

Caring for Those Passed By

Sister Pat Corley, CND, and Sister Mae Kierans, CSJ, were formerly, respectively, Coordinator for Residential Services and Manager of Transitional and Long Term Care at the Providence Center, Providence, RI. Their presentation focused on how their agency was reaching out to persons with a co-occurring diagnosis and uninsured. The approach combined a multidisciplinary continuum of care and a network of partnerships to provide a safety net for people who might otherwise be passed by.

Sister Mae Kierans

The inspiration for this symposium is the story of the Good Samaritan as told by Jesus and the title for our presentation is "Caring for Those That Have Been Passed By." I thought I would start by telling you my own experience of being in the story of the Good Samaritan, and believe me I was not the Good Samaritan. I was in the bus station in Toronto. I am a Canadian. Waiting one winter night to board the bus and in the waiting room was what I think Americans call a Native American. In Canada we call them First Nations People. He was a young man, who was drunk in the waiting room with us and not bothering any of us. We had been there for some time. The security guard came along and said, "Get out. You don't belong here. Get out." I thought, "I've got to do something. You know, I'm a nun. I work in the field. Mae, think of something." I couldn't think of anything except to go and attack the security guard. I thought, "I better not do that. Come up with another idea." Meanwhile the security kept coming around saying, "Get out of here. Get out of here. You don't belong here."

It was a cold winter night and I kept thinking, "Now, Mae, this is what you do. Think of something." All I could think of was beat up the security guard. As I was trying to think of what I should do, a young woman beside us got up and took out her pack of cigarettes and split it in half and gave half to the young man, and said, "Come with me." She brought him out to the street and hailed a cab, gave the cab driver some money, and told him where to bring the young man. That was a powerful experience for me.

That's a modern day Good Samaritan story. We hope that as you listen to the presentations today, that you will find in each of the presentations a particularity that you can apply to your own situation back home. It may not be the same exact template, because you may have a different situation. But it's our hope that you can apply what you hear to your situation back home.

Sister Pat Corley

The topic, I think, is such an important and moving one. There's a presentation in motivational enhancement for the dually diagnosed and someone mentioned motivational enhancement this morning. But here's a quote from this particular article. It says, "Due to the complex clinical presentations and host of special needs, the dually diagnosed consumers have long suffered from a lack of coherent treatment practices designed to address their unique circumstances.

Unfortunately the traditional practice of treating dual disorders as separate conditions has proven to be largely ineffective, regardless of whether their treatment was done in an inpatient or outpatient setting. However, recent work with the dually diagnosed over the past decade has led to the development of a comprehensive integrated treatment program that appears to offer tremendous promise, especially when the term of delivery is for 18 months or longer and is managed by a single provider or a unified treatment team.

"Building on the assumption that psychiatric symptoms and substance abuse are intimately related, integrated programs offer an array of clinical services including assertive outreach, intensive case management, medication management, skills training, stage sensitive substance abuse counseling, and motivational enhancement. In short, integrated treatments employ a comprehensive unified approach to the treatment of multiple interrelated problem areas for consumers with complex clinical presentations. The primary challenge now facing the healthcare community involves the process of integrating what we have learned from research into clinical practice."

This particular excerpt explains exactly what the program is that we're going to present to you today. I will begin by saying this is by no means the perfect program, and on a daily basis we experience frustration that's

like right up to here in terms of actually having the resources to implement this program. But from a conceptual point of view this is probably cutting edge. This is probably right on the forefront of what we're going to have to do, whether it's church related or public or private related for the treatment of substance abusing people. I will also say that I have been in recovery 25 years myself. Just from a personal perspective, we know the stigma that was attached to having a mental illness. I have been in the field for 18 years. In residential facilities we would not accept you if there was suicidal ideation in your entire lifetime. If there was ever a thought of suicide, if there was an attempt, forget it, you were out in the woods somewhere. If you were on medication, you could not get in.

