is research. I have received a copy of this consent form.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
[Optional] Signature of Witness	Printed Name of Witness	Date

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect. The person who is giving consent to take part in this study

- Understands the language that is used.
- Reads well enough to understand this form.
- Does not have any problems that could make it hard to understand what it means to take part in this study.
- Is not taking drugs that make it hard to understand what is being explained.

To the best of my knowledge, when this person signs this form, he or she understands:

- What the study is about.
- What needs to be done.
- What the potential benefits might be.
- What the known risks might be.
- That taking part in the study is voluntary.

_____	_____	_____
Signature of Investigator	Printed Name of Investigator	Date
_____	_____	_____
[Optional] Signature of Witness	Printed Name of Witness	Date

Appendix B

A. RECORD MANAGEMENT - DEMOGRAPHICS *[ASKED ONLY AT INTAKE/BASELINE]*

1. What is your gender?

- ○ MALE
- ○ FEMALE
- ○ TRANSGENDER
- ○ OTHER (SPECIFY) _____
- ○ REFUSED

2. Are you Hispanic or Latino?

- ○ YES
- ○ NO
- ○ REFUSED

***[IF YES]* What ethnic group do you consider yourself? Please answer yes or no for each of the following. You may say yes to more than one.**

	Yes	No	Refused
Central American	Y	N	Refused
Cuban	Y	N	Refused
Dominican	Y	N	Refused
Mexican	Y	N	Refused
Puerto Rican	Y	N	Refused
South American	Y	N	Refused
Other	Y	N	Refused *[IF YES, SPECIFY BELOW]*
	(Specify) _____		

3. What is your race? Please answer yes or no for each of the following. You may say yes to more than one.

	Yes	No	Refused
Black or African American	Y	N	Refused
Asian	Y	N	Refused
Native Hawaiian or other Pacific Islander	Y	N	Refused
Alaska Native	Y	N	Refused
White	Y	N	Refused
American Indian	Y	N	Refused

4. What is your date of birth?*

|____|____| / |____|____| /
MONTH DAY

|____|____|____|____|
YEAR

○ REFUSED

B. DRUG AND ALCOHOL USE

			Number of Days	REFUSED	DON'T KNOW
1.	**During the past 30 days how many days have you used the following:**				
	a.	Any alcohol ***[IF ZERO, SKIP TO ITEM B1c.]***	|____|____|	○	○
	b1.	Alcohol to intoxication (5+ drinks in one sitting)	|____|____|	○	○
	b2.	Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	|____|____|	○	○
	c.	Illegal drugs	|____|____|	○	○
	d.	Both alcohol and drugs (on the same day)	|____|____|	○	○

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

			Number of Days	RF	DK	Route*	RF	DK
2.	**During the past 30 days, how many days have you used any of the following:**							
	a.	Cocaine/Crack	|____|____|	○	○	|____|	○	○
	b.	Marijuana/Hashish (Pot, Joints, Blunts, Chronic, Weed, Mary Jane)	|____|____|	○	○	|____|	○	○
	c.	Opiates:						
		1. Heroin (Smack, H, Junk, Skag)	|____|____|	○	○	|____|	○	○
		2. Morphine	|____|____|	○	○	|____|	○	○
		3. Diluadid	|____|____|	○	○	|____|	○	○
		4. Demerol	|____|____|	○	○	|____|	○	○
		5. Percocet	|____|____|	○	○	|____|	○	○
		6. Darvon	|____|____|	○	○	|____|	○	○
		7. Codeine	|____|____|	○	○	|____|	○	○
		8. Tylenol 2,3,4	|____|____|	○	○	|____|	○	○
		9. Oxycontin/Oxycodone	|____|____|	○	○	|____|	○	○
	d.	Non-prescription methadone	|____|____|	○	○	|____|	○	○
	e.	Hallucinogens/psychedelics, PCP (Angel Dust, Ozone, Wack, Rocket Fuel) MDMA (Ecstasy, XTC, X, Adam), LSD (Acid, Boomers, Yellow Sunshine), Mushrooms or Mescaline	|____|____|	○	○	|____|	○	○
	f.	Methamphetamine or other amphetamines (Meth, Uppers, Speed, Ice, Chalk, Crystal, Glass, Fire, Crank)	|____|____|	○	○	|____|	○	○

B. DRUG AND ALCOHOL USE (Cont.)

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV
*NOTE THE USUAL ROUTE. FOR MORE THAN ONE ROUTE, CHOOSE THE MOST SEVERE. THE ROUTES ARE LISTED FROM LEAST SEVERE (1) TO MOST SEVERE (5).

