



Smith ScholarWorks

Theses, Dissertations, and Projects

2010

**Engagement and retention of clients with co-occurring disorders :
practice wisdom of a multidisciplinary treatment unit : a project
based upon an independent investigation**

Marsha Kay Odell

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Odell, Marsha Kay, "Engagement and retention of clients with co-occurring disorders : practice wisdom of a multidisciplinary treatment unit : a project based upon an independent investigation" (2010). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/519>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Marsha Odell
Engagement and Retention of
Clients with Co-Occurring
Disorders: Practice Wisdom of
a Multidisciplinary Treatment
Unit

ABSTRACT

Individuals with co-occurring mental health and substance use disorders typically have multiple impairments making them difficult to engage and retain in treatment. The most consistent finding across studies is that the most effective service delivery is integrated, i.e. the same clinician or clinical team provides appropriate mental health and substance abuse interventions in a coordinated fashion in a single setting with a goal of helping the client to manage both illnesses. While critical components of integrated service delivery have been identified, how these components are successfully integrated to engage and retain clients in a case has been more elusive.

This qualitative study employed a sample of convenience to discern what could be learned from the practice wisdom of seasoned practitioners on an integrated co-occurring treatment unit about specific successful engagement and retention strategies.

The major findings were that participants viewed engagement and retention as a seamless process and identified five categories of strategies that were used for both engagement and retention. All of these strategies had to do with the practitioner's use of self in relationship with the client. There was reciprocity in the valuing of the relationship and use of self with a client for engagement and retention on the part of participants, i.e., the relationship with clients was clearly one of the personally satisfying parts of the work.

ENGAGEMENT AND RETENTION OF CLIENTS
WITH CO-OCCURRING DISORDERS:
PRACTICE WISDOM OF A MULTIDISCIPLINARY TREATMENT UNIT

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Marsha Odell

Smith College School for Social Work
Northampton, MA 01063

2010

ACKNOWLEDGEMENTS

I would like to thank Patricia Rehmer, Commissioner of the Connecticut Department of Mental Health and Addiction Services; members of Institutional Review Board of the Connecticut Department of Mental Health and Addiction Services and its Chair, Andrea Routh; Karen Evertson, Chief Executive Officer of Capitol Region Mental Health Center and Claude Fields, Program Director of the Co-Occurring Disorders Unit at Capitol Region Mental Health Center for supporting my research study.

Additionally, I would like to thank the members of the Co-Occurring Disorders Unit at Capitol Region Mental Health Center for their guidance and inspiration when working with clients that are diagnosed with co-occurring disorders. I would especially like to thank those members of the Co-Occurring Disorders Unit who gave of their time and shared their valuable insights and practice wisdom as participants in my research study.

Finally, I would like to gratefully acknowledge my research advisor, Mary Hall, PhD., whose expertise and knowledge of the research and writing process were invaluable. Thank you for your encouragement and for never losing sight of the goal.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	6
III METHODOLOGY.....	18
IV FINDINGS	23
V DISCUSSION.....	41
REFERENCES	44
APPENDICES	
Appendix A: DMHAS APPROVAL LETTER.....	46
Appendix B: SMITH COLLEGE HSR APPROVAL LETTER.....	47
Appendix C: AGENCY APPROVAL LETTER	48
Appendix D: DMHAS IRB APPROVAL NOTIFICATION.....	49
Appendix E: RECRUITMENT SCRIPT	51
Appendix F: WAIVER FOR INFORMED CONSENT	53
Appendix G: INFORMATION SHEET.....	56
Appendix H: FOLLOW-UP EMAIL SCRIPT.....	58
Appendix I: INTERVIEW QUESTIONS.....	59
Appendix J: TRANSCRIBER'S PLEDGE	61

CHAPTER I

INTRODUCTION

Substance abuse is the most common and clinically significant comorbidity among clients with severe mental illnesses (Center for Substance Abuse Treatment [CSAT], 2005; Drake, et al., 2001; Drake, Mueser, Brunette and McHugo, 2004). These individuals typically have multiple impairments that are associated with a variety of negative consequences making them difficult to engage and retain in treatment (Drake, et al., 2001; Drake, et al., 2004). Among these are homelessness, hospitalizations and incarcerations.

Both illnesses may affect a person physically, psychologically and socially. Each disorder predisposes the individual to relapse in the other disorder. Each illness has symptoms that can impede a person's ability to function. These symptoms can overlap and mask each other making diagnosis and treatment planning difficult (CSAT, 2005). Relapse rates for substance use are higher for people with a concurrent mental disorder, as are the chances that symptoms of mental illness will return for those with a concurrent substance use problem (Flynn and Brown, 2008; Drake et al, 2004). Mortality and morbidity rates are greater among those with co-occurring mental and substance use disorders than either disorder alone (Muser et al, 2003).

Estimates about the prevalence of co-occurring disorders in the general population can vary widely depending on the setting (Hendrickson, 2006). Substance abuse treatment programs have typically reported that 50% to 75% of those seeking treatment

for a substance abuse problem also have a co-occurring mental disorder and mental health treatment programs have reported a rate of 20% to 50% of their clients as also having a co-occurring substance use disorder (CSAT, 2005). Of all people diagnosed with a mental illness it is estimated that 29% abuse either alcohol or drugs. For persons with severe mental disorders (schizophrenia, schizoaffective disorder, bipolar disorder and major depression with psychotic features) the prevalence is much higher. Fifty percent of the individuals with severe mental disorders are affected by substance abuse (National Alliance on Mental Illness [NAMI], 2010).

Historically there has been a good deal of confusion concerning the nomenclature for persons with both a mental illness and a substance use disorder. Terms such as co-morbidity, dual disorder or dual diagnosis were used but were not mutually exclusive. For example, the terms dual disorder and dual diagnosis had also been used to designate the co-morbidity of a developmental disability, e.g., mental retardation and a mental illness, or even the addiction to two substances (e.g., alcohol and a drug), (Drake, et al, 2004; Hendrickson, 2006).

In 2005 the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Treatment Improvement Protocol (TIP 42) in which the term Co-Occurring Disorder (COD) was adopted to designate the co-occurrence of a substance use disorder and a mental illness. COD serves to differentiate this population from others and also provides for the recognition that there can often be several substance use and mental disorders involved simultaneously (CSAT, 2005).

Programs historically did not address the unique problems of persons struggling with both a severe mental illness and substance use problem. Instead the mental illness

and substance use were initially treated as separate problems in separate facilities in either a sequential or parallel treatment model. Both of these models proved to be ineffective because it was difficult to stabilize one disorder without stabilizing the other and/or the two separate treatment facilities frequently pursued conflicting treatment agendas (Hendrickson, 2006). Over the past several decades there has been a good deal of research into service delivery for clients with co-occurring substance use and mental health disorders. The most consistent finding across studies is that the most effective service delivery is integrated at the clinical level, i.e., the same clinician or clinical team provides appropriate mental health and substance use interventions in a coordinated fashion with a goal of helping the client to manage both illnesses (CSAT, 2005; Drake, et al., 2001; Drake, et al., 2004; Hendrickson, 2006; Sacks, Chandler & Gonzalez, 2008).

There is strong evidence that people with co-occurring disorders who participate fully in integrated service delivery programs tend to achieve better outcomes than those who attend separate substance use and/or mental health clinics that are not integrated (Drake et al, 2004). Current literature suggests that the detection and treatment of co-occurring mental health and substance use disorders reduces medical costs, mortality rates, and psychiatric hospitalizations (Mueser et al, 2003). In addition to the critical components of substance abuse and mental health interventions an integrated service delivery model often includes comprehensive services such as peer support groups, family interventions, vocational services, liaison with the criminal justice system, money management, trauma interventions and housing supports (Drake, et al., 2004).

Although the above critical components of an integrated co-occurring treatment program have been identified, the articulation of when and how these critical components

should be integrated in each case has been more elusive. Most often it seems that the strategies to be used and the components to be integrated are available and the clinician or clinical team takes responsibility for blending the interventions into a coherent package that is articulated in the broadest general terms, e.g., the use of aggressive outreach, stages of change, motivational interviewing and interventions, contingency management, cognitive behavioral approaches, etc. (CSAT, 2005; Drake, et al., 2001; Drake, et al., 2004). Thus the need for greater specificity about the sequenced integration of selected critical components of the integrated co-occurring service in each case, and the specific treatment strategies for various combinations of co-occurring disorders, (e.g., alcohol and depression), have been widely recognized in the literature (Drake et al.,2001; Drake, et al.,2004; Hendrickson, 2006; Sacks, Chandler and Gonzalez, 2008).

In summary, much has been learned in recent years about the need for an integrated treatment approach for persons with COD. However, despite the negative consequences associated with COD, this population most frequently does not receive appropriate treatment and is considered difficult to engage and retain (Mueser et al, 2003). While the critical components of an integrated COD treatment program have been identified, the need for greater specificity about the sequenced integration of components in each case and the specific treatment strategies that are effective with different populations of co-occurring disorders have been widely recognized in the literature.

This qualitative study is designed to make its contribution to filling this gap by discerning what we can learn from the practice wisdom of seasoned practitioners within multidisciplinary clinical teams working in an integrated outpatient treatment program about their specific approaches to the sequenced integration of the critical components

that are available in a case; and the selection of specific treatment strategies and interventions that they have found effective in the engagement and retention of clients with specific combinations of co-occurring disorders.