Moving forward

Mae and I will collaborate on the fact that the most challenging project that we have to deal with right now is the medication of our clients, because they're indigent. Getting them paid for is the biggest issue. Ninety percent of our clients are on medication. When I began these folks simply would not have been in our treatment facilities. I say that by way of saying that we have come so far. The whole history of dealing with substance abuse and the mentally ill is a picture of moving forward constantly, and that's what this is about. Our goals today are to raise your awareness regarding the prevalence of dual-diagnosis in the general population, to present the brief historical overview of care for indigent mentally ill. Part of our expectation is that you are more aware of the history of the care for substance abusers; you know how that evolved to its present stage. We also hope to raise your awareness regarding the treatment needs of mentally ill addicted men and women. Another one of our goals is to describe a model of care for those that have been passed by as an incentive for developing a similar program in your own areas.

One of the historical things that I would mention here is how our organization got to this particular point. Mae will point out that in the 1970s the Providence Center began as a mental health organization. I would like to point out that simultaneously in the early 1970s the treatment center, called the Talbot House, began as a place for alcoholics. The motivation was, "If we could only get those drunks off the street, put a roof over their heads, and feed them, and then drag them off to meetings every day, they'd have a chance." That was the start of how the treatment centers got them off the street.

Simultaneously, probably five blocks away, the Providence Center was beginning as a mental health provider. Mae will get into the marriage of these two organizations about five years ago.

We want to offer some suggestions on how to get started in your own area, so that it's not just informational but rather a very practical presentation.

16.7% of our population has a drug problem. I underlined to myself that this was in 1991, because my feeling is that the percentage is probably higher. But I'm not concentrating on numbers; I'm concentrating on a concept here. So 16% of the population has some kind of a problem. 13% are alcoholic and 6% are drug addicts. That's in the general population.

If we were to separate out the population according to those specifically diagnosed with a mental illness, those who have a diagnosis of bi-polar, 56% of them also have a substance abuse problem, 43% are alcoholic, 33% are other drugs. The numbers don't add up because the subsets overlap. 47% of our schizophrenic population also has a substance diagnosis. That doesn't mean they dabble in it. It means they have a diagnosed substance abuse disorder. The panic disorder people, 35% of them have a drug and or alcohol problem. OCD, major depression, phobias, a very high percentage of these folks also have a substance abuse problem.

So you can see that with the best of intentions we work in the dark, certainly I was. I was working in a residential facility, and if you had the diagnosis you could not come in. In retrospect that's kind of scary and it's kind of sad. But I just keep reminding myself that we are moving forward. We are making progress. We are doing everything possible to incorporate treatment for these people. So having said that in terms of percentages, Mae will give you the historical overview.

Sister Mae Kierans

The source for this overview is an interview that I had with Charles E. Maynard, who was founder of the Providence Center in 1969. He was a social worker, working with a psychiatrist, and he had a secretary. That was the beginning of the Providence Center. It's not a Catholic agency, it's a public agency. We just happen to be

Sisters who are working for it. I discovered that Providence, Rhode Island, is 70% Catholic, so there happen to be a lot of Catholics working in this agency.

The other source for this overview is Ed Marciniak's article "Shortchanging the Homeless" in America, July 16, 2001. In the 1840s the mentally ill were in jail and poor houses. Do you remember the closing segment of the movie Amadeus, and Salieri is in the mental institution and they're chained to walls and they're locked up? In the 1840s that was where the care of the mentally ill was. Dorothy Dix started in Massachusetts and went through the rest of the United States developing a more humane treatment for the mentally ill. Great progress was made.

In the 50s and 60s, the places where they were treated deteriorated into custodial care. In the 60s and 70s governments were closing institutions throughout the United States. 500,000 beds were eliminated. Today there are fewer than 70,000 beds nationally, and the mentally ill that we can observe are back on the streets, in jail, and homeless. Our agency actually goes and looks for them under the bridges and in the woods to find them and offer them treatment. More prisons are being built to house the mentally ill, and the prison system is the largest provider for mental health and addiction services in the United States, and the most expensive. In Rhode Island, in 1965, the state also began closing beds. They approached Charlie Maynard and asked if he would provide medication clinics to the homeless and mentally ill within the community. They were supposed to go back to the institutions to receive their medications, but had refused to go there, because by this time they had been traumatized by their experience there. So he set up kind of street corner medication clinics and gradually over the years developed a system of care for the mentally ill, which now is an agency of 450 employees operating in many sites throughout the state of Rhode Island. Since 1989, Rhode Island has been rated the No. 1 provider of care for the mentally ill, largely because of the work of the Providence Center. The expert that gave us this statistic in one of our trainings was indicating it's not because Rhode Island is so small, he said Delaware is No. 37, but Rhode Island has consistently been the No. 1 provider since 1989. In the 1990s, 16% of the nation's mentally ill were imprisoned and very few were receiving treatment. In 2001, in New York City, nearly 3,000 mentally ill persons were behind bars. Upon release many are homeless, deteriorate, are rearrested and return to jail. In 1996, the Providence Center, a mental healthcare provider, wanted to offer mental health services to the addicted who were being excluded from treatment because of their mental illness, and merged with the Talbot Center. So, the largest mental health agency merged with the largest treatment agency that had a range of care for addictions including day treatment for women, short-term residential programs, a long-term residential program (where I am), and treatment programs in the prison. So that is a very quick overview of the care of the mentally ill.