2. During the past 30 days, how many days have you used any of the following:			**Number of Days**	**RF**	**DK**	**Route***	**RF**	**DK**
g.	1.	Benzodiazepines: Diazepam (Valium); Alprazolam (Xanax); Triazolam (Halcion); and Estasolam (Prosom and Rohypnol–also known as roofies, roche, and cope)	|____|____|	○	○	|____|	○	○
	2.	Barbiturates: Mephobarbital (Mebacut); and pentobarbital sodium (Nembutal)	|____|____|	○	○	|____|	○	○
	3.	Non-prescription GHB (known as Grievous Bodily Harm; Liquid Ecstasy; and Georgia Home Boy)	|____|____|	○	○	|____|	○	○
	4.	Ketamine (known as Special K or Vitamin K)	|____|____|	○	○	|____|	○	○
	5.	Other tranquilizers, downers, sedatives or hypnotics	|____|____|	○	○	|____|	○	○
h.		Inhalants (poppers, snappers, rush, whippets)	|____|____|	○	○	|____|	○	○
i.		Other illegal drugs (Specify)_____	|____|____|	○	○	|____|	○	○

3. In the past 30 days have you injected drugs?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION C.]

4. In the past 30 days, how often did you use a syringe/needle, cooker, cotton or water that someone else used?

○ Always
○ More than half the time
○ Half the time
○ Less than half the time
○ Never
○ REFUSED
○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time? *[DO NOT READ RESPONSE OPTIONS TO CLIENT.]*

- ○ SHELTER (SAFE HAVENS, TRANSITIONAL LIVING CENTER [TLC], LOW DEMAND FACILITIES, RECEPTION CENTERS, OTHER TEMPORARY DAY OR EVENING FACILITY)
- ○ STREET/OUTDOORS (SIDEWALK, DOORWAY, PARK, PUBLIC OR ABANDONED BUILDING)
- ○ INSTITUTION (HOSPITAL, NURSING HOME, JAIL/PRISON)
- ○ HOUSED:
  - ○ OWN/RENT APARTMENT, ROOM, OR HOUSE
  - ○ SOMEONE ELSE'S APARTMENT, ROOM OR HOUSE
  - ○ HALFWAY HOUSE
  - ○ RESIDENTIAL TREATMENT
  - ○ OTHER HOUSED (SPECIFY) _____
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

3. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

C. FAMILY AND LIVING CONDITIONS (Continued)

4. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

- ○ Not at all
- ○ Somewhat
- ○ Considerably
- ○ Extremely
- ○ NOT APPLICABLE
- ○ REFUSED
- ○ DON'T KNOW

5. *[IF NOT MALE,]* Are you currently pregnant?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

6. Do you have children?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

a. How many children do you have?

|____|____| ○ REFUSED ○ DON'T KNOW

b. Are your children living with someone else due to a child protection court order?

- ○ YES
- ○ NO
- ○ REFUSED
- ○ DON'T KNOW

[IF NO, REFUSED, OR DON'T KNOW GO TO SECTION D.]

c. *[IF YES,]* How many of your children are living with someone else due to a child protection court order?

|____|____| ○ REFUSED ○ DON'T KNOW

d. For how many of your children have you lost parental rights? *[THE CLIENT'S PARENTAL RIGHTS WERE TERMINATED.]*

|____|____| ○ REFUSED ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? *[IF ENROLLED,]* Is that full time or part time?

- ○ NOT ENROLLED
- ○ ENROLLED, FULL TIME
- ○ ENROLLED, PART TIME
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

2. What is the highest level of education you have finished, whether or not you received a degree?

- ○ NEVER ATTENDED
- ○ 1ST GRADE
- ○ 2ND GRADE
- ○ 3RD GRADE
- ○ 4TH GRADE
- ○ 5TH GRADE
- ○ 6TH GRADE
- ○ 7TH GRADE
- ○ 8TH GRADE
- ○ 9TH GRADE
- ○ 10TH GRADE
- ○ 11TH GRADE
- ○ 12TH GRADE/HIGH SCHOOL DIPLOMA/EQUIVALENT
- ○ COLLEGE OR UNIVERSITY/1st YEAR COMPLETED
- ○ COLLEGE OR UNIVERSITY/2nd YEAR COMPLETED/ASSOCIATES DEGREE
- ○ COLLEGE OR UNIVERSITY/3rd YEAR COMPLETED
- ○ BACHELOR'S DEGREE (BA, BS) OR HIGHER
- ○ VOC/TECH PROGRAM AFTER HIGH SCHOOL BUT NO VOC/TECH DIPLOMA
- ○ VOC/TECH DIPLOMA AFTER HIGH SCHOOL
- ○ REFUSED
- ○ DON'T KNOW

