

Fellowship House, Inc. Low Intensity Transitional Apartment Program: An Outcome Analysis

by

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Abstract

The Fellowship House, Inc. Low Intensity Transitional Apartment Program is a residential program designed to fit the needs of adults diagnosed with substance dependence and other mental illnesses. This study sought to determine the variables associated with successful transition out of the program and to determine whether or not this model of long-term treatment had significant results on clients' ability to maintain a clean, sober, and productive lifestyle from the beginning of the program's new structure (May 2012) and ending September 2013. Program goals include further developing the self-discipline and independent living skills necessary for living outside of institutions. Logistic regressions were used for data analysis.

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CHAPTER I. INTRODUCTION

Individuals who have concurrent substance abuse and mental health disorders are overrepresented in homeless shelters, hospitals, and jails (DiClimente, Nidecker, & Bellack, 2008; Schutz et al., 2013). They rely heavily on emergency care and frequently neglect physical and mental health needs resulting in poor health outcomes and lower life expectancies when compared to the general population (Dickey, Normand, Weiss, Drake, & Azeni, 2002). Having Co-occurring disorders is also associated with poor medication compliance, less motivational readiness to change, and lack of treatment engagement (DiCliment et al., 2008). These factors accompanied by high aggression and impulsivity, produce behaviors that often disqualify the individual with co-occurring disorders from certain health services, but instead brings them in contact with the criminal justice system (Crocker, et al, 2005).

Hospitalization and imprisonment of this population costs government agencies a significant amount of money and many are repeat offenders and users of the same services (Cousins, Antonini, & Rawson, 2012). For this reason, the federal government has begun to redirect strategies to incorporate more treatment services and initiatives. The Office of National Drug Control Policy (ONDCP) devised a strategy to develop community based recovery support services and programs. Recovery support services were to address housing, education, employments, and health also (Cousins et al., 2012).

The Federal Patient Protection and Affordable Care Act which was constructed in 2010, stresses the necessity of prevention of addiction, access to quality treatment services, and

coordination of care (Cousins et al., 2012). The Recovery Oriented Systems of Care (ROSC) model is an individualized model providing links between treatment and community supports and improves individual quality of life. These services are to be provided by peers, clinicians, and volunteers before, during, and after treatment (Cousins et al., 2012).

Since 1965, Fellowship House staff has provided treatment to substance-dependent individuals seeking their assistance. They believe that the most effective form of treatment for co-occurring disorders and substance dependence is a long-term, comprehensive, recovery-oriented system of care which incorporates resources such as United Way, Vocational Rehabilitation, and other social services in the community. Fellowship House maintains that they succeed by networking with other service agencies and recovering individuals in the community (Fellowship House, Inc., 2013).

While treatment plans are designed individually, particular goals are addressed with each consumer. In the Fellowship House Medium Intensity Program, the ROSC model is utilized and the treatment team stresses social support systems that suit the individual needs of the consumer. Each consumer becomes involved with the self-help community, beginning with participation in bridge group, an informative meeting designed to help transition to the addiction self-help programs of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA). Fellowship House staff emphasize education to the consumer's mental illness and addiction. Specialized classes are attended to inform the consumer on physical, mental, and spiritual aspects of addiction. Consumers also attend individual counseling and group counseling sessions weekly. Medication management is established for consumers on prescribed medication. This medication is kept in a central, locked area and is given out up to four times daily in accordance with the prescribers dosage instructions.

The Fellowship House dual diagnosis program evolved in the mid-1990s in response to the growing demand for residential treatment for addicted, mentally ill consumers. Consumers in the dual diagnosis program are diagnosed by mental health professionals with alcohol or drug dependence, and with a serious mental illness such as bipolar disorder, major depressive disorder, or schizophrenia. Fellowship House's administrators believe that the most substantial barrier to treatment for this population is that their addictive behavior interfered with treatment for their co-morbid mental health condition and their mental illness interfered with addiction treatment (Fellowship House, Inc., 2013). Specialized placement and treatment in the Low Intensity Transitional (LIT) Apartment Program, the program for which the study was completed, is available to assist with preparing them for successful and sustainable life outside of treatment.

The LIT Program assists consumers with further developing the self-discipline and independent living skills necessary for living outside of institutions. In the LIT Program, residents sign a rental agreement with the Low Intensity Case Manager and share financial responsibilities with their roommates. They remain involved in group and individual counseling at Fellowship House, but usually with decreasing frequency. The LIT Program residents also remain involved in the recovery community by serving as mentors for newer residents. The main goal of this phase of the program is to provide housing and support until each individual is ready and better prepared to move to a more independent setting. Fellowship House consumers are assisted daily by an interdisciplinary team including licensed and/or certified Counselors, licensed Social Workers, certified Peer Support Specialists, Case Managers, and community volunteers.

The LIT Program is currently (December, 2013) equipped to serve 43 residents. Fifteen of those residents are female and the other 28 are male. Of the 43 residents, 14 single bedrooms are reserved for residents who have an additional Axis I Diagnosis (Dual Diagnosis). These beds are partially funded by consumer service fees and partially funded by a contract with the Jefferson, Blount, St. Clair (JBS) Mental Health Authority. The 29 remaining residents must have income before being admitted into the LIT program unless they are in the program as a result of a court mandate through a legal entity that is funding their services. Resident income may be from full-time employment, part-time employment, retirement, Social Security Disability or any other legal means of acquiring income and residents must provide proof of said income. The facility where the residents are housed is supervised 7 days a week for 10 hours each day. In addition to on-site staff, residents have access to staff at the Medium Intensity Residential Program 24 hours a day 365 days a year as well as on-call administrative and maintenance staff in the event of an emergency.

Fellowship House's Low Intensity Transitional (LIT) Apartment Program is a transitional program designed to continue to meet the needs of individuals diagnosed with substance dependence, while providing less structure than intensive or medium intensity residential programs. Resident fees are based on income and are not to exceed \$500 per month. These fees cover the cost of housing, electricity, water, counseling and case management. In order to offset the actual cost of treatment in this program, residents are also required to participate in service work at the Medium Intensity Program facility. Transition provides continued access to recovery support systems, recovery maintenance, financial budgeting, and connection to community resources so that the residents may eventually leave treatment and be successful members of society.

The majority of referrals for the LIT Program come from the Fellowship House Medium Intensity Program; however, referrals are also received from area homeless shelters, JBS Mental Health Authority, University of Alabama at Birmingham (UAB) Treatment Alternatives for Safer Communities (TASC), and personal and other community referrals. In order for a referral to be made, certain criteria must first be met. The potential resident must (a) have a substance abuse assessment completed by a masters-level practitioner within the past year, (b) have a primary diagnosis of alcohol or drug dependence, and (c) have proof of having been clean and sober for at least 30 days. Referred individuals found to have met the criteria must interview with Fellowship House's Placement Coordinator and Low Intensity Residential Coordinator to determine whether or not he or she is appropriate for placement in the LIT Program. The interview consists of questions derived from the American Society of Addiction Medicine (ASAM) six dimensions.

Once it is determined that the person may thrive in the program, they are provided with an application and placed in a room after completing orientation, signing relevant consent documents, and a rental agreement. Placement in the program remains voluntary. Although a resident may be legally required to complete a treatment program, that legal mandate alone cannot guarantee initial or continued placement in the LIT Program. Residents must agree to abide by all rules of the program which are stated below as written in the orientation manual (see Appendix A).

It is common for residents to have been homeless, or dependent on family members, institutions, or other individuals before coming to treatment. The Fellowship House LIT Program addresses these factors through continuous placement groups where independent living and preparation for freedom from institutions is discussed. Continuing care is also addressed on

a regular basis. Consumers are encouraged to continue to engage in community supports, Alcoholics Anonymous groups and social activities that do not involve drugs or alcohol. Consumers are able to come to these groups and discuss barriers to independence and temptations that arise while moving towards their goals and get feedback from other past consumers who have achieved said independence. The orientation manual for this program addresses the importance of continuing care and self-help meetings (see Appendix A).

The Fellowship House LIT program is not located within the Fellowship House main building where therapists and other staff are on site. The apartment complex is instead located in the Southside community of Birmingham, Alabama, amidst other apartment complexes blocks away from the University of Alabama at Birmingham hospital and university. There are no signs on or around the complex identifying it as a treatment and recovery related facility. The apartments are owned by a landlord and a lease is signed between that landlord and Fellowship House administrators.

About one-third of psychiatric patients in the United States of America have alcohol or drug disorders (Karper et al., 2008). In addition, many of the residents in the LIT Program have reported histories of childhood abuse and neglect, unresolved grief, sexual assaults, and other life changing events. For this reason, consumers are given the opportunity to receive individual counseling on-site by university interns from various counseling programs in the state of Alabama. The interns have university supervisors and they have field supervisors who are paid employees of Fellowship House. Fellowship House requires that field supervisors be Licensed Professional Counselors (LPCs) with at least two years of experience working at Fellowship House, Inc.

Therapeutic as well as psychoeducational groups are available for residents to participate in according to their individual goals. These groups address topics including budgeting, grief, co-occurring disorders, medication management, recovery maintenance, and coping skills. Although consumers are required to attend a specific number of groups, they are given the opportunity to decide which groups they feel that they may benefit from most. Groups are facilitated by Fellowship House clinical staff, Peer Support Specialists, interns, or community partnering agencies.

Recovery coaching and peer support are services provided by Fellowship House staff members who are in recovery from alcoholism or drug addiction. Some of these staff members are also individuals with co-occurring disorders. They have significant experience with being clean and sober and are able to share their experiences with residents and suggest activities, readings, and support groups that they determine may be beneficial for residents. Recovery Coaches and Peer Support Specialists are certified by the State of Alabama Department of Mental Health as Peer Support Specialists. They also assist and connect consumers with identifying Alcoholics Anonymous sponsors and community recovery support networks. Having a supportive social network can be extremely beneficial for those residents with mental illnesses (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007). Recovery Coaches and Peer Support Specialists also aide the residents in identifying positive versus negative social interactions, teaching discrimination against social activities that are not beneficial for recovery maintenance, and modeling acceptable behavior and interaction in social settings. By facilitating social interactions that are positive and assisting with building a support network, individuals are able to produce more positive consequences and subsequently better recovery outcomes (Weiner et al., 2010).

Family support services are available through the Family Program. The purpose of the Family Program is to provide information, peer support, and referral resources for family members of individuals seeking addiction and co-occurring treatment at Fellowship House, Inc., to enhance the Recovery Oriented System of Care (ROSC) by empowering family members to support each other and their respective loved ones in recovery, and advocate for addiction and co-occurring recovery needs. Through this program, group, couples, family, and individual counseling are available to defined family members of Fellowship House's residential, pre-treatment, and aftercare consumers.

Case management is provided to each consumer in areas needed to re-enter society as independently as possible. Case management begins by assuring that consumer basic needs such as food, toiletries and medication are available. Other areas of case management include assisting with legal issues, transportation, and independent living skills. After the consumer has increased structure and stability in life through employment, self-help and treatment involvement, independent living goals are established. Some of these goals include connecting the residents to case management services within the community to which they are returning or relocating. Although case managers may locate potential service providers and complete initial referrals, it becomes the resident's responsibility to follow through with making their appointments and getting necessary paperwork and other information to the referred sources. Case managers complete daily room checks, assuring that all residents are safe and that a clean and livable environment is maintained. Case managers assist residents with developing daily living skills and maintaining healthy boundaries with roommates.