Sister Pat Corley

Just to fill in a piece of that statistic, the Talbot Treatment Centers started in the 1970s as a shelter, really just to get the men off the street. By the time in 1996 that the Providence Center merged with Talbot Treatment Centers, Talbot had a social setting detox, which meant no medical intervention at all. We had a short term provider, a long term program, four outpatient facilities, and what I think continues to be unique about our merged provider: we have programs inside the prison.

A very high percentage of the population in our treatment programs comes directly to us from the prison, direct from court to you and nothing intervenes. That's because Talbot had a program where we separated the women out. The men didn't get separated, but the women did get separated in what would have been the equivalent of a residential program inside the prison. They get a lot of their treatment and education in there and then come out for transitional, step down kind of stuff.

We all have our own definition of what addiction is, how we define it. Every time we do a presentation to somebody we have to start with our definition of addiction. It's probably a little bit different with a slightly different twist. However, we want to present it based on our own stance. The one thing that we have in common is that addiction has to do with pain. That's why we use the expression "getting high." You get high because you were feeling kind of low. You know you're going upwards, okay. It has something to do with pain.

Kinds of pain

What kind of pain are we talking about? We list some of the things that are emotional pain — rage, anger,

helplessness, fear. But people also relapse, people also get into the addictive process because of physical pain. Many people who have back surgeries, many people who have chronic illnesses, drink and then drug because it relieves the physical pain.

We are beginning to talk more about mental distress, which is in fact a very painful way to live. People will self-medicate their mental distress, their "mental pain." Then there's this whole concept of spiritual pain, this sense of hopelessness, that my life has no meaning, which is a big driving force in relapse and in the whole addictive cycle. So, we're talking about a response to pain of some sort.

We will respond to this pain either by using a substance or getting involved in a process, and that's why we have process addictions as well. The whole function of the substance or the process is to anesthetize the pain. All of the present medications have side effects which are unpleasant. I'm self-medicating physical pain, or I'm self-medicating an emotional pain, or I'm just going out into la-la land because I don't think anybody cares whether I live or die anyway. So it is a response. These things anesthetize or totally distract us from the pain. It relieves the pain. However, it becomes a pain in and of itself, and this is where the addiction kicks in. Secrecy isolates from ourselves and others. It deepens our sense of shame, our sense of worthlessness. The actual physical pain, if that's what we're suffering from, the physical pain gets worse. Then this is a self-perpetuating cycle, and that's when we're calling it addiction, when it is a self-perpetuating cycle, when we are using the substance to get over the use of the substance, and the original reason sometimes will be distant in our minds.

Sister Mae Kierans

The consequences of co-occurring disorders. We've talked about the mentally ill and we have separated them from mental illnesses and those suffering from addiction. But the consequences of co-occurring disorders, when you have both of those conditions together. Chronic relapse and re-hospitalization.

Because we have state contracts, we do follow the American Society for Addiction Medication criteria. We are a level 3, a long-term care program, and one of the criteria for re-admission is chronic relapse and re-hospitalization. So at some of our case clinical meetings we have to talk about how many detox and treatments this person has had.

While most of our patients come to us poverty stricken, and some have been poor all their lives, some come from middle class families and some of our people have more money than you or I will ever see and lost it all flying around the world in jet planes teaching companies how to install computer programs. Anyway there were some people that had lots of money. By the time they get to us they have burnt their bridges and are poverty stricken. They have usually burned their bridges and part of our process is to reconnect our people with their families again. We network with a lot of agencies that provide sober housing and mental health services and other services.