D. EDUCATION, EMPLOYMENT, AND INCOME (Cont.)

3. Are you currently employed? ***[CLARIFY BY FOCUSING ON STATUS DURING MOST OF THE PREVIOUS WEEK, DETERMINING WHETHER CLIENT WORKED AT ALL OR HAD A REGULAR JOB BUT WAS OFF WORK.]***

- ○ EMPLOYED FULL TIME (35+ HOURS PER WEEK, OR WOULD HAVE BEEN)
- ○ EMPLOYED PART TIME
- ○ UNEMPLOYED, LOOKING FOR WORK
- ○ UNEMPLOYED, DISABLED
- ○ UNEMPLOYED, VOLUNTEER WORK
- ○ UNEMPLOYED, RETIRED
- ○ UNEMPLOYED, NOT LOOKING FOR WORK
- ○ OTHER (SPECIFY)_____
- ○ REFUSED
- ○ DON'T KNOW

4. Approximately, how much money did YOU receive (pre-tax individual income) in the past 30 days from…

			RF	**DK**
a.	Wages	$ |__|__|__| , |__|__|__|	○	○
b.	Public assistance	$ |__|__|__| , |__|__|__|	○	○
c.	Retirement	$ |__|__|__| , |__|__|__|	○	○
d.	Disability	$ |__|__|__| , |__|__|__|	○	○
e.	Non-legal income	$ |__|__|__| , |__|__|__|	○	○
f.	Family and/or friends	$ |__|__|__| , |__|__|__|	○	○
g.	Other (Specify) _____	$ |__|__|__| , |__|__|__|	○	○

D. CRIME AND CRIMINAL JUSTICE STATUS

1. In the past 30 days, how many times have you been arrested?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW
[IF NO ARRESTS, GO TO ITEM E3.]

2. In the past 30 days, how many times have you been arrested for drug-related offenses?

|____|____| TIMES ○ REFUSED ○ DON'T KNOW

3. In the past 30 days, how many nights have you spent in jail/prison?

|____|____| NIGHTS ○ REFUSED ○ DON'T KNOW

4. In the past 30 days, how many times have you committed a crime? ***[CHECK NUMBER OF DAYS USED ILLEGAL DRUGS IN ITEM B1c ON PAGE 4. ANSWER HERE IN E4 MUST BE EQUAL TO OR GREATER THAN NUMBER IN B1c BECAUSE USING ILLEGAL DRUGS IS A CRIME.]***

|____|____|____| TIMES ○ REFUSED ○ DON'T KNOW

5. Are you currently awaiting charges, trial, or sentencing?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

6. Are you currently on parole or probation?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. How would you rate your overall health right now?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ REFUSED
- ○ DON'T KNOW

2. During the past 30 days, did you receive:

a. Inpatient Treatment for:

	YES	*[IF YES]* Altogether for how many nights	NO	RF	DK
i. Physical complaint	○	_____ nights	○	○	○
ii. Mental or emotional difficulties	○	_____ nights	○	○	○
iii. Alcohol or substance abuse	○	_____ nights	○	○	○

b. Outpatient Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____times	○	○	○
ii. Mental or emotional difficulties	○	_____times	○	○	○
iii. Alcohol or substance abuse	○	_____times	○	○	○

c. Emergency Room Treatment for:

	YES	*[IF YES]* Altogether for how many times	NO	RF	DK
i. Physical complaint	○	_____times	○	○	○
ii. Mental or emotional difficulties	○	_____times	○	○	○
iii. Alcohol or substance abuse	○	_____times	○	○	○

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT (Cont.)