Whereas counselors place a great deal of emphasis on success in the area of emotions, case managers tend to focus more on measuring a consumer's success by their ability to acquire

and continue basic needs management. Case management may also include outreach, treatment linkage, consumer advocacy, consumer support and supporting counseling. When the frequency of case management services is increased and the number of consumers per one case manager is twenty or less, the services are referred to as intensive case management. Case management is considered an essential service element when serving individuals with the combination of homelessness, mental illness, and substance use (Zerger, 2002).

In addition to services provided by Fellowship House staff, there are numerous groups and services provided by other agencies. Vocational assistance is provided through the State of Alabama Vocational Rehabilitation Program. Budgeting groups are provided with the help of representatives from Regions Bank. Birmingham AIDS Outreach provides HIV/STD education as well as tests. Residents are able to attend Bible study provided by Changed Lives Christian Center and parenting classes through Impact Family Counseling. Counseling interns from five different universities in Alabama have been available to assist with individual and group counseling.

As previously mentioned, a number of residents come into the LIT Program with existing legal cases and obligations. In order to cut down on the number of drug offenders in Alabama's prisons, drug courts have been established to get these offenders into drug rehabilitation programs. The more willing and non-violent offenders also go through a program that includes supervision by a case manager and regular drug testing. If the offenders remain drug free for at least a year, their charges are dropped. There are currently 60 drug courts in 57 counties in Alabama (Alabama Judicial System, 2012). Legal involvement is addressed in treatment, legal fines are included in budgeting, and legal status is reviewed periodically throughout participation in the program. Residents are provided with free legal advice from volunteers from Cumberland

Law School and Legal Aid of Alabama. Case managers often work closely with probation officers, parole officers, and attorneys to lower fines, approve housing transitions, and prove compliance.

Continuing care plans are developed at the beginning of treatment so that residents will continuously think about their ultimate goals and what they need to accomplish while in the LIT Program in order to reach said goals. This continuing care plan addresses what many therapeutic agencies address in treatment plans. It covers the number of support meetings that the resident will attend weekly, frequency of AA sponsor contact, participation in Fellowship House groups, participation in community groups or religious activities, addressing legal obligations, strengthening family relationships, and other issues that the resident and their treatment team decide upon after thorough rumination.

Independent living may include residing with family members, acquiring new housing, or moving back into a home that the resident owned or rented before coming to treatment.

Consumers are encouraged to continue attending continuing care groups after discharge and to volunteer to assist and mentor new residents. Occasionally it is determined while a resident is in treatment that the level of care maintained in the LIT Program is not appropriate to fit their needs for reasons such as continued relapse, medical needs, or severity of mental illness. These residents are referred to other programs, agencies, or hospitals and their treatment team ensures smooth transition and communication between the programs, agencies, or hospitals.

There are many different definitions of success. Some of these include achieving complete sobriety, developing an ability to cope with problems without the use of drugs or alcohol, and developing a change in emotional functioning. Others include graduation from a treatment program, completion of treatment plan goals, improvement in familial and other social

relationships (Zerger, 2002). In some instances, the consumer and the service agency have different definitions of what success will look like for the consumer. For this reason, both the consumer and the client may construct goals together.

Purpose

Many United States citizens with mental illness and co-occurring disorders enter into a cycle of institutionalization; a great deal of these consumers also become America's homeless (Freiedrick, Hollinsworth, Hradek, Friendrich, & Culp, 1999; Karper et al., 2008). People who are identified as being in this population often cause a strain on their family members and may be seen as being a burden to them and to their community. Lack of community resources and productive activities for them to engage in daily has contributed to the increase in homelessness (Freiedrick et al., 1999). The services offered in the LIT Program help to fill this need by providing affordable housing and clinical services to Alabamians with substance use disorders and co-occurring disorders.

Amidst the push to deinstitutionalize and gravitate towards community placement, there continues to be a need for determining which consumers need certain levels of treatment and if short-term or long-term treatment is most beneficial for certain subgroups. In an attempt to best place and treat each individual case of substance addiction or co-occurring disorder, an individual must complete a substance abuse assessment before entering an Alabama state certified residential treatment program. Fellowship House, Inc.'s LIT program, although not state certified, is less intensive and structured as high or medium intensity treatment programs and the placement is intended to be long-term.

Federal and state fiscal budget cuts and restraints have become a top priority (Cousins et al., 2012). Recovery support services and community-based treatment alternatives may reduce

the costs of providing treatment to people with substance addiction and co-occurring disorders (Humphreys & Moos, 2007). In a study completed by Humphreys and Moos (2001) consumers who relied more on community-based services reduced their healthcare costs by approximately \$5,000 per year.

In light of the state of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Alabama Department of Mental Health's recent push for an increase in effectiveness of community resources for those with mental illnesses and substance addiction, the completion of this study for Fellowship House, Inc.'s Low Intensity Treatment Program may prove beneficial for the agency and possibly for other similar agencies. The study will consider residents' placement/housing, services that the residents take advantage of, legal status, and drug or alcohol use before and after participating in the program. It is also necessary to determine what recovery tools, if any, that residents actually use once leaving treatment and their level of financial and housing independence.

SAMHSA emphasizes that recovery measurement is a necessity in order to explain the recovery processes and patterns so as to guide services and identify effective recovery tools. This will also aide in providing realistic expectations for service providers, service participants, participants' families, and society (SAMHSA, 2009). However, there is a paucity of research examining how effective these programs are at meeting the goals of providing quality, low-cost, evidenced-based care for adults with substance addiction and co-occurring disorders (Day & Strang, 2011; Gossop & Strang, 2000).

Determination of what impacts the residents via questionnaires will assist Fellowship House, Inc. in tailoring the services that it offers and increasing the incidence and magnitude of successful outcomes for those with whom the agency works. Similar agencies may also be able

to identify areas where their services run parallel with those offered at Fellowship House, Inc. and focus more energy towards areas that may need improvement. In order to increase the effectiveness of residential programs in Alabama and also decrease money spent by the government on repeat consumers in mental health and substance related agencies, program evaluations should be conducted as a method of development, a means for improvement, and determination of fund allocation. In order to provide an accountability of state-funded mental health programs, program evaluations should be administered in a timely manner. The purpose of this program evaluation was to assist Fellowship House, Inc. in determining if the way in which the program is run is practical and useful and what areas, if any, need improvement. Ideally, agencies that receive funds from the SAMHSA block grant will report outcomes to ADMH and strive to improve those outcomes.

Significance of Study

Recently, governmental funding sources have begun to focus more attention on providing people with substance disorders with treatment services necessary to lead productive lives, while saving the government money when and where possible. Lower levels of care tend to cost less money, but placing people in levels of care that do not sufficiently meet their needs tends to foster future relapse and increase reversion in repeat consumers (Chen et al., 2006; Day & Strang, 2011). In addition, researchers have suggested that more service-intensive programs may place more effort into ensuring that consumers have access to follow up services after completing treatment (Sledge et al, 1996).

Addiction treatment for adults who are also homeless is often intensive but time-limited (Kertesz et al., 2007). Goals set during the treatment period are often completed with the help of a myriad of referrals to other local community agencies in an attempt to provide holistic

assistance. The successful consumer may be able to secure steady employment and long-term housing begin to rebuild relationships, and find other sources of positive support in an effort to create a reliable recovery network in their community and continue abstinence (Kertesz et al., 2007).

Long-term residential programs who receive third-party funding are now being asked more to provide evidence that lengthy stays are more beneficial for certain populations and therefore justify continued funding (Greenfield et al., 2004). In some of the studies and outcomes presented, specific treatment services offered are not specified. Some other studies of addiction treatment have failed to show that one type of treatment is significantly better than others (Kertesz et al., 2007). Overall, there is limited research on such programs and an awareness of what components or factors influence success in these types of programs. This study focused on identifying outcome variables and thus has the potential to help in program development and research in clinical mental health.

Research Questions

The research questions for this program evaluation and study are:

1. What individual and program-specific factors are associated with successful completion of the Low Intensity Transitional Apartment Program at discharge?
2. What individual and program-specific variables are related to independent living and income outcomes after discharge from the Low Intensity Transitional Apartment Program at three months follow-up?
3. What individual program-specific variables are related to income outcomes after discharge from the Low Intensity Transitional Apartment Program at three months follow-up?

Definition of Terms

Aftercare Program – Aftercare participation is a continuation of existing services, notably group and individual counseling and self-help community participation. Each consumer's treatment file remains in active status for the first year after they leave residential treatment. This allows for an effective transition to a non-institutional lifestyle, while leaving supports in place to re-apply services as needed, such as a temporary return to supportive housing or a review of classes.

Community Placement – A participant having gained formal admittance into any program that has primary focus in addiction disorder treatment that does not include as a requisite in-patient care. In-patient care is defined as requiring the patient to remain in any given facility for more than 24 hours without the ability to leave by choice.

Consumer/Resident – For the purpose of this study, residents are determined to be persons formally admitted into a residential program with intent to remain in the facility for greater than 24 hours.

Co-occurring Disorder – Simultaneous presence of substance related and mental disorders. Co-occurring disorders are also commonly referred to as the following: dual diagnosis, dual disorders, comorbid disorder, coexisting disorders, mentally ill chemically dependent, and chemically addicted mentally ill. There is no indication as to whether the substance related disorder or other mental diagnosis is primary and whether one causes the other (American Society of Addiction Medicine, 2001).

Effectiveness – As measured by information obtained during the aftercare follow-up surveys (Appendix B) when compared with data obtained in the initial application (Appendix C).

Independent Living – Will be defined in this study based on the aftercare follow-up and results of the questionnaire (Appendix D) which focuses on quality of life (QOL) domains as defined by the Substance Abuse and Mental Health Services Administration. QOL domains include legal status, housing status, employment status, and ability to remain clean and sober.

Low Intensity Treatment – A level of treatment as defined by the Alabama Department of Mental Health. The program must offer at least five hours per week of clinical substance abuse services. This treatment focuses on continuing to apply recovery skills, avoiding relapse, improving social functioning, developing a support network, and reintegration in society (ADMH 2012). The standard program, as outlined in FSH policy, begins when the client moves into his/her apartment and ends when the client is discharged. Note: This is not necessarily when client leaves the program as clients could leave without having been discharged.

Medium Intensity Treatment – A structured environment with short-term residential services available for individuals diagnosed with chemical dependency. Twenty-four hour, awake staff must be available to supervise operations. People who receive services at this intensity have a level of addiction severity that clinicians have determined cannot be helped with out-patient therapy or other lower levels of treatment. Treatment at this level includes educational groups, therapeutic groups and one-on-one services (ADMH, 2012).

Severe Mental Illness – “A client is defined as having a severe mental illness when he or she has the following: a diagnosis of any non-organic psychosis; a duration of treatment of two years or more; dysfunction, as measured by the Global Assessment of Functioning (GAF) scale with a score of 50 or less” (Ruggeri et al., 2006).

Substance Dependence – A mental health diagnosis characterized by continued usage of alcohol or controlled substances despite the negative physical, mental, or environmental effects

following usage. Persons with this diagnosis often experience increased tolerance for the substance of choice and/or physical withdrawal systems when the utilized substance is not ingested. In addition, there is often a number of unsuccessful attempts to discontinue use although desire to discontinue use may be present.