Noncompliance with medication and psychosocial treatment: We do have our patients that will not follow their prescribed medication procedure. Violence, accidents, and injuries, plenty. A few days ago I removed a box cutter from one of our clients. That was quite a traumatic experience. Suicide ideation and attempts. Legal problems with criminal involvement, prison time.

As Pat said earlier, the parole officers do bring our clients to the door. We ask them that they bring the medical physical with them. Prostitution, as a way of earning income. Health problems. Malnourishment. Dental neglect. HIV, risky behaviors, exchanging needles, and unprotected sex. We network with everyone in Rhode Island and the Thunder Nest Clinic in the next town over works with homeless people. They have soup kitchens on Tuesdays where they will do medicals, and we can send our homeless clients that are uninsured over to their soup kitchen to have their medical taken at that time. They also come to our clinic and give HIV-AIDS education on a monthly basis. There is a lot of networking.

Sister Pat Corley

Those are what we call the consequences of dual diagnosis. But if you didn't know that this was a dual diagnosis presentation you would have thought those were the consequences of substance abuse, or those were the consequences of mental illness all by itself.

Multiply it geometrically and you have the consequences in the lives of those who are dually diagnosed, indi-

gent, homeless, all of those things, multiplied 1,000 times.

This marriage between Talbot Treatment Center and the Providence Center, like most marriages I presume, had its honeymoon period and then it had its rude awakening period. It was very hard for the substance abuse therapists and the mental health providers to really get in the same track. So the Providence Center invited in a consultant, Ken Minkoff, that would really work with us on it, so that we would be more understanding and empathetic with each other.

The very first thing that he said, and the percentages prove this true, is, "Dual diagnosis is an expectation not an exception. You can anticipate this when you are assessing people: More than 50% of them will have a diagnosable mental illness. Not somebody who says, 'I feel depressed.' No, they have been diagnosed as major depressive or bipolar or anxious or the personality disorders — not that we really need to hear from the personality disorder that they're diagnosed, because we know it the minute they sit down in their chair that they have a personality disorder. They're like sandpaper. That's how you know the personality-disordered people. They are like sandpaper when they get into your office."

The other thing that Dr. Minkoff says is that when mental illness and substance abuse disorders coexist, both of them are primary. The state of Rhode Island has put tons of money into this; we have a behavioral health department. We no longer just talk about substance abuse and mental illness. We talk about behavioral health. Sounds like we're going right along here, that these are adult primary illnesses, until we have to submit the Medicaid forms.

On the Medicaid form you can put only that the illness is substance abuse primary, or they won't pay for it. Down here in the footnote you can put parenthetically that there is a mental health problem which exacerbates this person's condition. But the theory and the practice are not side by side. However, they are both primary in most instances. The substance disorder or the psychiatric disorder can be considered secondary if, when one has stabilized or resolved itself, the other one disappears. Both mental illness and substance dependence are examples of primary, chronic, biologic illnesses that respond to the disease-relapse-recovery model for treatment.

No one model

There is no one model of dual diagnosis treatment. It is always an individualized treatment plan. For each patient the proper program for any one point in time depends on the type of dual diagnosis, the specific diagnosis, the phase of recovery, the level of acuity, severity, disability, motivation, all of those things. Individualized treatment plan.

The length of stay in any kind of program is individualized. Addiction treatment in psychiatric populations is basically similar; however, addiction treatment requires some modification for these individuals as we have experienced day after day. We just can't treat them the exact same way. The most significant predictor of treatment success is the presence of an empathetic, hopeful, and continuous treatment relationship.

How do the addicted people get well best? They get well best and most quickly when they're surrounded with or wrapped in a loving, empathetic kind of a situation. The same holds true if we're talking about the dually diagnosed.

Mae made reference before to levels of treatment, and I made reference a little while ago to the fact that Talbot Treatment Center had a higher continuum of care for the substance abuser, as the Providence Center had the entire continuum of care for the mentally ill. Not too long ago the American Society of Addiction Medicine developed their own criteria, so that every state and every agency and every organization didn't have its own assessment, didn't have its own "Where are we going to put you? We're going to put you in our treatment facility regardless of what your need is."

They developed a very clear and comprehensive standard of assessment for placement, and its called Patient Placement Criteria. This ASAM criteria looked at all six dimensions. There's not an area of your life which is not included in these six dimensions.