CHAPTER II

LITERATURE REVIEW

Co-Occurring Disorders within Our Society

Prevalence in the General Population

Estimates vary widely about the prevalence of co-occurring disorders in the general population but two major studies funded by the National Institute of Mental Health and conducted in the 1990's, the Epidemiologic Catchment Area (ECA) Study and the National Comorbidity Survey (NCS), which built on the work of the ECA study documented that significant numbers of Americans had co-occurring disorders (Hendrickson, 2006). The findings of the ECA study showed that the lifetime prevalence of the general population for having a substance abuse or dependence disorder was found to be 16.7%. However the percentages for individuals diagnosed with a substance abuse or dependence disorder and schizophrenia or bipolar disorder was 47 % and 56.1% respectively (Mueser et al, 2003). In contrast it was also found that 29% of individuals with a mental disorder had a substance use disorder. In addition, the study found that 37% of individuals with an alcohol disorder also had a mental disorder and 53% of individuals with a substance use disorder other than alcohol had a mental disorder (Hendrickson, Schmal and Ekleberry, 2004).

Three major epidemiological studies (CSAT, 2007) related to substance use and mental health disorders were conducted between 2001 and 2005, the National Comorbidity Survey Replication (NCS-R), the National Survey on Drug Use and Health

(NSDUH) and the National Epidemiological Study on Alcohol and Related Conditions (NESARC). None of these studies specifically studied the epidemiology of COD. The NCS-R focused on the prevalence of mental health disorders including substance use disorders in the general population but not the co-occurrence of these disorders. The NESARC study focused on mental health disorders when co-occurring with alcohol use disorders (AUD's), thus not taking into account the multitude of other drugs involved in COD. The NSDUH study focused on substance use and the identification of groups that are at a high risk for drug abuse, which included individuals with "serious psychological distress" in the past year. This study found that in 2005 approximately 5.2 million people within the general population that had a substance use disorder also had experienced serious psychological distress in the past year. Only 9% of this population received treatment for both mental health and substance use problems and 53% did not receive any treatment. Thirty-four percent received treatment for mental health problems and 4% received treatment for substance use only (CSAT, 2007).

Prevalence in Treatment Populations

Since the 1970's substance abuse treatment programs have typically reported that 50% to 75% of those seeking treatment for a substance abuse/dependence problem also have a co-occurring mental disorder. Mental health treatment programs, on the other hand, have reported a rate of 20% to 50% of their clients as also having a co-occurring substance use disorder (CSAT, 2005). Substance-induced disorders, e.g., symptoms of psychotic, mood or anxiety disorders induced by a substance, may be one possible reason for the higher rates of COD reported by substance abuse treatment programs.

Evolving Nomenclature

Co-Occurring Disorder

Although terms such as comorbidity, dual disorder and dual diagnosis have historically been used to refer to individuals with co-occurring mental health and substance use disorders, in 2005 the Substance Abuse and Mental Health Services Administration (SAMHSA) issued Treatment Improvement Protocol 42, Substance Abuse Treatment for Persons with Co-Occurring Disorders (TIP 42), in which they chose to specifically identify the co-occurrence of mental health and substance use disorders as a co-occurring disorder (COD).

SAMHSA provided the following definition of COD in TIP 42:

"Co-occurring disorders refers to the co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder" (p. xvii).

The terms dual disorder and dual diagnosis have often been used to indicate the presence of a developmental disability (mental retardation) and a mental illness, the co-occurrence of an alcohol and drug disorder and also to the presence of a diagnosis on both Axis I and Axis II. Thus the term co-occurring disorder serves to differentiate this population from others and also provides for the recognition that there can often be several substance use and mental disorders involved simultaneously (Hendrickson, 2006).

Flynn and Brown (2008) maintain that even with this specific designation of COD, the term is problematic because it is a "blanket descriptor" that covers all types of

substance use and mental health disorders as well as all levels of severity of those disorders.

Evolution of Integrated Treatment

In the 1970's, the deinstitutionalization of mental patients from hospitals and their integration into the communities gave them access to illicit drugs and alcohol, setting the stage for the emergence of a population that had both a mental illness and a substance use disorder (Hendrickson et al, 2004). In 1980, the American Psychiatric Association made it possible to provide for more than one diagnosis with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). The recognition of and provision for dual diagnoses "created the framework for the development of services for individuals with co-occurring disorders." (Hendrickson, 2006).

Hendrickson (2006) further states

"As the dual diagnosis concept began to gain a foothold, treatment programs began to initiate services for individuals with co-occurring disorders. These initial services used either a sequential, parallel, or integrated model of treatment... Sequential treatment was quickly found to be ineffective because it was very difficult to stabilize one disorder without stabilizing the other. Parallel treatment was not effective because it was difficult for an individual to concurrently participate in two different treatment programs in different locations that focused on different and sometimes conflicting treatment agendas" (p.6).

Having recognized the emergence and prevalence of clients with co-occurring disorders, researchers in both the fields of substance abuse and mental health began in the late 1980's and 1990's to study ways in which to treat this population effectively. Initially services were offered in either a sequential or parallel treatment model. The sequential

treatment model advocated that one treatment program initiate treatment, and when that particular disorder (ie. substance abuse) was stabilized, the client would be referred to the other treatment program to complete treatment for the other disorder (ie. mental health disorder). It was quickly recognized that this model was ineffective because it was difficult to stabilize one disorder without stabilizing the other. The parallel treatment model advocated the concurrent treatment of both disorders by separate treatment programs. This model was also recognized to be ineffective because it required the client to participate in two different treatment programs in different locations that focused on different and sometimes conflicting treatment agendas (Hendrickson, 2006).

Integrated Treatment

In integrated treatment the burden of addressing both the substance use and mental health problems and of ensuring coordination and compatibility of any philosophical differences that may emerge is shouldered by the treatment system rather than the client (Drake, O'Neal and Wallach, 2008). Kavanagh and Connolly (2009) make the point that integrated treatment does not mean simultaneous treatment. Rather, it involves a variety of methods by which diagnosis-specific, evidenced based strategies for each disorder are appropriately combined and coordinated in a single setting (Minkoff, 2001). Thus the essence of integration is the tailoring of content and process (Kavanagh and Connolly, 2009).

Mueser et al (2003) outlined the seven principles/components of integrated treatment as assertiveness in the engagement of reluctant clients, integrated services for both disorders, comprehensiveness of services provided, a reduction of negative

consequences of substance use while developing a working alliance, a long-term perspective of recovery, motivation based treatment and multiple modalities of therapy.

Individuals with Co-Occurring Disorders

Mueser and Drake (2007) hypothesize that the high rates of substance abuse in those diagnosed with a serious mental illness may be related to the common environmental risk factors for mental illness, substance abuse and health problems such as poverty, education, deprivation, stress, unemployment, living conditions and early trauma that may provide multiple different pathways.

Co-occurring disorders are associated with a multitude of negative life conditions that include interpersonal conflicts with family and friends, financial problems as a result of 1) spending money on drugs rather than basic needs such as food, clothing and housing and 2) lack of gainful employment, which often leads to homelessness, disinhibition and cognitive impairments that often result in violence and aggression toward others, legal encounters associated with drug behavior such as possession of drugs, disorderly conduct, theft and assault as a result of efforts to obtain drugs and risky behaviors that result in exposure to HIV and hepatitis infections. These circumstances work individually and collectively to put individuals with COD at risk of being victimized (Mueser et al, 2003; Drake et al 2004).

Research on Clients with Co-Occurring Disorders

Ridgely's 1986 review (as cited by Drake, Mercer-McFadden, Mueser, McHugo and Bond, 1998) of studies commissioned in the early 1980's by the National Institute of Mental Health (NIMH), the National Institute on Alcohol and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) found that in practice, patients with dual

disorders tended to receive services from one system and not from the other, and they were often excluded from both systems because of the complicating features of the second disorder. Thus the recommendation from this review was that mental health and substance abuse treatments should be integrated.

Efforts at this time were also being focused on trying to determine which system of care (mental health or substance abuse) could best treat clients with co-occurring disorders and the Quadrants of Care model was developed by the National Association of State and Alcohol and Drug Abuse Directors (NASADAD) and the National Association of Mental Health Program Directors (NASMHPD). This model places severity of mental illness on the horizontal axis and severity of substance abuse/dependence on the vertical axis creating four quadrants. The severity of each disorder determines the specific quadrant in which a client is placed which in turn establishes the locus of care. Although the quadrant model has been accepted as a useful tool for the classification of service coordination by severity it is limited by the heterogeneity of the co-occurring disorders population, the multitude of variations of both disorders within an individual client and the impact that each disorder has on the other (Sacks et al, 2008).

With the recognition and acceptance of a population with co-occurring disorders, research studies began to focus on the best method of treatment. Of 36 research studies conducted through the mid-1990's and reviewed by Drake et al (1998), ten were specifically identified as studying comprehensive integrated dual-disorders programs.

Their conclusion was:

“Most studies of dual disorders interventions have been limited by small study groups, lack of control groups, implementation problems, and difficulties in assessing substance abuse. Consequently, from a

research perspective, integrated treatment for dual disorders remains a working hypothesis with only modest empirical support" (Drake et al, 1998, p.602).

"Though methodologically weak when seen as research studies, these demonstrations began to show improved outcomes. They were critically important in identifying the need to address engagement, motivation and retention" (Drake et al, 2004, p.361).

In 2004, Drake, Mueser, Brunette and McHugo performed a review of 26 controlled studies focused on psychosocial interventions in integrated treatment programs. Five specific treatment principles/interventions for treating dual-disorders (COD) were identified as having a "level of evidence of 1" as defined by the Texas Psychosocial Rehabilitation Conference. Level 1 evidence requires at least five controlled studies with meaningful outcomes. The five principles/interventions that met this requirement were 1) integrated treatment, 2) stage-wise treatments, 3) outreach, 4) flexibility and 5) motivational counseling.