3. During the past 30 days, did you engage in sexual activity?

○ Yes
○ No → ***[GO TO F4.]***
○ NOT PERMITTED TO ASK → ***[GO TO F4.]***
○ REFUSED → ***[GO TO F4.]***
○ DON'T KNOW → ***[GO TO F4.]***

[IF YES] **Altogether, how many:**

		Contacts	RF	DK
a.	Sexual contacts (vaginal, oral, or anal) did you have?	|____|____|____|	○	○
b.	Unprotected sexual contacts did you have? ***[IF ZERO, GO TO F4.]***	|____|____|____|	○	○
c.	Unprotected sexual contacts were with an individual who is or was:			
	1. HIV positive or has AIDS	|____|____|____|	○	○
	2. An injection drug user	|____|____|____|	○	○
	3. High on some substance	|____|____|____|	○	○

4. In the past 30 days, not due to your use of alcohol or drugs, how many days have you:

		Days	RF	DK
a.	Experienced serious depression	|____|____|	○	○
b.	Experienced serious anxiety or tension	|____|____|	○	○
c.	Experienced hallucinations	|____|____|	○	○
d.	Experienced trouble understanding, concentrating, or remembering	|____|____|	○	○
e.	Experienced trouble controlling violent behavior	|____|____|	○	○
f.	Attempted suicide	|____|____|	○	○
g.	Been prescribed medication for psychological/emotional problem	|____|____|	○	○

[IF CLIENT REPORTS 0 DAYS TO ALL ITEMS IN QUESTION 4, SKIP TO SECTION G.]

5. How much have you been bothered by these psychological or emotional problems in the past 30 days?

○ Not at all
○ Slightly
○ Moderately
○ Considerably
○ Extremely
○ REFUSED
○ DON'T KNOW

G. SOCIAL CONNECTEDNESS

1. In the past 30 days, did you attend any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization? In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as: Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

2. In the past 30 days, did you attend any religious/faith affiliated recovery self-help groups?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

3. In the past 30 days, did you attend meetings of organizations that support recovery other than the organizations described above?

○ YES ***[IF YES]*** SPECIFY HOW MANY TIMES _____ ○ REFUSED ○ DON'T KNOW
○ NO
○ REFUSED
○ DON'T KNOW

4. In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?

○ YES
○ NO
○ REFUSED
○ DON'T KNOW

5. To whom do you turn when you are having trouble? *[SELECT ONLY ONE.]*

○ NO ONE
○ CLERGY MEMBER
○ FAMILY MEMBER
○ FRIENDS
○ REFUSED
○ DON'T KNOW
○ OTHER SPECIFY: _____

I. FOLLOW-UP STATUS
[*REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT FOLLOW-UP]*

1. What is the follow-up status of the client? ***[THIS IS A REQUIRED FIELD: NA, REFUSED, DON'T KNOW, AND MISSING WILL NOT BE ACCEPTED].***

- ○ 01 = Deceased at time of due date
- ○ 11 = Completed interview within specified window
- ○ 12 = Completed interview outside specified window
- ○ 21 = Located, but refused, unspecified
- ○ 22 = Located, but unable to gain institutional access
- ○ 23 = Located, but otherwise unable to gain access
- ○ 24 = Located, but withdrawn from project
- ○ 31 = Unable to locate, moved
- ○ 32 = Unable to locate, other (SPECIFY) _____

2. Is the client still receiving services from your program?

- ○ Yes
- ○ No

[IF THIS IS A FOLLOW-UP INTERVIEW STOP NOW, THE INTERVIEW IS COMPLETE.]

J. DISCHARGE STATUS
[REPORTED BY PROGRAM STAFF ABOUT CLIENT ONLY AT DISCHARGE]

1. On what date was the client discharged?

|____|____| / |____|____| / |____|____|____|____|
MONTH DAY YEAR

2. What is the client's discharge status?

- ○ 01 = Completion/Graduate
- ○ 02 = Termination

If the client was terminated, what was the reason for termination? [*SELECT ONE RESPONSE*.]

- ○ 01 = Left on own against staff advice with satisfactory progress
- ○ 02 = Left on own against staff advice without satisfactory progress
- ○ 03 = Involuntarily discharged due to nonparticipation
- ○ 04 = Involuntarily discharged due to violation of rules
- ○ 05 = Referred to another program or other services with satisfactory progress
- ○ 06 = Referred to another program or other services with unsatisfactory progress
- ○ 07 = Incarcerated due to offense committed while in treatment/recovery with satisfactory progress
- ○ 08 = Incarcerated due to offense committed while in treatment/recovery with unsatisfactory progress
- ○ 09 = Incarcerated due to old warrant or charged from before entering treatment/recovery with satisfactory progress
- ○ 10 = Incarcerated due to old warrant or charged from before entering treatment/recovery with unsatisfactory progress
- ○ 11 = Transferred to another facility for health reasons
- ○ 12 = Death
- ○ 13 = Other (Specify) _____