CHAPTER II. REVIEW OF THE LITERATURE

Alcohol and drug dependence are defined by consumption patterns and associated consequences of use. In the United States alone, it has been estimated that over 18 million individuals who use alcohol for its effects need substance use treatment and that almost 5 million Americans using illicit drugs also need treatment. Of those, less than one-fourth actually receives the treatment needed (Horgan, Skwara, & Strickler, 2001). Individuals need more than a desire to receive assistance in order to get help with substance use. There continues to be a lack of available space in treatment centers as well as other barriers that cause issues for those seeking treatment (Zerger, 2002). Drug abuse and dependence is related to poverty, housing, employment, and healthcare issues (Shavelson, 2001). Literature that explores management issues, screening processes, and complications of mental illness in supported housing programs has been scarce, but as research on the subjects expand, researchers continue to debate which programs are most effective for certain populations and how practitioners can best prepare for the myriad of tribulations that accompany substance use (Laudet, 2011). Individuals who seek substance abuse treatment are rarely seeking that treatment merely to end the substance use, but they also seek to alleviate the negative consequences associated with the usage and to acquire the better life that abstinence may cultivate (Laudet, 2011).

Human services agencies often seeks to provide evidence-based practices, but commonly what is actually provided is a combination of services that each agency has decided works for their purposes (Bamberg, Chiswell, & Toumbourou, 2011; Gifford, Davies, Edwards, Griffin, &

Lybanon, 2007). For this reason, human services often review their service models and stay up-to-date on current research and evidence for best practice. Methods such as program evaluation and program explication are designed to assist programs with authenticating service components and testing assumptions concerning the intended benefits to clients of said services (Bamberg, Chiswell, & Toubourou, 2011).

Agencies that provide services for substance dependence work to help the people that they assist decrease their substance abuse and increase psychiatric wellness in the least restrictive environment and lowest level of care (McLellan, Woody, Luborsky, O'Brien, & Druley, 1983). While determining the lowest level of care is advantageous, those working in the agencies must also protect against under treating consumers. Placement in the correct level of care, providing adequate time for treatment, and combating other issues associated with addiction thus become a delicate and ever growing effort focused on various tools necessary for the individual rather than a strict set of rules for placement and treatment services (McLellan et al., 1983). Individuals who are matched to the correct level of care have had better 6-month outcomes than those who were not. Those who are correctly matched report being more motivated to complete treatment and tend to stay in treatment longer (McLellan et al., 1983).

However, meeting the challenges of these goals has been difficult due to the complexity of treatment for these issues (Day & Strang, 2011; Milby et al., 2000; Zerger, 2002). Changes in policy and funding for clinical mental health and substance abuse treatment programs have also significantly impacted efforts to produce measurable outcomes. One of those changes we have seen is the focus on community-based treatment which is less costly than inpatient care. However, there continues to be questions about whether this type of treatment is as effective as longer term inpatient care (Day & Strang, 2011; Segal & Burgess, 2008). Some have suggested

that inpatient care leads to longer and more successful outcomes noting that there are several benefits to this type of care including providing medical supervision and safety and relief from many relapse triggers (Gossop, 2003; Kleber, 1999; Weiss, 1999). However, others have suggested that community based care can be as successful as inpatient care (Day & Strang, 2011). These researchers write that community-based treatment settings require the addicted individual to manage everyday situations that they may have to confront once discharged and that this type of treatment may encourage better coping skills. Additionally, inpatient is significantly more expensive and consumers in inpatient care are unable to work, provide care for their families, or conduct daily business (Day & Strang, 2011; Gossop & Strang, 2000). This debate increases the need for additional examination of the dimensions and outcomes of community based substance dependence care.

Issues in Substance Addiction Treatment

In general, the goals of substance addiction treatment often include attempting to find ways of completely replacing the social cues associated with using alcohol or drugs and changing lifestyle conditions that contribute to addiction and mental distress (Gabbard, 2000; Ganzer & Ornstein, 2008). Mental distress may be the consequence of past abuse or other unfortunate life events. A consumer's mental distress may also be the result of current social and/or environmental factors that are affecting them during treatment (Gabbard, 2000). Moreover, there are different levels of treatment and placement modalities for substance-related disorders. Some of these are short-term, while others require longer periods of participation. Some levels of care provide housing while other outpatient forms of treatment are more helpful for consumers who have employment or family obligations to consider (Day & Strang, 2011; Ganzer & Ornstein, 2008; Gossop & Strang, 2000).

One consistent factor across all types of substance abuse treatment is that treatment and services provided must be appropriate for specific levels of addiction severity (Day & Strang, 2000; Segal & Burgess, 2008). Service providers are thus faced with providing appropriate interventions individually while understanding that there is no specific route to treatment success and continued abstinence. They must also understand that ultimately, relapse is a feature of substance addiction and all consumers served will not maintain life-long sobriety. One of the most challenging aspects of this process is understanding that some is program-specific and some is consumer specific (Reed, 2012). Specifically, it is generally believed that personal motivation towards recovery, rather than specific program interventions are most instrumental in creating positive outcomes and that lack of motivation will negatively affect retention (Zerger, 2002).

In addition to considering these dynamics it is also critical to consider how these services are provided. Inpatient treatment has not proven to be more effective than community based treatment. In a study completed by Segal and Burgess (2008) psychiatric patients who were initially placed in community treatment rather than inpatient, used inpatient care significantly less than patients who were not initially referred to community-based treatment. This study concluded that initiating mental health treatment in the community appeared to prevent hospitalization for patients who were at risk of repeated long-term psychiatric hospitalizations (Segal & Burgess, 2008). There is limited research on the evaluation of community-based treatment programs, especially those that treatment co-occurring disorders (Shutz et al., 2013). This helps identify the need to more fully understand the outcomes and benefits of community based programs.

The program examined in the proposed study is Fellowship House, Inc. This program has evolved over four decades to include multiple service delivery methods and to provide addictions services to consumers. Initially, the agency only provided addiction services to male alcoholics. At that time, the program was based solely on the principals of Alcoholics Anonymous. In the 1980s, the agency began providing service to men who were addicted to any drugs. In the 1990s, the agency began to allow women to receive addiction services. It is important when examining this type of community based program we compare both residential inpatient programs and community-based programs.

Residential Treatment Programs

Residential treatment programs offer structuralized substance abuse treatment service with a regimen that is individualized and planned for each consumer (Association of Addiction Medicine, 2001). This treatment is provided in a 24-hour setting where the consumer is housed. The treatment programs have demarcated policies and protocols for clinical staff to follow. One purpose of providing residential services is to create a clean and sober environment while also exhibiting a positive environment of recovery (Association of Addiction Medicine, 2001). There are commonly 12 step-meetings available at or near the residential site (Association of Addiction Medicine, 2001).

There are four levels of residential treatment as defined by the American Society of Addiction Medicine (ASAM) (2001). These levels include the following, listed in order from the least intensive to the most intensive setting: Clinically Managed Low-Intensity Residential Treatment, Clinically Managed Medium-Intensity Residential Treatment, Clinically Managed High-Intensity Residential Treatment, and Medically Monitored Inpatient Treatment. Fellowship House, Inc. provides two of these levels of care: Clinically Managed Low-Intensity

Residential Treatment, and Clinically Managed Medium-Intensity Residential. Many individuals requiring residential treatment may also have continued problems with repeated relapse, optimal recovery environments, and readiness to change (ASAM, 2001).

Low Intensity/Community-Based Residential

Clinically Managed Low-Intensity Residential Service programs, also known as community based treatment, provide at least 5 hours of clinical services for consumers weekly. At the time that an individual is participating in low-intensity services, they have usually previously completed a higher level of treatment (ASAM, 2001). Treatment at this level is more focused on maintaining sobriety, applying skills learned in higher levels of care, improving daily functioning, and assimilating into healthy relational, educational, employment, and social environments. This level of care must be staffed 24 hours a day in order to provide ongoing support and reduce the occurrence of drug or alcohol usage. This level of care is typically a community-based service with residents and staff resolving issues in group meetings. In general, receiving services in a low-intensity residential program provides individuals with substance dependence the opportunity to practice new recovery skills and prepare to live completely independently (ASAM, 2001).

Low-intensity residential services are also appropriate for individuals who would otherwise succeed with intensive outpatient services, but lack an appropriate environment for recovery in which to live. Their current living arrangement may not promote abstinence or may present social stressors that create the desire to use alcohol or drugs as a coping strategy. Application of recovery skills and coping mechanisms are therefore consistently stressed throughout time spent in this treatment level. Clinically Managed Low-Intensity Services do not

include boarding houses, group homes, or sober houses where treatment services are not being provided on site (ASAM, 2001).

Low intensity service programs tend to have less positive outcomes for individuals with substance abuse and psychiatric disorders than treatment programs with higher service intensity dependent upon the nature of the consumer's substance use severity and overall mental deficit (Andrassy & Moos, 2001). Programs with inadequate intensity do not provide sufficient services and consumers subsequently relapse and/or decompensate (Andrassy & Moos, 2001; Test & Stein, 2000). Conversely, service intensive programs may foster dependence for consumers who are higher functioning (Timko, Nguyen, Williford, & Moos, 1993). They tend to rely more heavily on health care and develop some level of institutionalization. This reliance on institutions is due to a lack of control, and responsibility, along with an abundance of structure (Timko et al., 1993).

Studies have shown repeatedly that inpatient services are most appropriate for individuals with the most severe substance abuse and least level of functioning. In treatment programs with higher intensity, these consumers have reported higher levels of satisfaction and less boredom in the program, whereas people in high intensity programs who are higher functioning have reported lower levels of satisfaction along with high levels of boredom and more withdrawal when in the program (Thornton, Gottheil, Weinstein, & Karachsky, 1998). These studies have supported the assertion that the most severe consumers with co-occurring disorders have less substance use during and after having received substance abuse treatment in a high intensity program (Thornton et al., 1998).

Consumers who are matched to high intensity or inpatient treatment services are consumers with pronounced psychiatric symptoms (Chen, Barnett, Sempel, & Timko, 2006).

They have histories of recurrent psychiatric episodes, with or without the presence of substance usage. The severities of their problems also include problems with employment, family, and other social issues (Chen et al., 2006; Day & Strang, 2011; Test & Stein, 2000). This group may be able to utilize a lower level of care once they have received the assistance that they need in higher intensity treatment and are later reassessed and matched to a lower level of care (Chen et al., 2006).

Community-based treatment programs place their efforts on resocializing consumers and using the community as an agent for change. They see consumers with substance addiction as people with social deficits and that these deficits must be corrected through the use of structured group-living environments, self-help meetings, and a clean living environment (Day & Strang, 2011; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). There is an association with longer exposure to treatment in a therapeutic community and greater reductions in drug use. In order for there to be a benefit from the community-based treatment, the duration of treatment must last from 50 days to more than a year (Kertesz et al., 2009). When working with consumers with dual-diagnoses, staff members have to modify their approach with lowered structure and social demands partnered with greater social assistance (Deleon et al., 2000).

Medium-Intensity Residential

Consumers with moderate severity are those who have substantial symptoms without recurrent and pervasive history of psychiatric episodes. They are commonly matched to agencies that provide medium-intensity residential services (ASAM, 2001; Merckx et al., 2006). Residents in this category present with substance-related disorders that have caused an amount of impairment so great that it is determined that the individual is not appropriate for outpatient services and that outpatient services would not suffice in deterring substance usage. There is

often a cognitive or other functional deficit in a medium-intensity residential consumer and this deficit may be temporary or permanent (ASAM, 2001).

Clinicians working in this level of care should be prepared to work with individuals who have traumatic brain injuries, have mental retardation, or cognitive deficits related to age. In addition, many consumers who enter into medium-intensity residential programs are experiencing their first treatment attempt (Kertesz et al., 2009). Therefore, information about recovery, social factors and science of addiction, genetic components, and 12-step programs may be completely new information for them. They may present with a lack of awareness about their substance abuse problem and the effects that it has had or is having on their life (Merkx et al., 2007; Segal & Burgess, 2008). Medium-intensity residential services are design to heighten their readiness to change (ASAM, 2001).