Stage-wise treatment grows out of the "stages of change" model developed in the 1980's by Prochaska and DiClemente. The "stages of treatment" model is a specific adaptation of the stages of change for clients with co-occurring disorders developed by Osher and Kofoed. Although both models are very similar in that they define the progression of change through stages, the stages of change model is not necessarily specific to a therapeutic endeavor while the stages of treatment are. The five stages of change are defined as pre-contemplation, contemplation, preparation, action and maintenance. The stages of treatment has only four stages, generally combining the stages of contemplation and preparation into the stage of persuasion. The four stages of

treatment are defined as engagement, persuasion, active treatment and relapse prevention. The engagement stage refers to the period in which a *collaborative and trusting relationship is developed* between the client and the clinician/clinical team. The persuasion stage is defined by helping the client to *recognize the benefits of changing* behaviors and attitudes toward their co-occurring disorders. In the active treatment stage the client begins to *acquire skills and supports* for managing both illnesses and the relapse prevention stage is focused on helping the client *develop and use strategies* to prevent relapse (Mueser et al, 2003).

Outreach is the process whereby clients are actively engaged in the community, at shelters and on the streets. Flexibility refers to an attitude that does not require abstinence from substance use to enter treatment and motivational counseling is a technique based on motivational interviewing articulated by Miller and Rollnick (2002), which provides for a systematic examination of the client's ambivalence towards substance abuse and/or untreated mental illness.

Several other approaches and interventions did not meet level of evidence 1 requirements that need further research. These are other active treatment interventions, relapse interventions and comprehensive services. Comprehensive services include peer group supports, family interventions, vocational services, liaison with criminal justice system, money management and trauma interventions. Although housing supports are considered part of comprehensive services there is extensive research on homelessness that supports it as a positive intervention in helping clients to stabilize their lives (Drake et al, 2004).

In 2008, Drake, O'Neal and Wallach did a systematic review of 45 controlled trials of psychosocial interventions with adults with co-occurring disorders. This review included 22 experimental studies that used random assignment and 23 quasi-experimental studies that were conducted during the period 1991 - 2007. This review also included all 26 studies that had been reviewed by Drake, Mueser, Brunette and McHugo in 2004. This review of interventions was primarily focused on the domain of substance use and the consequences of substance use but also reviewed outcomes on mental health and other outcomes.

The results of this review identified three interventions that had fairly consistent positive outcomes on substance use; group counseling, contingency management and long-term residential treatment. The only intervention identified that had a positive effect on mental health outcomes was legal interventions. Three other interventions had mixed results for both substance use and mental health outcomes; individual counseling, case management and intensive outpatient rehabilitation. Family interventions was cited as being positive on both substance use and mental health outcomes but was identified as needing further study as there was only one study available for this review and the positive outcomes faded when the intervention was ended.

These authors cited a lack of standardization, absence of fidelity assessment, diversity of participants, varying lengths of the interventions, diversity of outcomes, and inconsistency of measures in the current research as limits of this review (Drake et al, 2008). These limits continue to present problems in the research as it relates to clients with COD and SAMHSA has only identified three evidenced based practices when working with the COD population; psychopharmacological interventions, motivational

interventions and behavioral interventions (eg. contingency management which employs a system of rewards for abstinence from substance use) (SAMHSA, 2005).

Additional interventions and components of integrated therapy that have shown promise for positive outcomes but are in need of further study for efficacy include stage-wise treatment, outreach, flexibility as it relates to substance abuse, individual, family, group and peer support counseling and comprehensive services that include liaison with criminal justice systems, vocational services, trauma interventions, money management and housing supports.

Engagement and Retention of Clients with Co-Occurring Disorders

Many factors affect the co-occurring disorders population that makes them difficult to engage and retain in treatment (Mueser et al, 2003; CSAT, 2005; Mueser and Drake, 2007). These include inpatient hospitalizations: eg., detox, psychiatric, medical; incarcerations and unstable housing such as homelessness, living in shelters and frequent moves. There are most often cognitive impairments resulting from either or both untreated disorders that can also interfere with the engagement and retention of these clients in treatment.

Two studies conducted by Swanson et al in 1999 and Baker et al in 2002 (as cited by Drake, et al, 2004) studied the outcome of motivational interviewing as a tool for engagement for clients being discharged from inpatient hospitalization. The outcomes were mixed. Swanson et al found that the inclusion of one motivational interview had a positive effect on the likelihood that the client would attend the first outpatient appointment and the study by Baker et al found that one motivational interview had no

difference on substance abuse clinic attendance after three months. Both of these studies were narrowly focused on motivational interviewing as an engagement tool.

One qualitative study conducted by Padgett, Henwood, Abrams and Davis (2008) focused specifically on the engagement and retention of homeless persons with a severe mental illness (N=39). Although a co-occurring substance use disorder was not a criterion for inclusion in the study, 86% of the participants had a documented history of substance abuse. The findings from that study found two system factors that negatively impacted the engagement of clients: rules and restrictions of the system (eg., medication requirements, curfews, close supervision, required attendance at groups) and lack of one-on-one therapy. The study found three factors that had a positive impact on engagement: pleasant surroundings (ie., quiet, clean facilities that provided privacy), access to independent housing and acts of kindness by staff. The authors concluded that "the success of the delicate negotiation beginning with outreach and engagement depends upon the fit between consumers' needs and the service system's 'offer'" (Padgett et al, 2008, p. 232).

It is commonly understood that treatment of any disorder cannot be realized unless the client is engaged and regularly attending treatment. Thus it is critically important to identify those treatment strategies, interventions and components that best support the critical stage of engagement and help clients to remain in treatment.

CHAPTER III

METHODOLOGY

Substance abuse is the most common and clinically significant co-morbidity among clients with severe mental illnesses (CSAT, 2005; Drake, et al., 2001; Drake, et al., 2004). These individuals typically have multiple impairments that are associated with a variety of negative consequences making them difficult to engage and retain in treatment (Drake, et al., 2001; Drake, et al., 2004).

The most consistent finding across studies conducted in the past twenty years is that the most effective service delivery is integrated, i.e. the same clinician or clinical team provides appropriate mental health and substance abuse interventions in a coordinated fashion in a single setting with a goal of helping the client to manage both illnesses (CSAT, 2005; Drake, et al., 2001; Drake, et al., 2004; Hendrickson, 2006; Sacks, Chandler & Gonzalez, 2008).

While critical components of integrated service delivery have also been identified, when and how these components are successfully integrated and the articulation of specific approaches to clinical interventions in a particular case has been more elusive.

This qualitative study was designed to make its contribution to filling this gap by discerning what we can learn from the practice wisdom of seasoned practitioners within multidisciplinary clinical teams working in an integrated outpatient treatment program about their specific approaches to the sequenced integration of critical components and

comprehensive services that they have found effective in the engagement and retention of clients with co-occurring disorders.

Research Setting

Research participants were a sample of convenience that was employed on a co-occurring disorders unit (CDU) at an outpatient mental health center located in Hartford, CT. In addition to the CDU, other treatment units within the mental health center include: General Psychiatry, Deaf and Hard of Hearing, Young Adult Services, Mobile Crisis, Medication Management, Trauma and Peer Support. There is also a Jail Diversion Unit that is housed at the courthouse. It is important to note that there is a centralized Intake Unit that provides initial screenings, assessments and referrals to all of the above treatment units.

All CDU clients have been screened, assessed and referred from the Intake Unit or another treatment unit. Neither the CDU nor the mental health center provides detox. Most CDU clients have been detoxed at another facility. However, in keeping with the stages of treatment philosophy this is not a requirement for referral to the CDU.

The CDU staff is divided into three multidisciplinary treatment teams of five to six members ("mini-team"). Each mini-team includes a mix of licensed clinical social workers, licensed professional counselors, master's level social workers, psychologists, registered nurses and case managers. The CDU also has three psychiatrists (two full-time and one half-time) that provide services for all clients within the unit regardless of their mini-team assignment.

Clients with co-occurring diagnoses that are accepted for service delivery are assigned a psychiatrist and a primary clinician. The primary clinician's mini-team

provides all of the client's integrated treatment in collaboration with the psychiatrist.

The component services that are available on the CDU are individual and group therapy (based on the stages of treatment: engagement, persuasion, active treatment and relapse prevention), case management and medication management. The clients also have access to other services within the mental health center that are outside of the CDU such as dialectical behavioral therapy (DBT), trauma groups, employment counseling and Peer Support Groups which includes a recently formed co-occurring group, "Double Trouble in Recovery." This group is lead by the Peer Support staff but is located in a nearby hospital.

The three mini-teams, psychiatrists and the program director meet jointly every morning to discuss clinical matters related to CDU clients including "overnight incidents" (e.g., mobile crisis interventions, police involvement, incarcerations, and hospitalizations), "entry alerts" (for clients being denied access to the center or requiring an escort while in the center), critical housing needs and availability, and general treatment planning for those clients that are preparing to be moved to a more or less restrictive treatment setting (e.g., discharge from/admission to inpatient hospital, release from prison, moving from/to a group home setting).

Study Authorization

Since the mental health center is part of the Connecticut Department of Mental Health and Addiction Services (DMHAS), final approval for this study was granted by the state Commissioner of DMHAS (see Appendix A). However, it should be noted that the DMHAS process of review was extensive and required prior approval by the Smith College School of Social Work's Human Subject Review (HSR) Committee (see

Appendix B) in addition to the Chief Executive Officer at the agency site where the study was conducted (see Appendix C) and the DMHAS Institutional Review Board (IRB) (see Appendix D).

Recruitment Process and Nature of Participation

Permission was granted for me to announce this study and extend an invitation for voluntary participation at a CDU morning meeting (see Appendix E). All staff members on the CDU met the requirement for participation of having worked with clients with co-occurring disorders for a minimum of three years.