Post Satisfaction Survey

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
1. How satisfied are you with the overall quality of this program (e.g., facility, food, staff interaction)?	1	2	3	4	5
2. How satisfied are you with the quality of the treatment? (e.g., counseling, groups)	1	2	3	4	5
3. Overall, how satisfied are you with your experience at ACTS?	1	2	3	4	5

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE ACTS PROGRAM.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4. The program was helpful in dealing with my substance abuse issues.	1	2	3	4	5
5. The program was helpful in dealing with my mental health issues.	1	2	3	4	5
6. The program was beneficial to my overall well-being.	1	2	3	4	5
7. I expect to use the information gained from this program.	1	2	3	4	5
8. Staff members treated me with respect.	1	2	3	4	5
9. I would recommend this program to other people.	1	2	3	4	5

10. What could program staff have done to make you stay longer?

11. Have you used alcohol or drugs at all during your stay in the program?

12. How do you plan to continue with your treatment once you are discharged?
    - Medication
    - Counseling
    - Case Management

13. What services did you find most helpful?

14. What services did you find least helpful?

15. What would you change about the program?

Residential Follow-Back Calendar

<u>Step One</u>: I want you to think about where you have been living for the last 6 months. We would like to know all of the places where you were staying during this time, including any shelters and any hospitals. This is (give today's date), so we'll begin by talking about where you are living now and work backwards from there. Please indicate the city and state you were living in as well.

1. Current month: _____
2. One month ago: _____
3. Two months ago: _____
4. Three months ago:_____
5. Four months ago: _____
6. Five months ago: _____
7. Six months ago: _____

<u>Step Two</u>: Next I want to read you a list of living situations just to make sure I haven't missed anything. I want you to tell me if you have been in any of these, even if only for one night, for the <u>past 6 months</u>.

In the past 6 months, have you stayed for at least one night in…

	<u>NO</u>	<u>YES</u>
8. Your own apartment, house, or room?	0	1
9. Your parent or guardian's apartment or house?	0	1
10. Another relative's apartment or house?	0	1
11. A friend's apartment or house?	0	1
12. Someone else's apartment or house?	0	1
13. A psychiatric hospital?	0	1
14. Some other type of hospital?	0	1
15. A substance abuse treatment or detox program?	0	1
16. A homeless or family shelter?	0	1
17. A domestic violence shelter?	0	1
18. A crisis or respite program?	0	1
19. Jail or prison?	0	1
20. On the street or some other place (e.g., abandoned building)	0	1
21. A community residence or group home?	0	1
22. A supported housing or certified apartment program?	0	1
23. Transitional housing?	0	1
24. A hotel or motel?	0	1
25. Any other place that hasn't been mentioned: _____	0	1

Now I am going to ask you some questions about any experiences you may have had with homelessness in your lifetime. By homeless, I mean times when you didn't have a regular place to live and you were living in a homeless shelter or temporarily in an institution because you had nowhere to go. Homeless also can include living in a place not typically used for sleeping such as on the street, in a car, in an abandoned building, or in a bus or train station.

26. How many times have you been homeless? _____ # of times

27. How old were you the first time you became homeless? _____ age in years

28. What is the total number of days, weeks, months, or years you have been homeless?

    1. Less than 1 month
    2. 1 month to < 6 months
    3. 6 months to < 1 year
    4. 1 year to < 2 years
    5. 2 years to < 5 years
    6. 5 years or more

29. In the last five years, what is the total number of days, weeks, months, or years you have been homeless?

    1. None
    2. Less than 1 month
    3. 1 month to < 6 months
    4. 6 months to < 1 year
    5. 1 year to < 2 years
    6. 2 years to < 5 years
    7. All 5 years

30. As an adult, have you ever lived with family or friends because you couldn't find or afford a place of your own?

    1. Yes
    2. No (skip to question 32)

31. As an adult, in the last five years, what is the total number of days, weeks, months, or years you have lived with family or friends, because you couldn't afford your own?

    1. None
    2. Less than 1 month
    3. 1 month to < 6 months
    4. 6 months to < 1 year
    5. 1 year to < 2 years
    6. 2 years to < 5 years
    7. All 5 years

32. Did you ever live in foster care before you became 18?

    1. Yes
    2. No

33. Did you ever live in a group home before you became 18?

    1. Yes
    2. No

Treatment Services Needed and Received

For this section, we will be asking you about services you may have had in the past two weeks, which is from _____/_____/_____ to _____/_____/_____.