One: Are you still intoxicated? Are you withdrawing?

Two: What are your physical problems?

Dimension three: What are your emotional and behavioral problems, if any?

Dimension four: Are you ready? Are you ready to change? Is there a readiness to accept treatment? And where we put you is going to depend on your readiness. Or where we suggest you go is going to depend on

your readiness.

The other, dimension five is your relapse or continued use or continued problem potential. If I were to let you go out of my office right this moment, what is the possibility that you would not pick up your drink or your drug before you cross the street? Or what is the possibility that your mental health symptoms would not escalate before you got across the street? That's what this dimension really talks about.

And the last, dimension six, is: What is your recovery or living environment? If you go back home, if I let you out of my office and you go home, what are you going home to? A toxic environment, no job, no money, no anything? Then that has to be considered. And where I am going to place you when I get finished with this assessment is totally dependent on those six dimensions. I may choose to place you in a hospital, and I may choose to place you in a psychiatric hospital, or a detox, or I may say, "This residential program is just where you need to be, so stay right here."

I am the coordinator of two programs; Mae is the manager of one of them. In these two residential programs in the state of Rhode Island, which is really kind of tiny, our facility alone takes in 500 people a year. Now some of them are two or three times around. That's 500 of the state's indigent, uninsured, substance abusing, mentally ill people. We are not the only show in town. But we've got 500 being admitted in a year, 165 into the long-term program, and about 350 or so into what we call the short-term. It can be two or three months. The long-term program can be a year, a year and a half, nine months, five months, whatever, whatever you need is what we're going to give you. Between those two programs we do 500 people placed in residential, above 40% of whom got deposited on our doorstep directly from the prison. So there's a lot to be considered there.

Typical client profile

What is the typical client profile in the long-term care? About 120 of them would be men and about 40 would be women. The average age would be in the mid-30s. They would be chronic recidivists. This long-term program got started and financed by the state. In order to get in, the original criterion was that you needed to have been in treatment at least 100 times. At least 100 times and then they had no problem filling the place up. That was the criterion for getting into long-term care. Now that has changed. You have to have had multiple treatments. This can't be your first. Multiple residential treatments, but not 100, although some of them have had 100.

They are usually dually diagnosed with co-occurring mental disorders. They may be borderline personalities. They may also be just cognitively impaired. They just can't make it in a faster paced, more educational kind of program. They just need a lot of time. Or they're so physically sick they need a lot of time. The other thing is they're homeless, they're indigent. We have a pretty big HUD grant, which allows us to have case managers that focus only on getting them set up in terms of sober housing. As I mentioned before, they often have legal issues.

What we have available for these folks is 24-7 clinical staff, or the paraprofessionals, the residential assistants. What I think is more important, because we're talking about the dually diagnosed, is we have 24-7 access to our own emergency services, which is not an emergency room. But emergency services is the Providence Center's psychiatric emergency services, and they have immediate contact with a psychiatrist or a doctor, anytime of the day or night. We have off-site coordinated psychiatric services with other providers. We have substance abuse therapists, and a host of other things available for these folks.

The key thing when we're talking about with this population is the connection with some kind of psychiatric provider and intense case management. The actual therapy for substance abuse falls someplace in between there. Mae will explain to you the intensity with which we get these folks out to AA and NA meetings, because that is so critical. But case management to get them their SSI, their Medicare, Medicaid, food stamps, any source of income that is available to them, we have to get, we have to make the connection, so that when they leave us, they leave with some way of maintaining themselves.

We need to make medical, psychiatric, dental, eye appointments; all of those kinds of connections have to be set up while they're in treatment, and of course after they leave treatment. We get them on the medical component of welfare. We get them to their court appearances.

The other critical thing is that people get out of our facility successfully. We don't call them successful completions unless they have a safe sober place to go. So connection with the sober houses, the transitional houses, HUD, Section 8 housing, all of those safe places including the Providence Center's roof homes. All of that is

part of the network that we do with them.

Sister Mae Kierans

One of the advantages that we have in Rhode Island is that we're near Massachusetts and Connecticut and all the institutes of higher learning that do so much research in this area. Pat mentioned Dr. Ken Minkoff, but there are a lot of professionals concentrated around us who are helping us to advance this project of treatment for the mentally ill.