It is to be noted that the IRB review determined this study was eligible for a waiver of informed consent procedures since the research presented "no more than minimal risk of harm to subjects and involved no procedures for which consent is normally required outside of the research context" (see Appendix F). In lieu of informed consent procedures an Information Sheet (see Appendix G) was developed that contained all of the required elements of an informed consent form but did not require a signature. This information sheet was provided to all potential participants at the meeting when the study was announced and additional copies were available upon request. A follow-up email (see Appendix H) was sent to all potential participants a few days following the meeting announcing the study to elicit their decision about participation.

Those that agreed to participate were seen in a face-to-face interview that lasted between 30-45 minutes. The interviews consisted of a series of general demographic background questions about each participant, followed by a series of more open-ended questions designed to explore what could be learned from the practice wisdom of these seasoned practitioners regarding their experience with the sequenced integration of

critical components available on the unit in a specific case that proved to be successful in the engagement and retention of a client with a co-occurring disorder (see Appendix I).

Data Collection and Analysis

The interviews were digitally recorded and additional notes were taken during and immediately following the interview. Transcription of the interviews was done by a professional transcriber after a Transcriber's Assurance of Research Confidentiality ("transcriber's pledge") was obtained (see Appendix J). A content analysis was conducted on the transcribed interviews to identify major themes related to the engagement and retention of clients with co-occurring disorders.

CHAPTER IV

FINDINGS

The interviews consisted of a series of general demographic background questions about each participant, followed by a loosely-structured interview of open-ended questions that focused primarily on a "success case" that was selected by each participant. The open-ended questions were designed to explore what could be learned from the practice wisdom of these seasoned practitioners regarding their specific approaches to the sequenced integration of the critical components that were available in a case and the selection of the specific treatment strategies they found effective in the engagement and retention of clients with specific combinations of co-occurring disorders.

Demographic Background of Sample

Fourteen staff members agreed to participate in the study (N=14) (see Tables 2 and 3). This represented 82% of the 17 staff members on the unit who qualified to participate. One mini-team had a participation rate of 83% while two teams had an 80% rate of participation.

Participants ranged in age from their early 40's to over 55. In terms of gender, eight participants were female (57%) and six were male (43%).

The sample population was racially diverse. In terms of racial/ethnic identification, five were White (35%), four were Hispanic/Latino (29%) four were Black African Americans (29%) and one identified as Black Cape Verdean (7%).

Their years of experience of working with COD clients ranged from 3 to 25 years, for a mean average of 15.5 years. Eleven of the 14 participants (79%) had over 10 years experience, only three participants (21%) had less than ten years of experience working directly with COD clients, however they each had over 20 years experience working in the mental health profession working with other populations. All of the study participants had worked with over 50 clients with co-occurring disorders in their careers and an overwhelming majority, 11 of the 14 participants (79%) had worked with over 100 clients. The number of settings in which participants had worked with COD clients ranged from one to five. The mode was two to three settings.

In relation to professional background seven of the participants were social workers with their MSW degree (50%); three were case managers (21%) of which two had a high school diploma (14%) and one had an associate's degree (7%); two were psychologists with PhD degrees (14%); one had a master's degree in counseling (7%) and one had a master's degree in nursing (7%). Eight of the participants (57%) were licensed in their respective field; five licensed clinical social workers (35%), two licensed professional counselors (14%) and one registered nurse (7%).

In summary, this was a well educated and seasoned group of practitioners who had collectively seen in their careers a minimum of 1,300 clients with co-occurring disorders.

<u>Participant</u>	<u>Gender</u>	<u>Race/Ethnicity</u>	<u>Level of Education</u>
1	Female	Black/African American	MSW
2	Female	Hispanic/Puerto Rican	MSW
3	Male	White	MSW
4	Male	White/Latvian	PhD
5	Male	Black/African American	MSW
6	Female	White	PhD
7	Male	Latino/Puerto Rican	MSW
8	Female	White/French-Irish	MS
9	Female	Black/African American	HS
10	Female	Hispanic/Peruvian	MSW
11	Male	Black/Cape Verdean	MSW
12	Female	White	MSN
13	Male	Hispanic/Puerto Rican	Assoc. Degree
14	Female	Black/African American	HS

Table 1 - Participant Demographic Information - Part 1

<u>Participant</u>	<u>Position</u>	<u>Co-Occurring Experience</u>	
		<u>Number of Years</u>	<u>Number of clients</u>
1	Clinician	15	100+
2	Clinician	3	50-75
3	Clinician	8	100+
4	Clinician	3	50-75
5	Clinician/Administrator	20	100+
6	Clinician	17	100+
7	Clinician	25	100+
8	Clinician	25	100+
9	Clinician	20	100+
10	Clinician	25	100+
11	Clinician	10	76-100
12	Clinician	10	100+
13	Case Manager	14	100+
14	Case Manager	22	100+

Table 2 - Participant Demographic Information - Part 2

Interview Questions

Question 1

The first interview question asked participants to select and describe a case where they had worked with a COD client that they considered a success in terms of engagement and retention (see Table 3).

The 14 clients this generated ranged in age from their 20's through their 50's. Nine of the clients were male (64%) and five were female (36%). In terms of race, the largest group was seven African Americans (50%). This was followed by three white (21%), two Latinos that were Puerto Rican (14%), one Jamaican (7%) and one client that was described as mixed race (7%).

The primary mental health diagnosis varied. Four clients were diagnosed with bipolar disorder (29%), three with major depression (21%), three with post traumatic stress disorder (21%), two with schizophrenia (14%), one with schizoaffective disorder (7%) and one with a traumatic brain injury (7%).

In terms of the clients' substance use disorder (SUD), the participants did not differentiate between abuse and dependence. Ten of the clients' SUD involved alcohol (72%). Of those using alcohol four used alcohol only, four used alcohol in combination with cocaine and two used alcohol in combination with two other substances. Two clients used marijuana and cocaine (14%), one client used marijuana only (7%) and one client was identified as having a polysubstance use disorder (7%).

The most frequently noted presenting problem was violence/physical assaults (7=50%), followed by homelessness (6=43%) and psychotic delusions (2=14%).

Age	Race *	Gender	Primary Mental Health Disorder	Substance Use Disorder	Presenting Problem/ Behavior
20's	B/AA	F	Post traumatic stress disorder	ecstasy alcohol marijuana	violence physical assaults aggression
40's	W	M	Traumatic brain injury	marijuana	violence physical assaults
40's	B/AA	M	Schizophrenia	cocaine marijuana alcohol	psychotic delusions
30's	Mixed	M	Post traumatic stress disorder	cocaine marijuana	violence physical assaults
50's	B/AA	M	Major depression	alcohol	homeless abuse of detox facilities
50's	W	M	Post traumatic stress disorder	alcohol	homeless social isolation
40's	L/PR	M	Schizophrenia	alcohol cocaine	violence physical assaults homeless
50's	B/AA	F	Bipolar	alcohol cocaine	psychotic delusions
20's	B/AA	F	Bipolar	alcohol	violence physical assaults
50's	L/PR	F	Bipolar	alcohol	violence physical assaults homeless incarcerations
50's	B/Jam	M	Schizoaffective	alcohol cocaine	relational conflicts homeless legal
40's	B/AA	M	Major depression	poly-substance	homeless
40's	W	F	Major depression	alcohol cocaine	homeless prostitution HIV+
50's	B/AA	M	Bipolar	marijuana cocaine	violence physical assaults

* B/AA - Black African American; W - White; Mixed - Undefined Racial Mix;
L/PR - Latino Puerto Rican; B/Jam - Black Jamaican.

Table 3 - Client Case Data

Other presenting problems included abuse of detox facilities, incarcerations, relational conflicts, social isolation, legal problems, prostitution and HIV.

The only discernable trend in the demographic backgrounds of the clients was that five of the seven (71%) African Americans were diagnosed with a mood disorder. Specifically, three were diagnosed with bipolar disorders (60%) and two were diagnosed with major depression (40%). Of these, three were men (60%) and two were women (40%). Both clients diagnosed with major depression were men. Both women were diagnosed with bipolar disorders. The remaining male was also diagnosed with bipolar.

Questions 2, 4 and 5

In general, the participants tended to struggle with questions where they were asked to distinguish between engagement and retention strategies. What specific engagement and retention strategies did you use in this case (#2); what team interventions (engagement and retention) were specific to the substance use disorder and what team interventions were specific to the mental health disorder (#4); and how were the services integrated (#5). An analysis of the data suggested that the difficulty was because the questions were asking participants to differentiate between processes that they experienced as seamless. Collectively, what did emerge were five categories of strategies that were used for both engagement and retention. All of these had to do with the practitioner's use of self in their relationship with the client. These were:

- the practitioner's attitudinal stance towards the client
- the practitioner's use of self to build trust with the client
- the practitioner's use of self to promote client self-efficacy
- collaboration with the client to secure concrete services around basic needs

- collaboration with the client to negotiate all sorts of role relationships.

The practitioner's attitudinal stance towards the client.

Participant 5:

When he (the client) was at the early stages, when he was in early persuasion, the intervention that goes along with that is *meeting the client where they are*, and what I'm talking about is actually going to them. When he was at (the detox center), we went to him, we didn't expect him to come over here, because in those early stages, in early persuasion, he had heard it all before.

Participant 6:

I'd say initially it was not placing demands on him (the client) of any kind, of *meeting him where he was* and hearing from him what his goals might be and not what my goals were for him. Eventually, I think they matched anyway, but it was helping him see that what he wanted to do was most important and helping him achieve it.

Participant 10:

My style is that I'm not judgmental of my clients. I *accept them where they're at*.