Clinically Managed Medium-Intensity Residential Services also provide a structured recovery environment with clinical services at a higher rate than in low-intensity residential programs (ASAM, 2001). The services are provided repetitively in order to assist consumers with consolidating information and to adjust for cognitive deficits (Kuerbis & Sacco, 2013; ASAM 2001). The programs allow time for special needs to be assessed and assisted with and the consumer must be involved in constructing their individual continuing care plan. Each program is to have nursing supervision and trained staff available to meet the medical needs of consumers. Medium-intensity residential programs are designed to help with general medical conditions. In addition, services such as vocational rehabilitation, case management, transportation, and housing placement are also frequently provided (ASAM, 2001; Milby, Schumacher, McNamara, et al., 2000).

Long-term Treatment

In 1993, the Center for Substance Abuse Treatment (CSAT) began a National Treatment Improvement Evaluation Study on long-term residential treatment programs. In this study, CSAT (1993) defined long-term residential treatment as being treatment for substance use disorders with treatment lasting three or more months (Gerstein & Johnson, 2000). The National Institute on Drug Abuse Treatment Outcomes Study (DATOS, 2000) defined the length of stay for long-term treatment as six months or more (Grella, Joshi, & Hser, 2000). Within these programs a consumer's length-of-stay is commonly determined by a number of factors. One such factor is the specific policies of the programs related to consumers, outcomes, and requirements for treatment. For example, programs often limit the amount of time that their consumers are able to remain in their programs (Greenfield et al., 2004; Kertesz et al., 2007). If there is a third-party payee such as an insurance company or other funding contract, there may also be limits on the amount of time that the payee will fund treatment. Individual variables may also influence treatment program outcomes and success (Greenfield et al., 2004). Consumers may grow weary of living in structured or communal environments or they incorrectly believe that they have received as much assistance as they need and discontinue treatment before they are truly prepared to address their addiction independently.

In addition to the factor of length-of-stay, treatment completion has been identified as a contributing factor to continued success post-treatment. Completion of treatment is defined as identifying and successfully implementing all treatment goals before leaving treatment or being discharged for disciplinary reasons (Greenfield et al., 2004). In the Greenfield et al. (2004) study, the difference between those who completed treatment and those who did not complete treatment for the group that participated for 1 to 90 days was not significantly different.

However, for the sample that participated in treatment for 91–181 days the differences were evident. Those who were unsuccessful in completing treatment had worse outcomes when compared to those who had completed their treatment plans. Consumers who completed their treatment plans and spent more than 90 days in treatment had an extremely high abstinence rate in general. Follow-up intervals did not prove to be an important factor of influence for post-treatment abstinence either.

Transitional Housing and Planning

One of the most important components of community-based substance abuse treatment, or aftercare, from more intense inpatient care is consideration of housing (Milby et al., 2009; Schutz et al., 2013). In community-based programs this is often a fundamentally critical aspect of treatment since a large number of persons in treatment struggle with independence, including self-sustaining housing (Cousins et al., 2012). The purpose of transitional housing is to increase consumer readiness for permanent housing by providing substance abuse treatment and assuring that other mental health needs have been addressed while preparing consumers to live independently. Encouraging sobriety and psychiatric treatment are considered as pertinent for permanent housing to be achieved and maintained (Tsemberis, Gulcurm & Nakae, 2004). These programs often combine shelter and social services with the intention of helping these individuals move from dependence on agencies and institutions to independence and make the homeless individual “housing ready” (Dordick, 2002).

In Dordick’s (2002) evaluation of a transitional housing program for substance abuse, there was unanimity among both the residents and the staff of that residents’ homelessness was a contributing factor in their substance abuse behavior and successful treatment required addressing their homeless status. Specifically, recovery was crucial to housing readiness and

housing was crucial to maintaining sobriety. Moreover, this program stressed that the “quality of sobriety,” which is a subjective measurement, is more important than the number of months clean and sober (Dordick, 2002).

A person who is housing ready will not only be able to afford permanent shelter but would be able to maintain a home (Milby et al., 2000). When in active addiction, money is often spent on drugs rather than housing necessities. Employment may also be lost or inconsistent because of behaviors exhibited when in active addiction (Milby et al., 2010). Sufficient income to secure housing may include a security deposit, down payment, utility fees and the first month’s rent. For this reason, federal housing initiatives began to place more emphasis on addressing individual pathologies and life events as well as the current housing market (Dordick, 2002; Milby et al., 2010). There is then a need for those who have substance addiction and/or other mental illnesses to gain control of their issues in order to achieve housing readiness (Dordick, 2002).

The United States Department of Housing and Urban Development (HUD) has mentioned reinforcing traditional values by rewarding people who work hard and encouraging family stability by assisting them with attaining structure and self-control (HUD, 1994). Therefore, therapy is being stressed more than simple housing placement. Governmental policymakers have migrated towards the idea of housing that is both affordable and supportive that offer families and individuals the opportunity to take advantage of services that may assist them with bettering themselves and their situations (Dordick, 2002). Transitional housing is designed to be a safe place to live with mental health, skills training, education, substance abuse, and HIV services accessible on-site or nearby (HUD, 1994). This housing should also encourage individual residents to be responsible and motivated as they make progress towards

demonstrating self-sufficiency. Additional governmental funding for transitional housing has come from the Department of Transitional Housing which was formerly the Department of Welfare (Dordick, 2002).

During the period in transitional housing, the previously homeless person should begin to demonstrate the ability to live autonomously and be liberated from institutional living (Kertesz et al., 2009). Sober transitional housing is alcohol- and drug-free housing where people who may be newly clean and sober are able to prepare themselves to transition back into their communities while having the safety of knowing that there will not be alcohol or drug temptations in their living environment (Day & Strange, 2011; Milby et al., 2000; Zerger, 2002). There has been greater appreciation for the development of long-term housing as a part of recovery from alcohol and drug issues by people who are classified as low-income or homeless. Transitional housing programs and planning should relieve suffering through the deliverance of case management placement services (Dordick, 2002).

Transitional housing is at the position in between living on the streets and living independently. It is to be the final stop before permanent housing, eliminating dependence on drugs, social agencies, family members, and anything else (Dordick, 2002). The residents are to learn through the transitional process to make enhanced choices for themselves and have a better quality of sobriety (Dordick, 2002). Overall, once we understand that housing is a critical aspect of successful community-based care it becomes imperative to understand the consumer, program and placement factors that might influence program success in these areas (Dordick, 2002; Milby et al. 2010).

Factors Influencing Success in Community-Based Substance Abuse Treatment

Homelessness

Homelessness is an age-old problem and the government has spent many decades changing policies, reallocating money, and conducting research in an effort to alleviate this issue (Kertesz et al., 2009). There is a strong relationship between substance addiction and homelessness and although one does not necessarily cause the other, there has been clear evidence showing that substance usage can often be the source or consequence of homelessness. Housing is an essential security need. The chronically homeless are characterized by their inability to secure or maintain steady housing. Although many factors may contribute to homelessness, the presence of substance abuse and dependence has commonly proven to be contributing factors (Kertesz et al., 2009; Milby et al., 2000; Tsemberis et al., 2004).

Residential addiction treatment programs serve as a main referral source for housing and other needed services in many communities with large amounts of homelessness (Kertesz, et al., 2007). In addition, this homeless population is frequently unable to gain access to many housing programs due to the existence of other conditions, most commonly psychiatric conditions or substance abuse (Kertesz et al., 2007; Kuhn & Culhane, 1998). Many housing programs are not prepared to assist consumers with co-occurring disorders and this may result in a sense of loss of control when an individual is evicted from housing. It is also difficult to engage people in long-term treatment or continuing care when stability and sustainability is nonexistent (Zerger, 2002).

Homelessness frequently presents a number of complex issues that the homeless individual considers as more of a priority than treatment for substance usage. Whereas providers may ruminate over ways to help the consumer achieve simple abstinence in treatment and make this a priority for the consumer, basic needs often must be addressed before a homeless consumer

is willing to begin considering long-term ways of managing alcohol or substance abuse (Zerger, 2002). Those with substance dependence sometimes find it difficult to be motivated for or focus on discontinuing drug use when basic needs, such as housing, are not met. Consequently, for the homeless, need for substance abuse treatment is often very low on their priority list.

Zerger (2002) reported that when homeless individuals were asked to list the three things that they need the most 42% of homeless individuals stated that they needed help finding a job, 38% stated that they need help with finding affordable housing, and 30% requested assistance with paying bills and other expenses that would assist in acquiring permanent housing. In addition, when asked what they identified as the most important factor in their life that was keeping them homeless 30% listed lack of income, 24% listed lack of employment, and 11% listed lack of affordable housing (Zerger, 2002). Ultimately, the need for safety, nourishment, and shelter outrank the need for treatment which may account for the higher percentage of premature exits from nonresidential programs as compared to residential programs (Zerger, 2002).

Data from the National Survey of Homeless Assistance Providers and Consumers (NSHAPC, 2013) reported that over 80 percent of homeless individuals at the time of the survey had been struggling with alcohol and/or drug-related disorders. Paralleling these findings, the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that about 58 percent of the United States homeless populations have co-occurring substance use disorders (SAMHSA, 2011). Of the 58 percent of homeless adults in their national survey data who reported having a history of substance abuse and addiction, only 17 percent reported having received inpatient or residential treatment for their abuse and addiction. Retention of homeless individuals has proven to be a problem in other treatment programs. In 1999, fourteen substance

abuse treatment programs were funded by the National Institute on Alcohol Abuse and Alcoholism Cooperative Agreement Program to specifically serve homeless individuals. Each treatment program reported that approximately two-thirds of their consumers left prematurely. When homeless consumers leave treatment, they not only fail at remaining clean, but also tend to return to unhealthy environments where they are subject to acquiring various health issues including sexually transmitted infections (Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999).

Similarly, Tsemberis, Gulcur, and Nakae (2004) noted that there is a disconnect between substance abuse treatment services used in housing programs that require abstinence and the level of drug use that continues to be a factor in residents' dismissal from certain program. They suggest that some individuals may actually be using treatment facilities as a means of housing. Residential facilities provide not only treatment services, but food, shelter, and access to getting other basic needs met. Homelessness and addiction are often accompanied by additional mental illnesses. People with this combination of unfortunate circumstances tend to present a difficult challenge for government policy makers, physical health care providers, and mental health service providers (Kertesz et al., 2007). For programs designed to assist with homelessness only, substance abuse at program entry increased the likelihood of repeat homelessness by 21 percent for those who used drugs but were not addicted, 26 percent for those categorized as alcoholics but have no issues with drugs, and 63 percent for those with both alcohol and drug dependence (Kertesz, 2009). Not only does substance use lead to loss of housing, but many landlords refuse to house tenants who have a known history of addiction.