Month Day Year Month Day Year

I would like to ask a few questions about some of the services that you needed and received in the past two weeks. For each item, you are asked to provide TWO answers. First answer "YES" if you needed that kind of service in the past two weeks or "NO" if you didn't need it. Then, answer "YES" if you received that kind of help in the past two weeks or "NO" if you didn't receive it. Remember, that your answer should be based only on the help you needed and the help that you received during the past two weeks.

Medical and Dental Care Problems:

During the past two weeks:

	NO	YES	RF	NA	DK
34. Did you need any medical or dental care?	0	1	7	8	9
35. Did you get any medical or dental care?	0	1	7	8	9
36. Did you need to stay over night in a hospital for physical health problems?	0	1	7	8	9
37. Did you stay overnight in a hospital for physical health problems	0	1	7	8	9
38. Did you need treatment in an emergency room for a physical health problem?	0	1	7	8	9
39. Did you receive treatment in an emergency room for a physical physical health problem?	0	1	7	8	9
40. Did you need to see a doctor or nurse at a clinic, mobile van, shelter, the place where you live, or any other place for a physical health problem?	0	1	7	8	9
41. Did you see a doctor or nurse at a clinic, mobile van, shelter, the place where you live, or any other place for a physical health problem?	0	1	7	8	9
42. Did you need to receive care for your teeth from a dentist?	0	1	7	8	9
43. Did you receive care for your teeth from a dentist?	0	1	7	8	9
44. Did you need any other medical care?	0	1	7	8	9
45. Did you receive any other medical care?	0	1	7	8	9

46. Now I'd like you to tell me where you went for other medical care during the past two weeks.
_____

47. What was the medical care for?_____

Alcohol and Drug Abuse Problems:

During the past two weeks:

	NO	YES	RF	NA	DK
48. Did you need any treatment for alcohol or drug problems?	0	1	7	8	9
49. Did you get any treatment for alcohol or drug problems?	0	1	7	8	9
50. Did you need treatment in a detox program?	0	1	7	8	9
51. Did you receive treatment in a detox program?	0	1	7	8	9
52. Did you need to spend time in a drug program other than detox?	0	1	7	8	9
53. Did you spend time in a drug program other than detox?	0	1	7	8	9
54. Did you need to talk about your alcohol or drug abuse problems with a counselor such as a doctor, nurse, addictions counselor, or case manager?	0	1	7	8	9
55. Did you talk about your alcohol or drug abuse problems with a Counselor such as a doctor, nurse, addictions counselor, or case manager?	0	1	7	8	9
56. Did you need to meet with a doctor a nurse to discuss medication?	0	1	7	8	9
57. Did you meet with a doctor or a nurse to discuss medication for an alcohol or drug problem?	0	1	7	8	9
58. Did you need to attend a meeting of AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) or other self-help group?	0	1	7	8	9
59. Did you attend a meeting of AA or NA or other self help group?	0	1	7	8	9
60. Did you need to attend any other group(s) run by a professional for any alcohol or drug problems?	0	1	7	8	9
61. Did you attend any other group(s) run by professional for any alcohol or drug problems?	0	1	7	8	9
62. Did you need any other type of help for your drug problems?	0	1	7	8	9
63. Did you receive any other type of help for your drug problems?	0	1	7	8	9
64. Where did you go for other help with alcohol or drug problem?					

_____

Psychological/Emotional Problems:

During the past two weeks:

	NO	YES	RF	NA	DK
65. Did you need any help with a psychological or emotional problem or bad nerves?	0	1	7	8	9
66. Did you get any help for a psychological, emotional problem or bad nerves?	0	1	7	8	9
67. Did you need treatment overnight in a psychiatric hospital?	0	1	7	8	9
68. Did you receive treatment overnight in a psychiatric hospital?	0	1	7	8	9
69. Where did you receive treatment? _____					
70. Did you need to attend a day hospital program or a day treatment center or other mental health center?	0	1	7	8	9
71. Did you actually attend a day hospital program or a day treatment center or other mental health center?	0	1	7	8	9
72. Did you need to meet with a doctor or nurse to discuss medication for psychological or emotional problem?	0	1	7	8	9
73. Did you meet with a doctor or nurse to discuss medication for psychological or emotional problem?	0	1	7	8	9
74. Did you meet with a counselor (doctor, psychiatrist, nurse, social worker, psychologist, or case manager) to talk about a psychological or emotional problem?	0	1	7	8	9
75. Did you meet with such a counselor (doctor, psychiatrist, nurse, social worker, psychologist, or case manager) to talk about a psychological or emotional problem?	0	1	7	8	9
76. Did you need any other kind of help for a psychological or emotional problem?	0	1	7	8	9
77. Did you receive any other kind of help for a psychological or emotional problem?	0	1	7	8	9
78. Where did you get this service _____					
79. Did you need to attend group therapy run by a professional?	0	1	7	8	9
80. Did you attend group therapy run by a professional?	0	1	7	8	9
81. Did you need to belong to a self–help group where people get together to help each other with psychological problems other than substance abuse?	0	1	7	8	9
82. Did you belong to a self-help group where people get together to help each other with psychological problems other than substance abuse?	0	1	7	8	9
83. Did you need to attend a drop in center where you could hang out with others?	0	1	7	8	9
84. Did you attend a drop in center where you could hang out with others?	0	1	7	8	9