The Providence Center sent me and a psych nurse to a year-long training offered by DATA to better learn how to deal with treatment that is combined, the mental health and the addiction. Other agencies in Rhode Island also sent their managers and supervisors, so I had a year of being in the classroom, a whole day a month, plus a half day of clinical supervision with a specialist to learn how to move forward.

We just happen to be located in a place that's very fertile in terms of research and incentive to move forward. We're out in Pascoag, and it's a beautiful setting on a lake, in a beautiful New England small village. One day I came into work after I had arrived about two months, and I was walking down the hall to my office passing the women's bedrooms, and I could hear as I was walking down the hall to get to my office, "Dear God, I am so grateful to have been brought to this place. Thank you for bringing me here." I looked into one of the women's rooms and this woman was on her knees beside her bed on the floor thanking God for bringing her to this place for long-term care, and she had this tremendous sense of gratitude.

We have daily clinical services to improve the residents' ability to structure and organize the task of daily living and recovery. We do our house keeping and repairs. Some of the guys are glad to show off how they know how to fix the vacuum cleaning, fix the lawn mower, fix the dish washer, and women that can help repair seat covers or curtains, and so we take care of the simple tasks of daily living. We do have a maintenance man who comes in and looks after the bigger ones.

Activities are designed to maintain the stability of the substance dependent resident: having a regular daily schedule, a healthy meal, sleep, recreation, clinical services to promote re-involvement in regular productive daily activity, random drug screens, a range of cognitive-behavioral methods and other therapies, especially to learn stress management skills, health education services.

We network with other agencies that are nearby. We monitor the patients' compliance in taking prescribed medication and helping them to understand side effects and the purpose of the medication. We do family therapy, trying to reintegrate our people back with their family members, and interventions to facilitate the resident's understanding of their relationship between dependence and attendant life issues. We have a van and a driver that takes our clients out to 12-step meetings and they must have a sponsor before they can have a pass to go out looking for housing or a job.

When they arrive, we work with them to develop an individualized treatment plan. There is individual and group therapy, educational groups that focus on relapse prevention, cognitive restructuring, life and social skills, women's and men's groups, Big Book study, substance abuse education. I mentioned before AA and NA meetings and sponsorship, community chores, relaxation and leisure activities.

Our activities counselor is fantastic. The clients all eat out of his hand. He has them playing volleyball outside my window, which is wonderful to hear. Basketball in the court. He does relaxation therapy with them. He takes part in their games. He has them working in the exercise room. He does quiz games with them. He loves it and they love it. They're learning how to structure their time, because some of them are disabled and may not be able to work because of the mental illness.

Getting started

Suggestions for getting started. Dr. Ken Minkoff had these suggestions when we were trying to marry the addictions program with the mental health program:

Systems Change:

- Incorporate the concept of co-occurring disorders into your into your mission statement, philosophy and policies.

- Determine where you are in terms of what you want to be.
- Begin an initiative that involves change at each level.
- Develop a means of measurement to define outcomes.
- Take abstract principles and build them into the system.
- Rewrite the program standards for co-occurring disorders.
- Include one set of performance indicators into the Quality Management Plan to show that you are moving in the right direction.
- Add a question on dual diagnosis to the consumer satisfaction survey.

Program Change:

- Create a formal mechanism for integrating care coordination and problem solving.
- Build it into the staff's normal way of thinking.
- Determine what can be done at the system's level to make things more routine.
- Define program standards for the dually diagnosed.
- Make dual diagnosis an expectation.
- Make an assessment tool to measure how effectively we are documenting stages of change.
- Have an adequate number of groups for clients at different stages.

Clinical practice standards:

- Document that those with co-occurring disorders have been identified.
- Have a welcoming philosophy. Don't use disparaging language. Consider the experience from the client's perspective.
- Create psychopharmacology guidelines and a peer review process to promote consistency.
- Create a task force to establish basic competency issues and determine how to evaluate them. Work into the human resources policies.
- Plan for continuous training. (I mentioned previously that the Providence Center is sending our staff off to training sessions that are offered regionally, but also the Providence Center is very aggressive in providing in-house training sessions for all of our employees using outside experts.)
- Empower the staff to be resources for one another.
- Break down cultural barriers by using staff exchange initiative.