Participant 13:

...just being there for the person. I saw *she* (the client) *was meeting us halfway*. When a person meets me halfway, I'm going to do my best to be there and do as much as I can for the person, because I can see that she's doing a lot of work.

Participant 1:

Not judging. I think what's critical for most of the people on my case load that I have worked with so far, is just not judging their substance use, or not judging some of the choices that they have made to engage in substance use, and to get it, and some of the pursuits that they have made to get it. Just saying that this is a safe place to come in and just talk about it, and just talk about why you think you do what you do, where it started and where does it come from. I think that's a critical part. Because as soon as you start to judge or they feel like you're judging them, it's all going to break down.

Participant 9:

I just treated her (the client) like she was a human being.

Participant 5:

The other major part I played in this is that the client knew that I was the person working behind the scenes to ensure that everything was in fact happening and I had to do reassuring quite often because he just wouldn't accept his clinician's word or the (detox facility's) word. He would come to me, or the clinician would bring him to me, and I'd say, yeah, this really is going to happen and here is the person that is going to make sure it's going to happen. And sometimes you need someone behind the scenes who can make all of these things happen... I served that purpose for this individual, but that was important because it *gave him a sense of hope* that the things that we were saying were going to happen for him, were in fact going to happen. It wasn't going to be like his life had been, where promises are made but no one ever follows through with them. Here you have someone who is going to follow through with them and the only thing they have in mind is your best interests. It's like there's nothing that we want from you other than success.

Participant 6:

Because I had a special connection with him (the client) and I think I did some unique things with him for an individual that had really been given up on which, I guess, those are my favorite people, the ones I think others have given up on and I want the challenge of trying. And my work with him, in almost every person I have worked with, how I see it is *to help people find hope*, and for him we were able to find hope in the promise of housing and financial security – not so different from the rest of us.

Participant 14:

Always giving him (the client) something positive to take with him when he was down and out. I could recognize his facial expressions, even to this day. *Giving him encouraging words* continuously and *not giving up on him*. Treating him like a person, not so much as a client. There is a difference.

Practitioner's use of self to build trust with the client.

This included assertive outreach ie., beyond the office, out in the community; being available, reliable and doing what you say you are going to do; listening to the client and when possible allowing the client to set their own goals.

Participant 3:

He (the client) was on an inpatient unit that was not staffed to take people on community visits. His family no longer lives in Connecticut. So, unless I was there, he didn't get out of the hospital and, I might add, he is still not someone who does well in an office setting as far as a therapy session goes, so having an environment like, you know, two guys driving around in cars, smoking a bunch of cigarettes, drinking coffee, you get down, you talk about what is real. That's a natural thing to do. Coming into someone's office, sitting in a chair, and one person talking about the details of their life, I don't know too many situations where that really occurs, so I think the work in the community provided an environment where the type of discussion and work we were doing was more normal.

Participant 13:

I was her (the client) case manager. I would make sure she made it to her medical appointments. She had some legal issues, so I was there with her through the legal issues. I supported her with the housing: helped her get the housing, went through all the paperwork for the bridge subsidy. I noticed that there was a lot more to it, as we went to these places. There's a lot of support that goes on in the vehicle. A lot of talking, a lot of disclosure on her behalf. It's a really good opportunity that I believe clinicians don't have in the office. When you're out there, sometimes things come out, because the person is stimulated by different areas. You can go through a neighborhood and she'll look and say, I remember when I was on those corners. Things will come out that way.

Participant 6:

I think people that do homeless outreach do this anyway, but it was not unusual for people in the homeless outreach team to carry a cell phone and if the veteran called you at 8:00 at night on that cell phone, you answered it. So, *being available* and always getting back to him (the

client). It didn't take me days or weeks to get back to him and follow up. We had almost daily contact.

Participant 13:

One of the things was something as simple as returning a phone call. When she (the client) would call me, she would get that call back. We would keep her appointments. We would meet her basic needs in everything surrounding her life, the legal, the medical and the psychiatric treatment she was receiving here. I believe she saw the support that was going on, from myself and another staff member, and it was magnetic for her because she would mention that a lot. She would mention that the treatment she was getting from both of us was very helpful to her, so it worked really well. *We were there for her.* I believe as long as the clients want it, the staff will pick up on it. I've seen the staff go over and beyond to make things work for clients.

Participant 8:

I tend to use humor a lot. One of the things that I usually do with a lot of my clients is I let them know how long I've worked here, and that I've heard everything you can imagine and then some, so they don't have to feel uncomfortable telling me anything because I've heard it all and I have a lot of good ideas about what might work and what might not work. I can present those ideas, but it's not going to work and treatment isn't going to go farther unless they decide it's something they want to work on. So, I always give them an opportunity to tell me what they want to work on. I can come up with all these things that will look great on the treatment plan and it will sound wonderful, or not, but unless you're wanting to do it, nothing is going to happen, so you have to *tell me what you want to do.*

Participant 12:

First of all, it was to build a trusting relationship. He (the client) certainly didn't come in here knowing what recovery was all about. He really wanted to stop using and not want to kill himself, but he wasn't sure that this was going to work, so it was just establishing a trusting relationship where he felt understood and heard that was the first thing. And then, my genuine investment in him making progress and *picking what areas he wanted to start with and making a plan to do little steps.* So, it was like taking it one bite at a time instead of being totally overwhelmed in every area. We just picked one little thing and moved forward, but he would pick the thing. It was interesting because his goal was to get a car. Now, here was a man who didn't have a house,

and going to a shelter was like a death sentence for him. He really wanted to go back to school, and work, and out of all the things that I would have thought that he wanted to work on, he wanted a car first. So, we did the car first and he actually did get the car and then everything fell into place after that. It was amazing to me. I was thinking, a car? Don't you think you should maybe get a refrigerator, and food, and a haircut?

Participant 2:

A lot of the times with him (the client) it was mostly *listening* because he needed an outlet. You know, living in a group home, everybody is giving you orders. This is what you need to do. This is what you have to follow through with. Coming here, I gave him the chance to vent, to talk about his anger, to talk about what's going on in the home and I wouldn't make any recommendations. I would say this is your time. We are going to use it to your benefit and when you're ready to work on strategies on how to work with your anger, and that kind of thing caught him. He said 'I use this time to just get out my anger and talk about problems and kind of vent.' And that worked really well.

Participant 4:

The way he (the client) saw problems mainly was well, you can't say that he saw problems, the way he reacted to problems, because it was very reactive, it wasn't planned, it wasn't very frontal lobe oriented, it was pretty much reacting... I think the primary engagement tool when I got involved was making sure that he knew that *he was being heard* and that he was significant and important...

The practitioner's use of self to promote client self-efficacy.

Participant 11:

I think the piece about relationship is really significant. I think there were many turning points in the relationship. One that I can pinpoint happened maybe six years ago. He (the client) was looking for an apartment. I took him out to meet with this potential landlord and the thinking was we did everything we needed to do, so we're just going to go over there and talk to this landlord and get the apartment. When we got there, we were told that he wasn't going to be able to get the apartment, and one of the things that this person struggled with in the past, and I think he's made a lot of progress, is just being able to manage the anger when things like that happen to him. So, he was very angry, and I myself was very angry. Prior to that, we had some

conversations about how to manage your anger appropriately so it doesn't cause you not to get your needs met, so, he was able to manage himself appropriately. I think he looked at me also and saw how angry I was and that's something that he continues to mention, that was sort of a point where he saw that I was on his side and that made a tremendous difference. So, moments like that – moments of him feeling enough trust to open up and share certain things, the engagement began like that and years and years down the road, we still have a relationship.

Participant 6:

One of the things that I did that I think was pretty unique was when he (the client) realized that I was blind, we started talking about what things I needed in my life and the subject of Braille came up and I said I could teach him Braille. He didn't believe it, but I told him that it's not as hard as it looks and I started working with him. At times he would come into the office where I had a little cubicle and I had my Braille writer there, and I would show him the symbols of Braille and I would Braille out a message to him. Usually, it had something to do with encouraging him to stay focused on his goals and that kind of thing and his homework would be to decipher that Braille note. Then he would come back to me and we would talk about it. And so, that was one of the things I think helped that particular person and myself connect very strongly. It was an ongoing process and then when he would go to short-term rehab, I'd send him a little Braille note and he'd know that I was thinking of him – I mean, other than that I would stop in and see him, too. But that connection with the Braille assignments and the Braille homework really made a difference for him because he saw that he could learn and it was something special that he could do that maybe some others couldn't. It made him feel special I think.

Participant 9:

With her substance abuse, once we got her inpatient and she hadn't been using for a long time, she didn't have a desire to use, so it wasn't much that we had to do with substance abuse... I think it was just from spending the time with her and just trying to engage her a lot. Like I said, she was missing that nurturing, that family thing. I don't think she had a good relationship with her Mom, so when we stepped in we were like more of a mother image to her, something that she needed...

Collaboration with the client to secure concrete services around basic needs.

The two most frequently cited needs were stable housing and Supplemental Security Income (SSI). Other client needs included transportation, medical treatment and unspecified "basic needs."

Participant 5:

We're saying that we're going to do this stuff, and here's how we're going to do it. The retention piece was actually doing what we said we were going to do and to continue doing them. One example would be when I first got the approval to pay for his apartment, I was told well, we're only going to pay for 3 months, after 3 months he's on his own. Well, the client was very, very nervous, because he knew after 3 months, since he doesn't have a work history - he's never worked in his life because he was in jail for a good part of it - he wasn't receiving any entitlements, and here he would have to figure out after three months how his rent and other housing needs were going to be paid for. I said, don't worry about that, I will make sure that you're going to be able to remain in your apartment. Now, when I said that, I wasn't absolutely sure how I was going to go about doing it. All I knew is that I had to deliver. If we were going to retain him, I had to deliver.