Homelessness in Birmingham. The Fellowship program operates in Birmingham Alabama. Since it has been established that homelessness and housing status are such critical components to addressing substance abuse in community-based programs, it is necessary to

examine this issue within this community. Birmingham, Alabama is one of 222 communities nationally that announced in August, 2006 they would be a part of a 10-year planning process dedicated to decreasing homelessness and ending chronic homelessness. Policymakers in the state and city have acknowledged the effects of substance use and addiction on this population, their children, and the community as a whole (Milby et al., 2009). Birmingham Health Care launched a project intended to gather more information on the proportion of individuals in the community who presented with a combination of homelessness, cocaine-dependence, and psychiatric distress (Milby et al., 2009). Birmingham Health Care is a non-profit community health center that provides physical health, behavioral health, dental health, and pharmaceutical services to Birmingham residents regardless of ability to pay (Birmingham Health Care, 2013). As part of this initiative, the center provided a sample of Birmingham's homeless and substance addicted population with six months of addiction treatment utilizing behaviorally-oriented, evidence-based practices. This treatment included psycho-educational groups, work therapy, individual counseling, drug testing, and treatment planning and review. All participants were also provided with case management and job skills classes; however, some participants were provided with abstinence-contingent housing, others with non-abstinence-contingent housing, and the others received no housing. Once six months of treatment was completed, six months of aftercare group and individual counseling remained available for program participants (Kertesz et al., 2007).

The data from this trial suggested that one-year housing and employment outcomes for homeless adults who received behavioral treatment paired with housing were improved by 60 percent whether or not that housing was abstinence-contingent. Researchers also suggested that if this pattern is similar in larger studies, that the percentage of male consumers with stable

employment could double at the one year mark and 12 percent more consumers should be able to attain stable housing at that one year mark. For the treatment group that was not provided with housing, only 34 percent attained sufficient housing and employment after one year. This low level of achievement was regardless of whether the participant held a high level of attendance and participation in treatment (Kertesz et al., 2007).

The Kertesz et al. (2007) study therefore suggests that the inclusion of substance abuse treatment in housing initiatives may be a way to decrease homelessness. Programs that provide only housing and intensive case management have increased outcomes for stable housing, but fail to reduce substance use (Milby et al., 2005). Contingency management techniques and goal attainment have documented efficiency in relation to treatment of substance addiction (Milby et al., 2000). There are a number of issues that lead to homelessness. In Birmingham, Alabama, there are different paths to rehabilitation available in the community, but fewer pathways to assistance with the possible causes of individual addiction or homelessness. Much of homelessness is the result of loss of employment. Persons with drug usage may have also lost the support of family, friends, and government benefits as a result of drug and alcohol usage (Burt et al., 2001). The community's mentally ill may be seen as a burden on their family members and the community.

In Birmingham, Shelter Plus Care is a common means of housing for the area homeless. This program is a federally funded initiative in many metropolitan areas in the United States. The required period of abstinence for assistance through this program in Birmingham was initially three months of continuous abstinence and was later increased to six months. This time period is congruent with many other Shelter Plus Care programs in the nation. Unfortunately, many homeless individuals who are also substance dependent or have co-occurring disorders

find it extremely difficult to achieve this continued abstinence without the presence of housing and treatment. For this reason, they are likely ineligible for this resource, and therefore, homelessness in this city is not eradicated sufficiently through the help of this program (Kertsez et al., 2007).

There have been four different research analyses completed with the Birmingham model. This model utilizes behavioral analysis and incentives. The developers of this approach consider substance abuse to be a learned behavior and that although said usage is harmful, it is continued because of the rewards such as feelings of euphoria, numbness, or other desired physical sensations (Prendergast et al., 2006). This model offers community reinforcement such as social, vocational, and recreational opportunities as long as sobriety is maintained. In the event of a relapse, the opportunities are removed. In theory, long-term abstinence has the potential to result in rewards once independence or semi-independence is achieved. These rewards may include employment, housing, and relationships (Milby et al, 2008). The fourth Birmingham trial concluded that people with longer periods of abstinence achieved had stable housing for at least a year after the end of treatment. Specifically, the successful consumers had twenty-eight or more weeks of sobriety, but treatment does not always lead to housing (Milby et al., 2010).

Addiction Severity and Co-Occurring Disorders

Addiction Severity

In general, studies have shown that in general, prevalence of more severe substance use and psychiatric disorders are a predication of worse substance use treatment outcomes (Karper et al., 2008; Moos & Moos, 2006; Tsemberis et al., 2004). Fewer psychiatric symptoms predict greater outcomes and increased improvements in substance use disorders when the consumers are in residential substance abuse programs. Those who report more severe substance use have

better responses to treatment when that treatment is in a residential setting. They tend to thrive in the structure provided in more intensive treatment settings (Moos & Moos, 2006).

Greater severity of substance use is associated with “hitting bottom” where the individual with addiction has essentially lost the majority of positive factors in their life, including but not limited to relationships, housing, possessions, employment, and finances (Tiet, Ilgen, Byrnes, Harris, & Finney, 2007). This leads to greater social pressure from loved ones, legal entities, and others. Said pressure may provide motivation to attempt and successfully complete treatment. Most severe consumers show greater improvement in residential or inpatient treatment facilities as opposed to intensive outpatient facilities because the most severe consumers are able to improve when greater structure is provided initially. Consumers who are appropriately matched to the level of care are provided with the complementary structure to assist with conquering the initial cravings and anxiety surrounding beginning substance abuse treatment (Tiet et al., 2007).

No single treatment is appropriate for all addicts (National Institute on Drug Abuse (NIDA), 2012). Due to the ease of access to many opiate drugs legally and illegally, paired with their extremely addictive nature, treatment providers have found a need to develop and utilize new techniques for combating this particular type of addiction (Dickerson, 2013; Hammett, Roberts, & Kennedy, 2001). Medication can assist with weakening drug cravings and establishing normal brain functioning during detox (NIDA, 2012). In residential treatment settings, medications may be monitored and medication management may be taught. This type of integrative treatment may prove to be more effective for those with the most severe addictions (Dickerson, 2013; Hammett, Roberts, & Kennedy, 2001).

Co-Occurring Disorders

Consumers that are considered to have co-occurring disorders are those who are typically diagnosed with alcohol or drug dependence and a co-presenting serious mental illness such as bipolar disorder, major depressive disorder, or schizophrenia (Hides, Samet, & Lubman, 2012). A cycle of institutionalism commonly plays out for this population in hospitals, jails, shelters, prisons, and a variety of treatment centers (Hayes et al., 2003). The increase in the number of consumers with co-occurring disorders has presented a challenge to health care systems (Hayes et al., 2003). Researchers have suggested that 10 to 20 percent of the United States homeless population is comprised of individuals with co-occurring substance use and severe mental illnesses (Zerger, 2002). Availability of services for co-occurring disorders has also decreased as a result of efforts to reduce consumer time spent in residential and inpatient treatment centers and to place consumers in less restrictive environments. Moreover, it has been suggested that many consumers in this population do not benefit from more intensive services; therefore, providing intensive services to them can increase their reliance on institutions and agencies rather than fostering independence (Chen, Barnett, Sempel, & Timko, 2006).

Often any therapeutic response to these issues and this population is limited to addiction treatment or mental health treatment, rather than an integrated plan to address the whole person (Hide et al., 2012). The goal of treatment centers that provide services for co-occurring disorders should be to empower this population to live as independently as possible, with freedom from reliance on institutions (Hide et al., 2012; Schutz et al., 2013). Consumers with co-occurring disorders have a higher rate of relapse, greater social impairment, and a higher rate of suicidal behavior. Researchers debate whether or not much of the non-substance related diagnoses are substance induced or if many consumers with mental illnesses commonly attempt to self-

medicate (Hide et al., 2012). Males appear to report a higher rate alcohol and drug-related problems as their primary issue while women tend to report mental illness as theirs (Zerger, 2002). However, overall there are indications that we may not be adequately addressing the overall needs of this population (Karper et al., 2012; Kertesz et al., 2009).

Individuals with co-occurring disorders that include mental disorders such as schizophrenia and mood disorders accompanied by psychotic feature are classified as having high severity, while those with mood and anxiety disorders without the presence of psychotic features or personality disorders are classified as having moderate severity (ASAM, 2012; Karper et al., 2012). Those with moderate severity disorders are often able to be treated with the help of treatment programs that primarily cater to the substance disorders only (ASAM, 2012). People with high severity disorders are best treated in treatment programs that specialize in assisting individuals with dual-disorders. Treatment agencies with co-occurring specialization integrate addiction treatment with mental health treatment and assist with stabilizing psychiatric symptoms so that the consumer can better participate in addiction programs. This stabilization may include partnerships with or referrals to psychiatric services outside of the treatment program and coordinating and facilitating care with psychiatric service providers (ASAM, 2012).

When considering these issues it is important to note that housing issues further complicate the process of working with this population. Tsemberis, Gulcur, and Nakae (2004) indicated that contrary to previous assumptions that individuals with co-occurring disorders can be in independent housing. They cite findings related to the Housing First model used in New York City. The participants in this study were able to keep their apartments clean, and bills paid with moderate assistance from case managers and counselors. These residents were allowed greater levels of autonomy and were not evicted when relapse occurred. This approach

combined dual diagnosis treatment with a harm-reduction approach. The harm-reduction approach maintains that although a person with substance addiction may utilize drugs periodically, success is still achieved if they have decreased other harmful behaviors such as committing crimes, participating in risky sexual behaviors, or any other seemingly negative activities (Cherner, Nandlal, Ecker, Aubry, & Petty, 2013; Tsemberis et al., 2004). The harm-reduction approach in the Housing First program positively affected residential stability and there was not an increase in substance use or psychiatric symptoms. Consumers with high psychiatric symptoms may be motivated by their desire for less distress to decrease substance use and address it in treatment (McKellar, Harris, & Moos, 2006).

Legal Involvement

People with substance use disorders do not always have the option of going to treatment. Often times, the results of their addictions have placed them in jail or other institutions (Zerger, 2002). The Alabama Department of Corrections reported in 2008 that drug offenders accounted for close to 34 percent of the 11,729 inmates who served time in the Alabama prison system (Birmingham News, 2012). Drug related offenses included sale of, distribution of, intoxication by, and possession of drugs or drug paraphernalia. This 34 percent did not account for addicted individuals who were incarcerated for robbery, prostitution, and other crimes that were committed to support their addiction. In 2005, 73 percent of inmates in United States prison systems reported that they used drugs regularly before being incarcerated. It is also recorded that at that time, 50 percent of the inmates arrested in that year were intoxicated during the time that they committed their crime (Petersilia, 2005).

In order to cut down on the number of drug offenders in Alabama's prisons, drug courts have been established to get these offenders into drug rehabilitation programs. The more willing

and non-violent offenders also go through a program that includes supervision by a case manager and regular drug testing. If the offenders remain drug free for at least a year, their charges are dropped. There are currently 60 drug courts in 57 counties in Alabama (Alabama Judicial System, 2012).

Due to the rise in people with addictions in the prison system, programs have and are being placed in prisons to provide addiction education and rehabilitation for prisoners while they serve their time. There are specialized Alcoholics Anonymous meetings in prisons, but prison systems are beginning to move more towards individualized treatment and utilization of evidence-based practices in correctional institutions. Cognitive behavioral therapy is being used to enhance the therapeutic community (Pelissier et al., 2001). Therapeutic communities have a holistic view of substance abuse considering issues of conduct, personality, moral values and emotional management. Goals include creating a lifestyle change that eradicates undesirable behaviors and stimulates value in being clean and sober (Rawlings & Yates, 2001).

In the Tsemberis, Gulcur and Nakae (2004) study, the number of prior arrests at baseline also served as a predictor for greater improvement in substance abuse problems. They found an 80% retention rate and reported that consumers felt that the sense of having a choice was a motivating factor to maintain sobriety. In addition, the National Institute on Drug Abuse has stated that it is not necessary for treatment to be voluntary in order for it to be effective (National Institute for Drug Abuse, 2000). Therefore, many criminal offenders may be better rehabilitated in a setting designed to address their substance usage than in a jail or prison setting. Substance use treatment is also significantly less expensive than jails and prisons (Zerger, 2002).