Other services not covered above:

During the past two weeks:

	NO	YES	RF	NA	DK
85. Did you need to talk with someone about job training?	0	1	7	8	9
86. Did you talk to someone about job training?	0	1	7	8	9
87. Did you need to have your work skills and interests tested to find out what kind of work you can do or be trained for?	0	1	7	8	9
88. Did you receive testing for your work skills and interests to find out what kind of work you can do and be trained for?	0	1	7	8	9
89. Did you need to work in a sheltered workshop?	0	1	7	8	9
90. Did you work in a sheltered workshop?	0	1	7	8	9
91. Did you need to meet with someone who could help you look for a job?	0	1	7	8	9
92. Did you meet with someone to get help in looking for a job?	0	1	7	8	9
93. Did you need to get training to help keep a job?	0	1	7	8	9
94. Did you get training on how to keep a job?	0	1	7	8	9
95. Did you need to attend educational classes such as a GED preparation class and adult literacy class or other kind of class?	0	1	7	8	9
96. Did you attend educational classed such as a GED preparation class and adult literacy class or other kind of class.	0	1	7	8	9
97. Did you need to meet with someone who could help you look for, find, or keep housing?	0	1	7	8	9
98. Did you meet with someone who could help you look for, find, or keep housing?	0	1	7	8	9
99. Did you need to meet with a lawyer about a legal problem?	0	1	7	8	9
100. Did you meet with a lawyer about a legal problem?	0	1	7	8	9
101. Did you need to meet with someone about getting food stamps, public assistance, VA benefits, unemployment compensation, or other types of benefits and services?	0	1	7	8	9
102. Did you meet with someone about getting food stamps, public assistance, VA benefits, unemployment compensation, or other types of benefits and services?	0	1	7	8	9
103. Did you need to meet with a person who helped you manage your money, for example, helping you with banking, paying your bills, or going shopping with you.	0	1	7	8	9
104. Did you meet with a person who helped you manage your money, for example, paying your bills or going shopping?	0	1	7	8	9
105. Did you need to meet with a staff person about improving your independent living skills, such as doing your own housekeeping, preparing food, personal hygiene or laundry?	0	1	7	8	9
106. Did you meet with a staff person about improving your independent living skills, such as doing your own housekeeping, preparing food, personal hygiene or laundry?	0	1	7	8	9
107. Did you need to meet with staff about understanding your medications?	0	1	7	8	9
108. Did you meet with staff about understanding your medications?	0	1	7	8	9
109. Did you need to meet with staff about improving your personal health?	0	1	7	8	9
110. Did you meet a staff about improving your personal health?	0	1	7	8	9
111. Did you need any other services other than those we talked about?	0	1	7	8	9
112. Did you receive any other services other than those we talked about?	0	1	7	8	9

113. Where did you go for these other types of services during the past two weeks? _____

114. What kind of service did you receive? _____

Psychiatric Crisis Services:

During the past two weeks:

	NO	YES	RF	NA	DK
115. Did you need to use a telephone emergency service for mental health problems (hot line, crisis line)?	0	1	7	8	9
116. Did you use a telephone emergency service for mental health problems (hot line, crisis line)?	0	1	7	8	9
117. Did you need to have someone from a mental health agency make an emergency home visit?	0	1	7	8	9
118. Did you need have someone from a mental health agency make an emergency visit?	0	1	7	8	9
119. Did you need to go to a psychiatric emergency room or to a community center for an emergency visit?	0	1	7	8	9
120. Did you make an emergency visit to a emergency room or to a community center for an emergency visit?	0	1	7	8	9
121. Did you need to find a protective shelter because of violence or conflict in the home?	0	1	7	8	9
122. Did you go to a protective shelter because of violence or conflict in the home?	0	1	7	8	9

Change Assessment Scale (URICA)

Each statement below describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you agree or disagree with each statement. In each case, make your choice in terms of how you fell right now, not what you have felt in the past or would like to feel. For all statements that refer to your "problem" answer in terms of problems related to your drinking. The words "here" and "this place" refer to your treatment center.