... So, with the housing, the SSI, the individual treatment, the group treatment and medications, he has been alcohol free now for probably a year-and-a-half, living in an apartment, doing quite well.

Participant 7:

So, we took a risk. Well, what is going to happen if we find the apartment and it doesn't work? We probably will have to start over. So, one of our case managers was able to find an apartment in a nice area, a nice building, and we set everything for him (the client) in terms of additional support like SSI and some additional case management and let's see what happens. That was three years ago and he is still there. In those three years he has been hospitalized maybe twice and brief hospitalizations in fact. I think it was sort of like magic. We got him the apartment, we got him some furniture and everything fell into place. He has developed again and put to work all of those skills that he was not showing that much and he takes very good care of his apartment. I think that he feels very proud about this accomplishment.

Participant 9:

I did a lot of case management with her. I did a lot of going and seeing her, talking with her, taking her places, helping her get housing, helping her with her furniture, taking her to her doctors' appointments. Any time she had problems she would call me or the clinician to talk about them because she had a good relationship with us.

Collaboration with the client to negotiate all sorts of role relationships.

These collaborations were with the mini-teams, within the agency, with other providers, with family and the client's social network.

Participant 6:

I think that the way the team worked out in the community, we had regular meetings with one another, I mean we saw each other every day, so the communication was pretty consistent and then we were starting to connect him with other providers, like the clinician from the PTSD unit, or if he was in rehab, or detox, we were going into the hospital and meeting with the providers to tell them what our experience has been with him and to hear from them what their thoughts were about working with him. So, although it wasn't a set meeting time, there was consistent communication by phone. And, because that's how the team functioned, you would just drop in to the hospital, find the clinicians, find the nurses, find the docs and talk with them about what has been going on in his life and what we need to do.

Participant 7:

I would say a lot of assertive techniques like trying to have regular contacts with the client. Other people, like the case manager, helped in developing a trusting relationship with other people in the community like family and other providers. At some point, you develop a team approach. Maybe not really formalized, but other people that in some way or another was involved in the case or motivated to help this person, putting those efforts together. And the cultural dynamic in terms of both of us being Puerto Ricans, I think that at some level, I have to go through similar experiences that he might have gone through in terms of being a minority. That in some way helps to develop a better connection in terms of communication and understanding.

Question 3

Can you order these (engagement and retention) strategies in terms of importance? Most frequently noted (14) were responses associated with the attitudinal stance of the practitioner required for building a trusting relationship with the client. The second most frequently noted (6) were the practitioner's actions that contributed to building a trusting relationship, eg., assertive outreach; being available and reliable; and listening to the client. The third most frequently noted (5) were collaborations with the client to secure concrete services and negotiate role relationships in the client's network.

Participant 6:

Building the degree of trust that we had was probably primary, because once we had that trust, he knew he could count on me to help him achieve whatever it was that he needed, so I think the relationship was the most important aspect of the work that we did, and following up. So, he trusted me, he would ask me to do something and I would do it so that he could actually see that I was going to be good to my word.

Participant 7:

I think the relationship with the client, relationship with the support networks, and assertive approach. I would say those are the three.

Participant 10:

I think meeting her where she's at was most important. Probably the second most important thing is listening, accepting her and being there as a support and when it came to her alcohol abuse, not being punitive about it. You know, you shouldn't be drinking, you really should take medications. Because, it's not about me, it's her treatment. It's educating them about the consequences and this is your treatment.

Participant 13:

One of the things was something as simple as returning a phone call. When she would call me, she would get that call back. We would keep her appointments. We would meet her basic needs in everything surrounding her life, the legal, the medical and the psychiatric treatment

she was receiving here. I believe she saw the support that was going on, from me and another staff member, and it was magnetic for her because she would mention that a lot. She would mention that the treatment she was getting from both of us was very helpful to her, so it worked really well. We were there for her. I believe as long as the clients want it; the staff will pick up on it. I've seen the staff go over and beyond to make things work for clients.

Question 6

Is there anything else you would like to say based on your experience about the successful engagement and retention of clients with co-occurring disorders?

The participant's responses were in greater depth and poignancy about the seminal importance of establishing the relationship with the client in the interest of engagement and retention as one would anticipate. The new issue that emerged in their responses was coming at the relationship for what it means for the practitioner as opposed to just a strategy for engaging and retaining the client. The participants spoke to the demanding nature of the work, the reciprocal nature of the relationships, and the things that impede and impinge on those relationships.

Participant 5:

I would say that clients with co-occurring disorders prove to be challenging to most clinicians because mental health alone and addictions alone are very difficult. To work on both of those things together requires a level of patience that is almost indescribable. You have to experience it to fully get it. Every day, or 90% of the time, you're up on your game in terms of dealing with the needs of these particular clients. The demands are high, the needs are many, and every single day you have to be up to the challenge because something different is being brought every day.

... It's quite a challenge but it's doable. It's a willingness to do it. Having the right attitude as the provider, but also having the adequate resources in order to do it... With this population you have to, I know it sounds cliché, thinking outside the box, but the normal way of thinking about working with these folks with normal meaning sequential or linear, when working with co-occurring clients, you have to throw all

that out. .. You set yourself up for many days and nights of frustration if you try to think about these particular clients this way. You have to really think about it in the more abstract and creative way, to provide services in a way that meet their needs, but keep you sane at the same time.

Participant 10:

I have done a lot of things here in this agency. Sometimes the system is very difficult to work with. In the past, I think what's really helpful is doing outreach and support visits which have dwindled a lot. I don't know if that's even relative, but I think that's also really important. I did more outreach and I went out and met them at their own environment to build my relationship with them and I think that was really important. We don't do that anymore. It's almost like a grocery where you get a number, and you lose the individual.

Participant 11:

I think when you talk about treatment there's a line there that says I'm the person that provides the services, and you're the person that receives the services. I think my approach is a little different, sort of a collaboration. The relationship to me is really, really important. Getting to know the person and one of the things I always try to do, which I think is very helpful is also establishing a relationship with the family members.

Participant 13:

There were more case managers and we were able to spend more time with them in their environment. Some of the clients invite me over – can you come over and spend some time at the house? I don't do that anymore, because I'm back to back with clients today. So, I think the cuts that have been going on, the services that have been cut, is a big one. I think that's affected a lot of the clients because we're not able to provide certain things for them. You could see that once you give them that boost, and you give them that apartment, they go on and they get a job and you can see how they went from being seen weekly, to monthly, to every three months, and sometimes even leaving the program. You don't see that a lot any more.

Participant 14:

Being interested in their lives and actually letting the individual know that they are educating me. I put the role back on them, telling them that

they are giving me something. I really do learn from my clientele. It makes a difference and it kind of keeps you posted on what's out there, how it's being presented, the game, what's real and what's not, keeping it honest. When individuals come to us and they are on drugs, we're in this role where they have to kind of lie to us because they feel we're disappointed and that they failed. I tell them, we're not here to judge, we're here to help you. When you're ready, we'll do the steps but I'm not here to say you're on a punishment and get angry with you because you picked up, because something could have happened. Basically, you just judge individuals a step at a time and you learn from them.

CHAPTER V

DISCUSSION

Substance abuse is the most common and clinically significant co-morbidity among clients with severe mental illnesses (CSAT, 2005; Drake, et al, 2004). These individuals typically have multiple impairments that are associated with a variety of negative consequences making them difficult to engage and retain in treatment. The most consistent finding across studies conducted in the past twenty years is that the most effective service delivery is integrated, i.e., the same clinician or clinical team provides appropriate mental health and substance abuse interventions in a coordinated fashion in a single setting with a goal of helping the client to manage both illnesses (Hendrickson, 2006; Sacks, Chandler & Gonzalez, 2008).

While critical components of an integrated service delivery have been identified, when and how these components are successfully integrated in a particular case has been more elusive. This qualitative study was designed to make its contribution to filling this gap by discerning what could be learned from the practice wisdom of seasoned practitioners on an integrated co-occurring treatment unit of an outpatient mental health center about specific approaches effective in the engagement and retention of clients with co-occurring disorders.

Major findings were:

- 1) Participants did not differentiate between strategies that were specific to engagement and/or retention; rather they seemed to view engagement and retention as a seamless process.
- 2) However, five categories of strategies did emerge that were used for both the engagement and retention of clients. All of these strategies had to do with the practitioner's use of self in relationship with the client. These were:
 - the practitioner's attitudinal stance towards the client
 - the practitioner's use of self to build trust with the client
 - the practitioner's use of self to promote client self-efficacy
 - collaboration with the client to secure concrete services around basic needs
 - collaboration with the client to negotiate all sorts of role relationships.
- 3) Participants considered the three most important of these strategies as:
 - the practitioner's attitudinal stance towards the client
 - the practitioner's use of self to build trust with the client
 - collaboration with the client to secure concrete services around basic needs and to negotiate role relationships in the client's network.
- 4) There was reciprocity in the valuing of the relationship and use of self with a client for engagement and retention on the part of the participants, i.e., the relationship with clients was clearly one of the personally satisfying parts of the work.

It is to be noted that this was a sample of convenience in an outpatient mental health center and thus these finding cannot be generalized beyond this sample.

The idea of a seamless integration of engagement and retention with these clients has been reported in the literature (CSAT, 2005; Mueser et al, 2003). These findings speak to the seminal importance of relationship(s) in the successful engagement and retention of clients with co-occurring disorders. Specifically, reliable and facilitating relationships. While the seminal importance of the relationship in any clinical endeavor in mental health field is certainly not a new idea, the five ways in which this is done does make a contribution to the greater specificity about how the engagement and retention of clients with co-occurring disorders is achieved.