Social Connectedness

Disaffiliation is frequently an issue that alcoholics and addicts face. When in active addiction, an individual may steal from their friends and family, begin to avoid those friends and family and exhibit behaviors when in social settings that may cause others to avoid being around them. Losing these bonds may decrease motivation for participating in treatment and compliance with treatment and may also contribute to emotional distress (Zerger, 2002). Social support is associated with positive outcomes in treatment and reduction in drug and alcohol use after treatment. This support includes drug and alcohol recovery support as well as support from family and friends (Lamberti et al., 2001; McCrady, 2004).

Counselors will often encourage their consumers to process the actions that they completed and activities they participated in while in active addiction and recognize the role that they have played in diminishing personal bonds and contributing to mistrust (Dordick, 2002). As a part of the recovery process they may also begin to repair those relationships and not rely on family for monetary assistance. Although social connectedness can be considered, it may not be a required resource for stable living. Reliance on friends and family keep consumers in a state of dependence and vulnerability (Dordick, 2002). However, for consumers who have romantic partners, those whose partners do not have substance use disorders and who have social networks of friends who are not heavy drinkers and drug users are better able to maintain abstinence after treatment (Mohr, Averno, & Kenny, 2001). Partnership status as well as relationship stability and quality increase the existence of continued sobriety following substance abuse treatment (Tracy, Kelly, & Moos, 2005).

For women specifically, family and childcare are prioritized above employment. Women who enter treatment often have the presence of child protective services cases in addition to other

legal issues. Many of these cases are the result of neglect or perceived neglect on the part of the mother when under the influence of substances (Greenfield et al., 2004). Adults who are using drugs or alcohol diminish their ability to care for children, and money designated for bill payment is often spent of supporting a drug habit in this population.

An applicable component of substance use treatment is the replacement of drug related activities with new social undertakings. Drug related activities may include selling drugs, going to certain parties, prostituting, and being surrounded by others who are using. The individual must create new opportunities and behavioral reinforcements as a means of avoiding relapse triggers (Kertesz, et al, 2007). Peer support was developed as a part of the social model of drug treatment in order to show consumers examples of clean and sober living. Peer Support Specialists are individuals who are in recovery and who remain connected to various 12 step meetings and participants. Peer support and Alcoholics Anonymous are both noted as valuable in the medical model of treatment. The role of these Peer Support Specialists also includes engaging the newly clean and sober individual in a manner in which they may be better able to relate and more willing to respond to (Zerger, 2002). They rely more on their personal experience as a recovering addict rather than on the professional training that counselors or social workers may use to guide their practice (Dordick, 2002).

In considering the importance of social connectedness in treatment and success after treatment, Laffaye, McKeller, Ilgen, and Moos (2008) stated that there are three social network variables that significantly correlate with each other. These variables are friends' substance diagnoses, friends' current drug use, and friends' support for quitting. When the factors were grouped together as "social network substance use status", the grouped factor correlated significantly with the individuals' adherence to the philosophy of Alcoholics Anonymous (AA).

These participants tended to have a greater number of friends in AA, kept an AA sponsor, and attended more AA activities. Overall changes in social network support from negative peers to positive peers, whether in AA or otherwise, extend long-term outcomes for those with substance use disorders (Connors, Tonigan, & Miller, 2001).

Alcoholics Anonymous. The perspective of Alcoholics Anonymous is that recovery from addiction is a never ending process and can never be cured. Years of research has indicated repeatedly that involvement with Alcoholic Anonymous and participation in other 12 step programs, such as Narcotics Anonymous and Cocaine Anonymous, produce better outcomes for substance abuse treatment (Moos & Moos, 2007). Participation in AA includes attending meetings and having an AA sponsor. A sponsor is an individual who also deals with addiction and has a significant amount of time clean and sober. AA participants' sponsors serve as a source of support from someone who relates to the individual and is able to share their own experiences while encouraging their sponsoree to remain clean and sober. In a longitudinal study by Moos and Moss (2007), individuals who participated in AA were more like to remain involved and continue to be successful at 1 year and 16 year follow-ups when compared to individuals who only received treatment in the first year and did not continue participation in AA. Amongst attendance in groups, acceptance of the 12-step philosophy and completion of those 12 steps has been shown to increase abstinence independently of regular meeting attendance (Weiss et al., 2005)

Laffaye et al. (2008) indicate three aspects of coping related to sustained abstinence. The first is counter conditioning which includes substituting the substance usage with healthy behaviors. AA members and participants who are more involved in AA are more liable to have developed and depend upon coping strategies to lessen substance use (Laffaye et al., 2008). The

second, self-re-evaluation, involves having a positive self-view and deciding that substance use is no longer consistent with one's positive self-view. The third is stimulus control. People with substance dependence are taught to identify triggers or people, places and things that bring about the urge to drink or use drugs. Stimulus control involves removing those factor that trigger drug and alcohol usage and adding reminders for abstinence (Laffaye et al., 2008).

Continuum of Care

Currently, Fellowship House, Inc. follows a Continuum of Care model. The term 'Continuum of Care' is often used to describe linear programs. Linear approaches have theoretical foundations that typically use theories of human behavior change. These programs adopt the idea that behavioral self-regulation must be restored, along with acquiring a constructive social environment and tangible resources before long-term, stable housing can be achieved. There must first be evidence that the individual is engaged in recovery (Zerger, 2002). This service delivery model is designed to address multiple needs of the homeless population including substance abuse and mental illness. The Continuum of Care begins with outreach. Fellowship House's pre-treatment program includes a component where staff provides case management and educational group services in various homeless shelters in Birmingham, Alabama. In these groups, participants are given information about the scientific components of substance addiction services available for treatment and prevention.

Psychiatric rehabilitation studies have indicated that it is more effective to teach skills required for survival within that environment. This is the purpose for community placement in the continuum of care (Tsemberis et al., 2004). The Fellowship House Low-Intensity program is in an apartment complex in the community rather than in a building connected to administrative

services. This allows for the residents to become accustomed to maintaining their future living space and experiencing community issues while continuing clinical support nearby.

Continuum of Care housing programs endorse the abstinence-based sobriety model, meaning that consumers must maintain clean drug and alcohol screenings. The model maintains that without abstinence and adherence to treatment, stable housing is not possible. Furthermore, having housing may serve as a motivating factor for maintaining abstinence and sobriety or motivate residents to address addiction if the idea was not previously considered (Tsemberis et al., 2004). Many programs that follow the Continuum of Care model have rules that restrict some consumer choices. In these programs, when rules are violated, it may serve as a reason for discharge. For this reason, individuals who are a part of Continuum of Care models statistically utilize treatment services more than individuals who receive housing through programs utilizing other models.

The United States Department of Housing and Urban Development has given grant funding to non-profits who could readily provide housing and social services in an integrated manner while also to connecting consumers to other community resources. The purpose of using non-profits is also to localize services (Housing and Urban Development, 1995). Ultimately, anyone involved with a continuum of care should move through a system beginning with outreach and assessment. Once assessed, emergency shelter may be obtained if necessary. Next, available and relevant transitional housing where supportive services are available would be maintained for up to two years while the consumer actively budgets and plans for the future. Lastly, permanent and stable housing should be achieved (Dordick, 2002). Even the independent living still may involve participating in subsidized housing programs such as Section Eight.

Program Evaluation

Need for Evaluation

Program evaluation is critical in programs that serve people with a myriad of unique issues especially in the case where funds are provided by government funding and other third party payees (Bloom, 2010; Kirsh, Krupa, Horgan, & Carr, 2005; Reed, 2012). There is a need to gather information on the effectiveness of programs that serve human subjects in an effort to determine whether or not funding is reducing their need for hospital commitment (Bloom, 2010). In Alabama there has been an increasing need for community placement for people with substance addiction in mental illness (Alabama Department of Mental health [ADMH], 2012). Programs must now be evaluated how the methods that they currently use are working and what aspects, if any, they may need to adjust in order to create a program that better fits consumer needs and the overall objectives of individual programs (Bloom, 2010).

Due to the expense of housing and rehabilitating criminals with documented mental illnesses and substance dependence, the Alabama Department of Mental Health (ADMH, 2012) has been advocating for alternative sentences and forms of treatment. The assumption is that people with substance dependence and mental illnesses would benefit more from treatment in the community than from a jail or prison sentence. The de-institutionalization movement has also played a part in the state of Alabama seeking more opportunities for community placement and resources for people with mental illnesses. In 2011, the then Mental Health Commissioner of the State of Alabama unveiled a plan to close three of the four largest psychiatric hospitals in Alabama. This movement has been linked to the Wyatt “right to treatment” litigation (ADMH, 2012). As a result of this litigation the ADMH Division of Mental Health and Substance Abuse was required to reduce institutionalization levels and increase community options for housing.

The Department determined that these community options, including Fellowship House, Inc., were less costly but more efficient (ADMH, 2012). In 1971, Bryce Psychiatric Hospital housed more than 5000 patients and in 2012 that number dropped to less than 240 (ADMH, 2012). Although there has been a significant decrease in patients in mental health hospitals since 1955, the number of readmissions to mental health hospitals has increased (Test & Stein, 2000).

The Olmstead decision in 1999 held that unjustified containment of people with disabilities constitutes as discrimination and the U.S. Supreme Court mandated that public entities must provide community based services when those services are deemed appropriate and the services are available (U.S. Department of Justice, 2013). The Olmstead decision promotes the idea of integration for individuals with mental illnesses and co-occurring disorders. The Wyatt Implementation Plan and Olmstead plan included workgroups consisting of ADMH administrators, mental health providers, advocacy groups, and consumers and family members. This group continues to work towards reducing the use of state institutions and increasing and expanding community options. Overall, the goal of the plan is to increase consumer independence and inclusion. Community integration and service expansion has also been one of the focuses of the Substance Abuse and Mental Health Services Administration (SAMHSA) and this government agency has continued to provide funding to states to assist with perpetuating this idea.

There an assortment of evaluation research available for supported housing programs, housing for the homeless, and addiction treatment programs but little on transitional housing programs for adults with addiction (Karper et al., 2008). Because of under-funded federal, state and local governments, program evaluation is not always considered a necessity (Bloom, 2010). Instead, programs are required to meet a minimal set of standards for service implementation and

are audited regularly to assure that funds provided are used for consumer services. Whether or not those services are deemed beneficial does not have to be proven; however, completing a program evaluation can assist organizational leaders who are truly concerned for the population that they serve. Additionally, program evaluations are often completed for the purpose of funding endeavors because once charitable funding is granted, the agency must then explain in depth how funds were utilized and further provide evidence of how those funds improved the lives of consumers if it is the agency's desire to continue receiving or to increase funding (Kirsh et al., 2005). Program evaluations create the opportunity for improvement of program operation, quality assurance, and community participation (Reed, 2012).

Development and implementation of goals by community mental health programs should not only be externally controlled but should also be evaluated internally so that the programs can exceed standards (Kirsh et al., 2005). Community mental health and addictions programs are also able to evaluate for the purposes of enhancing public relations, holding program staff and partners accountable, and delivering quality services to identified populations (Kirsh et al., 2005). There is need for ongoing evaluation and periodically more in-depth evaluation of what is best in relation to program initiatives. Ultimately, positive attributes of the program can be enhanced while negative features can be discarded or phased out.