There are five possible responses to each of the items in the questionnaire:

1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree

Circle the number that best describes how much you agree or disagree with each statement.

	SD	D	U	A	SA
175. As far as I'm concerned, I don't have any problems that need changing					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
176. I think I might be ready for some self improvement					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
177. I am doing something about problems that had been bothering me					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
178. It might be worthwhile to work on my problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
179. I'm not the problem one. It doesn't make much sense for me to consider changing					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
180. It worries me that I might slip back on a problem I have already changed, so I am looking for help					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
181. I am finally doing some work on my problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
182. I've been thinking I might want to change something about myself					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
183. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5

	SD	D	U	A	SA
184. At times my problem is difficult, but I'm working on it					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
185. Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
186. I'm hoping that I will be able to understand myself better					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
187. I guess I have faults, but there's nothing I really need to change					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
188. I am really working hard to change					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
189. I have a problem and I really think I should work on it					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
190. I'm not following through with what I already changed as well as I had hoped, and I want to prevent a relapse of the problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
191. Even though I'm not always successful in changing, I am at least working on my problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
192. I thought once I resolved the problem I would be free of it but sometimes I still find myself struggling with it					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
193. I wish I had more ideas on how to solve my problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
194. I have started working on my problem but I would like help					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
195. Maybe someone or something will be able to help me					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
196. I may need a boost right now to help me maintain the changes I've already made					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
197. I may be part of the problem, but I don't really think I am					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
198. I hope that someone will have some good advice for me					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
199. Anyone can talk about changing; I'm actually doing something about it					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5

	SD	D	U	A	SA
200. All this talk about psychology is boring. Why can't people just forget about their problems					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
201. I'm struggling to prevent from having a relapse of my problem					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
202. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
203. I have worries but so does the next guy. Why spend time thinking about them					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
204. I am actively working on my problems					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
205. I would rather cope with my faults than try to change them					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5
206. After all I have done to change my problem, every now and then it comes back to haunt me					
substance abuse	1	2	3	4	5
mental health	1	2	3	4	5

Social Support Survey Instrument

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Circle one number on each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
207. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
208. Someone to give you information to help you understand a situation	1	2	3	4	5
209. Someone to give you advice about a crisis	1	2	3	4	5
210. Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
211. Someone whose advice you really want	1	2	3	4	5
212. Someone to share your most private worries and fears with	1	2	3	4	5
213. Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
214. Someone who understands your problems	1	2	3	4	5
Tangible support					
215. Someone to help if you were confined to bed	1	2	3	4	5
216. Someone to take you to the doctor if you needed it	1	2	3	4	5
217. Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
218. Someone to help with daily chores if you were sick	1	2	3	4	5
Affectionate support					
219. Someone who shows you love and affection	1	2	3	4	5
220. Someone to love you and make you feel wanted	1	2	3	4	5
221. Someone who hugs you	1	2	3	4	5
Positive social interaction					
222. Someone to have a good time with	1	2	3	4	5
223. Someone to get together with for relaxation	1	2	3	4	5
224. Someone to do something enjoyable with	1	2	3	4	5
Additional item					
225. Someone to do things with to help you get your mind off things	1	2	3	4	5

Social Network and Support Questionnaire

Thinking back to people you had contact with over the last 3 months. Of these people, whom did you talk to, visit, or do things with most frequently?

Name of person	Type of Relationship	Do you feel close to this person?	How far does this person live from you?	How often do you talk with this person?	How long have you known this person?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Type of relationship
1=spouse/significant other
2=parent
3=child
4=other relative
5=friend
6=counselor
7=other

How far does this person live from you?
1=lives in the same building
2=within the same block
3=within 30 minutes
4=within 2 hours
5=more than 2 hours

Do you feel close to this person?
1=no
2=sometimes
3=yes

How often do you talk with this person?
1=almost every day
2=at least once a week
3=at least once a month
4=less than once a month