It is also significant that when participants were asked if there was anything they wanted to add, a dominant theme was the satisfaction that they take in the relationships with these clients. There is not much in the literature about the reciprocity of gratification in the relationships clinicians establish with clients. Given how long these participants had been working with this population, a mean average of 15.5 years, participants' sustained enthusiasm and commitment to these clients was also striking. For example, when I issued the invitation to all on the unit to participate, 14 out of the 17 staff (82%) readily agreed and seemed to enjoy talking about their experiences. One might have anticipated more burn out, if only because substance abuse is considered a relapsing disorder.

REFERENCES

- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders*, Third Edition, Washington, DC: Author.
- Center for Substance Abuse Treatment (2005). *Substance abuse treatment for persons with co-occurring disorders: treatment improvement protocol (TIP) Series #42*. DHHS Publication No. (SMA) 08-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment (2007). *Understanding evidence-based practices for co-occurring disorders*. COCE Overview Paper 5. DHHS Publication No. (SMA) 07-4278. Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services.
- Center for Substance Abuse Treatment (2007). *The epidemiology of co-occurring substance use and mental disorders*. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services.
- Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F., Clark, R. & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469-477.
- Drake, R., Mercer-McFadden, C., Mueser, K., McHugo, G. & Bond, G. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24(4), 589-608.
- Drake, R., Mueser, K., Brunette, M. & McHugo, G. (2004). A review of treatments for people with severe mental illness and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal*, 27(4), 360-374.
- Drake, R., O'Neal, E. & Wallach, M. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment*, 34, 123-138.
- Flynn, P. & Brown, B. (2008). Co-occurring disorders in substance abuse treatment: issues and prospects. *Journal of Substance Abuse Treatment*, 34, 36-47.
- Hendrickson, E. (2006). *Designing, implementing and managing treatment services for individuals with co-occurring mental health and substance use disorders: blueprints for action*. Binghamton, NY: Haworth Press.
- Hendrickson, E., Schmal, M. & Ekleberry, S. (2004). *Treating co-occurring disorders: A handbook for mental health and substance abuse professionals*. Binghamton, NY: Haworth Press.

- Kavanaugh, D. & Connolly, J. (2009). Interventions for co-occurring addictive and other mental disorders (AMD's). *Addictive Behaviors*, 34, 838-849.
- Miller, W. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. New York: Guilford Press.
- Minkoff, K. (2001). *Service planning guidelines: Co-occurring psychiatric and substance disorders*. Fayetteville, IL: Behavioral Health Recovery Management. Retrieved May 5, 2010, from <http://www.bhrm.org/guidelines/ddguidelines.htm>.
- Mueser, K. & Drake, R. (2007). Comorbidity: What have we learned and where are we going? *Clinical Psychology: Science and Practice*, 14(1), 64-69.
- Mueser, K., Noordsy, D., Drake, R. & Fox, L. (2003). *Integrated treatment for dual disorders: a guide to effective practice*. New York: Guilford Press.
- National Alliance on Mental Illness (2010). *Dual diagnosis and integrated treatment of mental illness and substance abuse disorder*. Retrieved January 3, 2010, from <http://www.nami.org/dualdiagnosis>.
- Padgett, D., Henwood, B., Abrams, C. & Davis, A. (2008). Engagement and retention in services among formerly homeless adults with co-occurring mental illness and substance abuse: Voices from the margins. *Psychiatric Rehabilitation Journal*, 31(3), 226-233.
- Sacks, S., Chandler, R. & Gonzalez, J. (2008). Responding to the challenge of co-occurring disorders: suggestions for future research. *Journal of Substance Abuse Treatment*, 34, 193-146.



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

PATRICIA A. REHMER, MSN
COMMISSIONER

February 22, 2010

Karen Evertson, MSW
Chief Executive Officer
Capitol Region Mental Health Center
500 Vine Street
Hartford, CT 06112

Re: Proposed Study: "Engagement and Retention of Clients with Co-occurring Disorders"

Dear Karen:

Marsha Odell's proposed thesis study of approaches to engaging and retaining persons with co-occurring disorders has been reviewed by the Office of the Commissioner and approved. She may proceed to conduct this study at CRMHC.

Please extend my best wishes for a successful research project.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Patricia A. Rehmer".

Patricia A. Rehmer, MSN
Commissioner

Cc: Linda Frisman, Ph.D
Andrea Routh, MSW

(AC 860) 418-7000
410 CAPITOL AVENUE, P.O. BOX 341431 • HARTFORD, CT 06134
www.dnhas.state.ct.us
An Equal Opportunity Employer

Appendix B



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

December 25, 2009

Marsha Odell

Dear Marsha,

Your amended documents have been reviewed. You have done an excellent job in presenting the literature review, in simplifying and clarifying your procedures and in rewriting the Informed Consent letter. You also have done a nice job of focusing your questions on the most important aspects of the question you are studying. All is now in order and we are glad to give final approval to your very interesting study. I am always delighted to see a study set in a practice situation and closely related to the work you are doing.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in black ink that reads "Ann Hartman / Ph.D.".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Hall, Research Advisor



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
Capitol Region Mental Health Center

January 11, 2010

Marsha Odell
18A Sedgwick Road
West Hartford, CT 06107

Dear Ms. Odell,

Capitol Region Mental Health Center endorses and requests IRB approval of the research proposal "Engagement and Retention of Clients with Co-Occurring Disorders: Practice Wisdom of a Multidisciplinary Treatment Unit. The proposal has been reviewed and approved within CRMHC, and we hope it will receive DMHAS' support.

Please contact me at 297-0901 if you have questions or need further clarification.

Sincerely,

A handwritten signature in black ink, appearing to read "Karen Evertson", followed by a long, horizontal flourish.

Karen Evertson, CEO
Capitol Region Mental Health Center

Cc: Andrea Routh, M.S.W.

(860) 297-0800
500 Vine Street - Hartford, Connecticut 06112
An Equal Opportunity Employer



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES
A HEALTHCARE SERVICE AGENCY

NOTIFICATION OF IRB APPROVAL

PATRICIA A. REHMER, MSN
COMMISSIONER

February 17, 2010

Approval Date: 2-17-10
Type of Review: Full Committee
Title of Study: Engagement and Retention of Clients with Co-Occurring Disorders: Practice Wisdom of a Multidisciplinary Treatment Unit
Reference Number: 10-01
Principal Investigator: Marsha Odell
Approval Expiration Date: 1-28-11

Dear Ms Odell:

- Your study, referenced above, has received approval by the DMHAS-OOC Institutional Review Board.
- IRB approval is valid through 1-28-11
- In line with this notification the IRB has also approved:
 - Waiver of the requirement for documentation of informed consent related to the family member interview pursuant to 46.117 (c) (2): the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.
- The study must be re-approved in order for research activities to continue beyond the above noted expiration date. An Application for Continued Approval will need to be submitted at least 30 calendar days prior to the approval expiration date. (Application can be found on the DMHAS website at <http://www.dmhas.state.ct.us/IRB.htm>). You will be contacted regarding the date of the continuation review.
- If any changes are contemplated following the date of this approval, a written request outlining the proposed changes must be submitted to the IRB for review and approval before implementation. No changes to the approved protocol or informed consent may be made without IRB approval.

(AC 860) 418-7000
410 CAPITOL AVENUE, P.O. BOX 341431 • HARTFORD, CT 06134
www.dmhas.state.ct.us
An Equal Opportunity Employer

- The IRB committee requests that they are informed, as outlined in the DMHAS IRB Policy, of any adverse events or protocol deviations related to your study.

Sincerely,

Andrea Routh
Andrea Routh, MSW, Chair, Institutional Review Board
(860)-418-8836

2-17-10
Date

Cc: Maureen Hulsart, CRMHC

Appendix E

Recruitment Script

Good morning.

First, I would like to thank you for your time. I will try to keep this as brief as possible.

As you all know I am a social work intern from Smith College School for Social Work.

For my master's degree thesis I am conducting a qualitative study that hopefully will make a contribution to expanding our professional knowledge base about the engagement and retention of clients with co-occurring disorders. As you know, the critical components of integrated service delivery have been pretty well identified in the literature but how and when these components are successfully integrated in a particular case has been more elusive.

So my study is designed to see what we can learn from the practice wisdom of seasoned professionals, that work in multidisciplinary teams in an integrated service delivery system, about how best to integrate critical components to effectively engage and retain clients with co-occurring disorders.

I have been given permission by Smith College, the DMHAS Institutional Review Board, Karen Evertson, Mike Levinson and Claude (Fields) to conduct my research here.

I would like to extend an invitation to each of you to participate in this study and share your practice wisdom. Over the past few months I have gotten to know most of you pretty well and I am very aware of the collective knowledge and practice wisdom in this

room when it comes to working with clients with co-occurring disorders. I know each of you has a contribution to make and hope that each of you will accept my invitation to participate. Of course, your participation is voluntary and is in no way related to your employment here at Capitol Region and whether or not you choose to participate will be kept confidential.

I have copies of an information sheet that outlines the specifics of participation for each of you to review as you consider your participation. I will also be sending out a follow-up email within a few days to confirm whether or not you wish to participate. If you have any questions regarding participation or the details of the study please feel free to contact me.

Again, I would like to thank you for your time.

Appendix F

Connecticut Department of Mental Health and Addiction Services
Institutional Review Board - Office of the Commissioner
Quality Management & Improvement
410 Capitol Avenue MS # 14
PO 341431
Hartford, CT 06134

APPLICATION FOR WAIVER OF INFORMED CONSENT REQUIREMENTS

APPLICATION FOR WAIVER OF HIPAA AUTHORIZATION REQUIREMENTS

Please complete form electronically, print out and submit signed copy. Application and related materials may be forwarded to the IRB chair electronically but must be followed by a signed hard copy.