The current evaluation will explore a similar program that houses an extremely similar population. By increasing the body of literature available for this identified population via a program evaluation, low intensity treatment programs may be able to implement necessary maintenance of similar programs and continue to improve and transform for the better. A key element to effective program evaluations in these programs is looking at many of the elements previously discussed; maintaining sobriety and housing. These quality of life variables may be

essential to program evaluation in community based programs treating substance abuse addiction (Laudet, 2011).

Quality of Life Measurements

Treatment for substance abuse is aimed at promoting abstinence and reduction of substance use. In the long run though, treatment providers seek to improve consumers' overall quality of life. Quality of life (QOL) refers to facets of an entity's functioning that are important to them (Laudet, 2011). This may include family relationships, legal aspects, safety, finances, physical health, or a number of other aspects; however, in many traditional assessments, these factors are not commonly evaluated (Donovan et al., 2005). When they are evaluated, people with substance use disorders not only score lower in QOL factors than the general population, but have scored as low as or lower than people with diabetes, with lung diseases, or people anticipating cardiac surgery (Smith & Larson, 2003). People with substance addiction often report shoddier general health and more limited physical functioning than the general population. A greater severity of issues with substances is associated with poor functioning in almost all domains of QOL (Gonzales et al., 2009).

There is agreement that clinical variables, functional adjustment, and personal variables are incorporated in the definition of quality of life. Overall quality of life includes a consumer's satisfaction with life as a whole rather than only disease-related functioning or limit thereof (Laudet, 2011). QOL includes the individual consumer's opinion of their own position in life in relation to their culture, values, goals, standards, and expectations. Clinicians tend to focus attention on symptom management while consumers' focus tends to navigate towards optimal well-being which may also be referred to as "recovery" in the field of substance abuse (Black & Jenkinson, 2009).

Quality of life assessments not only serve as evaluation tools, but may also be used for diagnostic purposes and research has suggested that there is prognostic value in QOL assessments. Smith and Larson (2003) found that higher QOL in pretreatment predicts better outcomes in inpatient psychiatric units regardless of the consumer's baseline psychiatric status. The term health encompasses not only physical well-being and absence of disease, but also mental and social well-being (Laudet, 2011). Active substance abuse affects most areas of functioning, including employment, familial bonds, mental health, housing, and access to certain services (Orford et al., 2006). Those entering treatment for substance use have reported that they would like for treatment to address a full range of issues that permeate their lives and prevent them from achieving satisfaction. They are more likely to prematurely discontinue treatment if comprehensive assistance is not available and there are unmet service needs (Laudet, Stanick, & Sands, 2009)

QOL assessments are more relevant for people in long-term recovery. These persons may no longer receive treatment for substance use, but still continue to tussle with pathological conditions that are a result of previous use because substance dependence is a chronic condition. QOL improvement is especially relevant when treating incurable conditions (Laudet, 2011). QOL provides information on the effects of disease after treatment. The concept of recovery continues to be revised and broadened in the substance abuse field and simple abstinence from alcohol and drugs is no longer the sole focus of treatment because abstinence is not likely to bring immediate relief from all of life's problems (McLellan, Chalk, & Bartlett, 2007). It is possible to see a reduction in drug and alcohol use without seeing improvement in any other area, so family members, consumers, clinicians, and funders now conceptualize recovery as

abstinence plus improved quality of life rather than simply being free of symptoms (Dennis, Foss, & Scott, 2007).

For this reason, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2011) defined recovery as “a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life” (Center for Substance Abuse Treatment, 2006). SAMHSA’s National Outcome Measures (NOMs) focus on Quality of Life (QOL) domains and these measures are increasingly utilized by treatment facilities and the National Institute of Health’s Patient-Reported Outcomes Measurement Information System (PROMISE) initiative. This initiative was created to address the need to quantify clinically relevant patient-reported symptoms and health-related aspects of QOL throughout various chronic conditions (National Institute of Health, 2013).

More recent service models address quality of life as a treatment consideration. Recovery Oriented Systems of Care (ROSC) is a service model that relies on consumers’ experiences and self-reports of well-being in order to guide treatment and provide individualized care for each consumer. The model is person centered and strength-based, providing a continuum of care for the consumer and their family members while engaging community support services for assistance with health, wellness, and recovery (Clark, 2008). ROSC services are intended to adapt to the changing needs of consumers throughout their lifespan and extend comprehensive support services in an integrated fashion while bettering QOL and improving overall functioning. The services may include education about substance dependence, housing, vocational assistance, family therapy, peer support services, case management, transportation, recovery coaching, and self-help meetings (Kaplan, 2008). The ROSC model has pronounced potential for addressing the multitude of service necessities in conjunction with the primary issues of substance use. It is

a multisystem, integrated approach that conceivably nurtures abstinence and somewhat resolves impairments (Laudet, 2011). In conjunction with this model, intake for programs that utilize this approach may consider the American Society of Addiction Medicine (ASAM) six dimensions.

Dimension 1, Acute Withdrawal and Intoxication, questions the person's current level of intoxication and whether or not the person is currently experiencing withdrawal symptoms from drugs or alcohol (ASAM, 2001). Dimension 2, Bio-Medical Conditions and Complications, addresses the presence of current physical illnesses, other than withdrawal, that may need to be addressed or that may cause issues with successfully completing treatment (ASAM, 2001). Dimension 3, Cognitive, Behavioral, and Emotional Conditions, questions the presence of current psychiatric illnesses as well as behavioral, emotional, and cognitive issues that may interfere with treatment or create a risk for other residents and if the person is able to manage activities of daily living (ASAM, 2001). In Dimension 4, Readiness/Motivation, the interviewer assesses the individual's level of commitment to changing problematic behaviors, degree of cooperation with treatment, and whether or not he or she is aware of the relationship between their drug or alcohol use and negative events in their life (ASAM, 2001). Dimension 5, Relapse, Continued Use, Continued Problem, is the dimension in which interviewers assess the interviewee's relapse potential, awareness of relapse triggers, and ability to cope with cravings and mental illness (ASAM, 2001). Questions in Dimension 6, Recovery Environment, seek to determine if family members or living situations pose a threat to the interviewee's success in treatment or if there are positive family and friends available for support. Dimension 6 also determines if the individual is completing treatment as a legal mandate or requirement of another entity and if the presence of these is motivation for participating in treatment and assists with identifying case management needs that should be addressed during treatment. The overall

purpose of this interview is to determine the potential resident's possible success in a particular program and to refer them to a different level of care if it is determined that there is a better more feasible option for treatment (ASAM, 2001).

Laudet and Stanick (2010) reported that when the level of QOL satisfaction for consumers ending outpatient treatment is strong, it significantly predicts commitment to abstinence. Gonzales and his colleagues (2009) also found that the consumers who received the greatest number of services in their study had the most mental health improvement. Likewise, those who received the least amount of services experienced the least amount of improvement. In a study researching women with alcoholism specifically, the women who reported higher life satisfaction at the time of treatment intake also achieved higher rates of abstinence after discharge and the women with lower scores on QOL assessments at treatment intake experienced higher rates of relapse (Rudolf & Priebe, 2002). For people who are addicted to substances, but are in recovery the potential of losing improvements in QOL that they have amassed while drug-free presents as a deterrent for relapse and motivation for sustained abstinence (Blomquist, 2002).

Conclusion

There is a great deal of suffering that derives from alcohol and drug dependence. The actions of alcoholics and addicts not only bring a deal of stress and agony for them, but also for their loved ones and the community. Substance use is common in psychiatric patients and also worsens their symptoms and contributes to financial problems and homelessness (Karper et al., 2008). Those needing assistance must have this assistance provided in the least restrictive environment. Comprehensive evaluation is therefore necessary to ensure integrated treatment, for this population. Many community agencies still provide treatment for either substance abuse

or mental health separately despite continued research citing the need for service delivery that addresses both issues and despite numerous consumers presenting with dual diagnoses (Havassey, Alvidrez, & Owen, 2004).

The homeless mentally ill use more emergency department services and generally tend to have more medical needs, which adds to their complexities. These complex barriers must be acknowledged and addressed in order to improve outcomes. These consumers frequently require case management and other specialized strategies along with a team of individuals to be involved in their treatment in order to optimize service outcomes because integrated treatment has been recognized as an essential intervention for achieving positive outcomes with the homeless, mentally ill, substance addicted consumer (Karper et al., 2008). Federal Social Security Disability policy allows disability benefits for non-addictive mental illness and for disabilities acquired because of drug use, but the amount of these benefits is often not enough to sustain housing especially if the disabled is in active addiction.

Other theories have proposed that consumers who select the level of treatment that they would like to participate in will be more likely to produce positive outcomes because in theory, people tend to have some insight into what works best for them (Calsyn, Winter, & Morse, 2000). In addition, staff matching may be a relevant option for treatment agencies to consider in view of this populations tendency to not trust service providers. Other factors include staff training and the ability of these staff members to adequately address mental health, substance abuse, and other complicating factors. The initial goal of ceasing or reducing drug and alcohol use are extremely necessary, but seldom suffice for meeting the long-term goal of improving comprehensive health and social adjustment, which may also improve public safety (McLellan et al., 2005).

A particular treatment strategy may be effective in assisting someone with beginning to change while being ineffective with maintain sobriety and avoiding relapse. Motivation and responsibility are crucial elements for recovery (Dordick, 2002). Recovery is not merely staying clean and sober and accumulating clean time. It is instead, an acquisition of multifaceted success factors and an ability to prioritize. There have been multiple studies discussing and determining what type of treatment works best for each gender, age group, drug of choice, and other factors; ultimately, treatment for substance use should be individualized, taking all of these factors into account and tailoring treatment interventions to fit individual needs (Caton, Wilkins, & Anderson, 2007). Integrated models of treatment such as Recovery Oriented Systems of Care, address consumers' quality of life in recovery. These services are also easily combined with a continuum of care (Laudet, Becker, & White, 2009).

Substance usage continues to be a concern for society and policy makers. With stronger potency of current drugs and the creation of new substances to be abused, clinicians need to adapt and stay abreast of current issues and best practices for assisting this controversial population. While certain celebrities and musicians continue to glorify drug and alcohol usage, other media outlets constantly seek new ways to transmit information about the dangers of substance use, where help can be obtained, and how to prevent initial use. Drugs and alcohol effect more than the mere individual who ingests, but also the loved ones concerned for their well-being and the society who desire safety for them and their families.

CHAPTER III. METHODOLOGY

This chapter will discuss the research methodology and design used to conduct a study focusing on the residential treatment at the Fellowship House, Inc. Low Intensity Transitional Apartment Program. The specific focus of this quantitative study was the outcomes of treatment, with specific focus on transition to *independent living* and *income*. This goal is achieved through a focus on aiding the individual in the personal, social, and vocational adjustment necessary for the maintenance of a sober and productive life that includes improved legal status, decreased alcohol and drug use, improved living situations, and improved vocational status. This focus is manifested through facilitation of various therapeutic and educational groups provided by staff and interns of the program.

Research Questions

1. What individual and program-specific factors are associated with successful completion of the Low Intensity Transitional Apartment Program at discharge?
2. What individual and program-specific variables are related to independent living and income outcomes after discharge from the Low Intensity Transitional Apartment Program at three months follow-up?
3. What individual and program-specific variables are related to income outcomes after discharge from the Low Intensity Transitional Apartment Program at three months follow-up?