Date of Application: 01/28/10

Title of study: *Engagement and Retention of Clients with Co-Occurring Disorders: Practice Wisdom of a Multidisciplinary Treatment Unit*

Principal investigator: Marsha Odell

WAIVER OF CONSENT/ELEMENTS OF CONSENT

Does the protocol propose waiver of informing participants of some or all of the required elements of informed consent? yes no If yes, please specify the nature of the waiver that is being requested:

Please check the criteria below for the categories that apply and provide brief explanations:

CATEGORY I – all criteria must be met in order for a waiver to be approved.

The research is to be conducted by or is subject to approval of state or local government; and

The research is designed to study, evaluate or otherwise examine (i) public benefit or service programs, (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs; and;

The research could not practicably be carried out without the waiver or alteration.

Please provide a brief explanation of how the research project meets these criteria:

CATEGORY II - all criteria must be met in order for a waiver to be approved.

The research involves no more than minimal risk to the subjects; and

The waiver or alteration will not adversely affect the rights and welfare of the participants; and

The research could not practicably be carried out without the waiver or alteration; and

Whenever appropriate, the participants will be provided with additional pertinent information after participation

Please provide a brief explanation of how the research project meets these criteria:

WAIVER OF DOCUMENTATION OF INFORMED CONSENT

Does the protocol propose waiver of the requirement to obtain a signed consent form for some or all participants? yes no If yes, please check the category below that applies and provide a brief explanation:

CATEGORY I

The only record linking the participant and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each participant will be asked whether they want documentation linking them with the research and the participant's wishes will govern;

OR

CATEGORY II

The research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context.

Please provide a brief explanation of how the research project meets the selected criteria
This study is eligible for a waiver of documentation of informed consent under 46.117(c)(2). The research presents no more than minimal risk of harm to subjects and involves no procedures for which consent is normally required outside of the research context.

Please describe how, in lieu of a signed consent, participants will be provided with information about the study and their involvement: *All potential participants will be given an information sheet when the study is announced at the joint daily meeting. This information sheet will cover all required elements of consent, but will not require their signature.*

WAIVER OF HIPAA AUTHORIZATION REQUIREMENT

Protected Health Information (PHI) is defined as "Individually identifiable health information that a health care provider, health plan, health care clearinghouse or employer creates or receives and includes information about the past, present or future physical or mental health of a person, the provision of health care to a person or the payment for the provision of care to that person."

Does the protocol propose the use or disclosure of PHI without informing the research participant? yes no

Please check the type of information that will be used:

- | | |
|--|---|
| <input type="checkbox"/> Names | <input type="checkbox"/> Geographic subdivisions smaller than a state |
| <input type="checkbox"/> Dates (except year) directly related to individual (e.g. DOB, discharge date) | <input type="checkbox"/> Fax numbers |
| <input type="checkbox"/> Telephone numbers | <input type="checkbox"/> Social security numbers |
| <input type="checkbox"/> Electronic mail addresses | <input type="checkbox"/> Health plan numbers |
| <input type="checkbox"/> Medical record numbers | <input type="checkbox"/> Certificate/license numbers |
| <input type="checkbox"/> Account numbers | <input type="checkbox"/> Device identifiers & serial numbers |
| <input type="checkbox"/> Vehicle identifiers/serial numbers | <input type="checkbox"/> IP (Internet Protocol) address numbers |
| <input type="checkbox"/> URLs (http://...) | |

- Biometric identifiers (including finger and voice prints)
- Full-face photo images or comparable images
- Linkage codes to allow re-identification
- Any other unique identifying data. Please describe:

Please describe from where the PHI will be accessed:

- Please check the criteria below that apply and provide a brief explanation.
- All criteria must be met in order for a waiver to be approved.
- Use or disclosure of the PHI involves no more than minimal risk to the privacy of research participants because of the presence of at least the following:
 - There is an adequate plan to protect PHI identifiers from improper use or disclosure. Please describe plan:
 - There is an adequate plan to destroy identifiers at the earliest opportunity absent a health or research justification or legal requirement to retain them. Please describe the plan (note any research or legal requirement to retain identifiers):
 - I confirm that the PHI will not be used or disclosed to a third party except as required by law, for authorized oversight of the research study, or for other research uses and disclosures permitted by the Privacy Rule. Please initial here and date to confirm your agreement with this statement: _____
 - The research could not practicably be conducted without the waiver or alteration. Please explain why it is not possible to get the authorization of the participants whose PHI you wish to use:
 - The research could not practicably be conducted without access to and use of PHI. Please explain:

Marsha Odell
Principal Investigator – Signature

01/28/10
Date

Appendix G

Title of Study: Engagement and Retention of Clients with Co-Occurring Disorders: Practice Wisdom of a Multidisciplinary Treatment Unit

Information Sheet

Dear Participant:

I am currently a student at Smith College School for Social Work, located in Northampton, Massachusetts. I am engaged in a research study exploring what we can learn from the practice wisdom of seasoned practitioners that work in integrated co-occurring treatment programs about the specific approaches to combining critical components of an integrative service delivery that are most effective in the engagement and retention of clients with co-occurring disorders. This study is for my Master's thesis and possible presentation and publication.

Your current employment in the co-occurring treatment unit qualifies you to participate in my study. If you agree to participate, you will participate in a face-to-face interview that will last approximately one hour. It will be conducted at a time and in a location that is convenient to you and provides privacy. It is anticipated that the interviews will take place at the Capitol Region Mental Health Center site. The interview will consist of a brief set of structured demographic questions, followed by a series of more open-ended questions encouraging you to reflect on the specific approaches you have found most effective in the engagement and retention of this population. The interview will be recorded and I may make additional notes during the interview. If you do not wish the interview to be recorded you should not volunteer.

Every precaution will be taken to ensure your confidentiality. All recorded interviews, transcripts, and notes will be identified by a numeric code and any personal identifying information will be removed. During the course of writing and research only my thesis advisor and I will have access to these records. If someone other than me transcribes the interview they will be required to sign a confidentiality pledge. All materials will be secured in a locked cabinet and remain secured for three years in keeping with federal guidelines and will be destroyed when no longer needed. In future publications and presentations research material will be presented in aggregate and every effort will be made to protect the identity of a participant when using specific quotes. However, given the special case of your long work association with other participants in this study, complete anonymity may not be possible.

There are few anticipated risks to participating in this study. However, in any experience of self-reflection, it is always possible that strong feelings may be evoked which you may feel warrants further attention in supervision or peer consultation. I have been trained and will be taking every precaution to ensure the confidentiality of the participants but there is always the possible risk, albeit small of a breach of confidentiality.

There is no financial compensation for participating in this study. This study is not designed to benefit participants directly but it is my hope that you will benefit from knowing that you are contributing to building our professional knowledge base in this area; as well as the opportunity to reflect on your own clinical experience.

Participation in this study is voluntary and you may decline to answer any question during the interview. For security and confidentiality purposes there will not be any identifying information linking you to your interview responses therefore once the interview is complete it will not be possible to withdraw from the study.

Thank you for your participation in this study.

Questions regarding any aspect of this study or your participation should be directed to:

Marsha Odell

Smith College School for Social Work

Northampton, MA

If you have any complaints or questions
about your rights as a research participant you may contact:

Chair of the Human Subjects Review Committee

Smith College School for Social Work

Northampton, MA

Please keep a copy of this information sheet for your records.

Appendix H

Follow-Up Email

Hello _____,

As I mentioned in our morning meeting a few days ago I am writing to follow-up on my research study. I hope you have had the opportunity to review the informed consent and are considering participating in this study. If you have any questions about the study please let me know.

Participation is voluntary and I will understand if you choose not to participate. My hope is that you will participate and add the richness of your experiences and practice wisdom to this study.

Please let me know your decision by _____ (Date)_____.

Thank you for your time and consideration.
Marsha Odell

Appendix I

RESEARCH QUESTIONS

Demographic Background Questions

We are going to begin by asking you some demographic questions about your personal and professional background.

1. Gender: M _____ F _____ O _____

- 1a. Age: 36-40___ 41-45___ 46-50___ 51-55___ 56-60___ 61+___

2. How do you identify yourself in terms of race / ethnicity?

3. Highest level of education, highest clinical degree, professional licenses:

4. Additional certifications or training specifically related to co-occurring disorders:

5. How long have you worked at Capitol Region? What is your position? What other settings have you worked in with co-occurring clients? Position and years?

6. When you think of all the clients that you have worked with that had a co-occurring disorder over the course of your career, would you say that number falls between:

1-25 _____ 26-50 _____ 51-75 _____ 76-100 _____ Over 100 _____

Interview Questions

Now I am going to ask you a series of more open-ended questions about your experience working with clients that have been diagnosed as having a co-occurring disorder.

- 1) Select a co-occurring client that you have worked with that you consider a success case when you think about engagement and retention. I would like for you to tell me about that case. Please make sure that you disguise the client's identity. (Listen for: presenting problem, diagnoses, recommendations, etc.)
- 2) What specific engagement and retention strategies did you use in this case?
- 3) Can you order these strategies in terms of importance?
- 4) In the case you described, what team interventions were specific to the substance use disorder and what team interventions were specific to the mental health disorder?
- 5) In the case you described, how were the services integrated?
- 6) Is there anything else you would like to say based on your experience about the successful engagement and retention of clients that have co-occurring disorders?

Transcriber’s Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Marsha Odell shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Marsha Odell for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

_____	Transcriber Signature
_____	Date
_____	Marsha Odell, Researcher
_____	Date