This study was completed using data that was previously collected by the Continuing Care Coordinator of Fellowship House. The participants for this study included previous residents from the Fellowship House Low Intensity Transitional Apartment Program. This program focuses on transitioning adults with substance dependence and co-occurring disorders from treatment settings to independent living as defined by maintenance of safe and stable community housing. This program accepts consumers who have low income as well as those receiving disability benefits from the government. The sample for the study included consumers who participated in the three-month program aftercare surveying. This included consumers (participants) who either completed treatment or had been discharged for other reasons between the periods of March 2012 through May 2013. Aftercare survey data was collected among these discharged consumers, those discharged from the program into the community or to other referral agencies, beginning in February 2012. Although aftercare surveying is attempted at 3, 6, and 12 months after the consumer has discontinued treatment, there were not a sufficient number of responses at 6 and 12 months to examine outcome variables for those follow up intervals.

Approval from the Executive Director was obtained relating to the use of this data. A total 107 consumers were discharged from the program during the timeframe examined in this study, March 2012 through May 2013. However, during that time follow-up data was only collected among 74 participants. Three (3) of those consumers were confirmed as deceased before follow-up was attempted. The other consumers who data was not available for were unable to be contacted by the Continuing Care Coordinator due to incomplete aftercare consent forms, disconnected telephone numbers, and unreturned phone calls. The sample for this study includes consumers who participated in the first of three steps of program aftercare surveying. This sample was used for the analysis. This data was maintained by the Continuing Care

Coordinator of the program via ClaimTrak electronic health records (EHR) system, transferred to an excel file and provided without identifying information (consumers' names) to maintain anonymity.

The ClaimTrak EHR for use by Fellowship House was developed with the help of various clinical staff in order to tailor-make a system that would be able to document and track all services provided and available at Fellowship House. The system is able to interface with billing and other necessary state systems in order to maintain consistency in codes and service definitions. The system is periodically updated and services are monitored and adjusted as needed. The information is accessed by staff via a remote desktop connection and servers being accessed via this connection are housed in a facility in Arizona.

Program Consumers

The consumers were all adults ages 19 or older. One hundred seven (107) consumers were discharged from the program during the study period. Follow-up attempts were made for 100 consumers. Three (3) of the consumers who were discharged from the program have since died and no aftercare surveys were completed for them. Phone numbers and consent forms were not properly obtained for an additional 4 consumers and follow-up attempts were not made for said consumers. Of the remaining consumers, the consumers were both male (n = 64, 64%) and female (n = 36, 36%) and all had a primary diagnosis of a substance use disorder as an admission requirement for participating in the program. Fifty-one (51%) identified as Caucasian and 49 (49%) identified as African American.

Participants' discharge from the program is characterized in two ways. Consumers can be discharged in good standing discharge at the end of treatment, meaning that the treatment was discontinued because it was determined that the resident was prepared to move into independent

living. This group labeled for the purposes of this study as *Successful* consists of 63 participants. Participants may also be classified as having received other than good standing discharges. This includes disciplinary discharges, meaning that the resident was discharged because of failure to follow program rules and policies; medical discharges, meaning that the resident was discharged because the program was not appropriate to address the resident's medical needs; and therapeutic discharge, meaning that the resident was discharged because it was determined that the level of care was not appropriate to meet the needs of the resident.

A higher level of care is often needed and these consumers return to hospital or other higher levels of treatment that are needed (Reed, 2012). This group has been labeled *Unsuccessful* (n = 37). The sample includes the majority of the participants (n = 63) within *Successful* with the *Unsuccessful* group totaling 37 participants. Other groups as mentioned above include those who are deceased (n = 3, 2.8%) and those without necessary information for follow-up (n = 4, 3.7%).

Program Description

Logic models for program evaluations identify what a program will do step-by-step and how said program will achieve stated goals. This allows for evaluators of the program to be able to identify goals, inputs, outputs, strategies, and outcomes of the program (United Way, 2008). This allows for the evaluator to determine what has been accomplished and implemented in accordance with the stated goals and objectives of the program. For this study, the program had already been in existence and the outcomes had been identified to determine the variables that assist with meeting the outcomes. The survey questions were not designed for analysis and research and therefore a complete program evaluation and development of an effective logic model was not possible.

Program Goal

The goal of the Fellowship House Low Intensity Transitional Apartment Program is to continue development of socially appropriate behaviors and gain a greater foundation on and support in a clean and sober environment. The ultimate goal of the program is to aid the residents in obtaining the personal, social, and vocational adjustment necessary for the maintenance of a sober and productive life free from institutions, including Fellowship House.

Other Unexamined Services Provided

Each resident has access to numerous services. Recovery coaching and peer support are services provided by Fellowship House staff members who are in recovery from alcoholism or drug addiction. Some of these staff members are also individuals with co-occurring disorders. They have significant experience with being clean and sober and are able to share their experiences with residents and suggest activities, readings, and support groups that they determine may be beneficial for residents. Recovery Coaches and Peer Support Specialists are certified by the State of Alabama Department of Mental Health as Peer Support Specialists. They also assist and connect consumers with identifying Alcoholics Anonymous sponsors and community recovery support networks. Having a supportive social network can be extremely beneficial for those residents with mental illnesses (Gulcur et al., 2007). Recovery Coaches and Peer Support Specialists also aide the residents in identifying positive versus negative social interactions, teaching discrimination against social activities that are not beneficial for recovery maintenance, and modeling acceptable behavior and interaction in social settings. By facilitating social interactions that are positive and assisting with building a support network, individuals are able to produce more positive consequences and subsequently better recovery outcomes (Weiner

et al., 2010). Each of these service providers assist with different aspects to the consumers' development of independent living skills.

Case management is provided to each consumer in areas needed to re-enter society as independently as possible. Case management begins by assuring that consumer basic needs such as food, toiletries and medication are available. Other areas of case management include assisting with legal issues, transportation, and independent living skills. After the consumer has increased structure and stability in life through employment, self-help and treatment involvement, independent living goals are established. Some of these goals include connecting the residents to case management services within the community to which they are returning or relocating. Although case managers may locate potential service providers and complete initial referrals, it becomes the resident's responsibility to follow through with making their appointments and getting necessary paperwork and other information to the referred sources. Case managers complete daily room checks, assuring that all residents are safe and that a clean and livable environment is maintained. Case managers assist residents with developing daily living skills and maintaining healthy boundaries with roommates.

Whereas counselors place a great deal of emphasis on success in the area of emotions, case managers tend to focus more on measuring a consumer's success by their ability to acquire and continue basic needs management. Case management may also include outreach, treatment linkage, consumer advocacy, consumer support and supporting counseling. When the frequency of case management services is increased and the number of consumers per one case manager is twenty or less, the services are referred to as intensive case management. Case management is considered an essential service element when serving individuals with the combination of homelessness, mentally illness, and substance use (Zerger, 2002).

Participants

The participants of this program include adults age 19 and over that have a primary diagnosis of a substance use disorder. The consumer must have completed a state of Alabama Substance Abuse Assessment within six months of being admitted to the program. Their last date of drug or alcohol usage must be no less than 30 days before entrance into the program as evidenced by documented urinalysis screenings. If the consumer has additional mental or physical diagnoses that require medication, the consumer must have a sufficient supply of those medications on hand during the date of intake. The overall objective of the program is identified in the strategies with specific interventions as provided based on program goals and services rendered.

Outcomes

Due to the low intensity treatment program being already in existence, the outcomes are what will be focused on within the study. The above criteria were gathered in order to provide better understanding of this proposed program and should aide in the development of an adequate determination of variables which should be measured. The outcomes are what were focused on. To determine what impacts the successful transition into the community from the program and what negatively impact those who are not successful in the community, an outcomes based model was be utilized. These outcomes include type of discharge (successful or unsuccessful), whether or not the consumers had stable housing (independent or dependent) three months after discharge, and whether or not the consumer had income (income or no income) three months after discharge.

The variables in the study were based off of existing data and these variables are those that are viewed to have the greatest impact on successful transition as identified by SAMHSA's

National Outcome Measures. SAMHSA's National Outcome Measures (NOMs) focus on Quality of Life (QOL) domains and these measures are increasingly utilized by treatment facilities and the National Institute of Health's Patient-Reported Outcomes Measurement Information System (PROMISE) initiative (National Institute of Health, 2013). The outcomes, as stated by SAMHSA, included in the program data provided by the program include stability in housing, employment/income, criminal justice involvement.

Measure

The Fellowship House, Inc. Aftercare Follow-up Survey (Appendix B) was used to collect information on consumer outcomes. The program focuses on increasing independent living skills that are primarily defined along the lines of maintaining sobriety, appropriate legal status, and independent living. This survey includes questions concerning substance use since leaving treatment, legal status, living situation, employment, and recovery tools utilized. The survey is found in Appendix B. Figure 1 illustrates which follow-up questions correspond to study variable.

			Research Question Addressed
Dependent Variable	Definition	Data Source	
Discharge Type	Successful or unsuccessful discharge from the program	ClaimTrak EHR	RQ1
Independent Living (NOMS Stability in Housing)	Self-supported living arrangement not dependent on family, friends, or another treatment center	Aftercare Survey question: What is your living arrangement today?	RQ2
Income (NOMS Employment/Income)	Whether or not monetary fund are regularly available to support living expenses.	Aftercare Survey question: What is your vocational status?	RQ3
Pre-admission Variable	Definition	Data Source	
Race		ClaimTrak EHR via state identification	RQ1, RQ2, RQ3
Gender		ClaimTrak EHR via state identification	RQ1, RQ2, RQ3
Prior Placement	Living arrangement before entering treatment	Claimtrak EHR via AL Substance Use Assessment	RQ1, RQ2, RQ3
Secondary Variable	Definition	Data Source	
Legal Status		Aftercare Survey question: What is your legal status?	RQ1, RQ2, RQ3
Co-Occurring Disorder	Whether or not a dual diagnosis is present	ClaimTrak EHR via AL Substance Use Assessment	RQ1, RQ2, RQ3
Program-Specific Variable	Definition	Data Source	
Days in Treatment	Number of days spent in the program	ClaimTrak EHR	RQ1, RQ2, RQ3
Number of Groups Attended	Number of groups attended while in treatment	ClaimTrak EHR	RQ1, RQ2, RQ3

Figure 1: Follow-up Survey Question Correspondence

Successful completion of the program is determined by the discharge status assigned at the date of discharge. Successful completion is defined as having completed all treatment goals

without disciplinary factors affecting participation in the program. Unsuccessful discharge is defined as either leaving the program without notice, substance relapse, or discharge due to disciplinary reasons. Independent living is defined as maintain a living arrangement that is self-supported and not dependent on family, friends, or another treatment center. The question “What is your living arrangement today?” is used to measure the independent living status of the consumer. Any answer other than “In my own place” indicates that the consumer is not living independently. The program based aftercare follow-up survey questions on SAMHSA’s National Outcome Measures, which focus on Quality of Life measures. These measures include housing stability, employment/income, and involvement with the criminal justice system. The measures were created to address the need to quantify clinically relevant patient-reported symptoms and health-related aspects of QOL throughout various chronic conditions (National Institute of Health, 2013). The question in the aftercare survey that addressed the employment/income outcome identified by SAMHSA was, “What is your vocational status?” The question in the aftercare survey that addressed involvement with the criminal justice system was, “What is your legal status?” The question in the aftercare survey that addressed housing stability was “What is your living situation?” Each of these questions were designed with consumer understanding in mind and worded in ways that could be easily understood by marginally educated consumers and their family members.

Race, gender, and prior placement are all recoded in the ClaimTrak electronic health records system (EHR) at admission with information from state identification and self-report. Mental health diagnoses are obtained during Alabama Substance Use Assessments completed by master’s level clinicians and record via the EHR. The number of groups that consumers attended while in treatment was recorded via the ClaimTrak EHR. The length of treatment stays are recorded via the ClaimTrak EHR also. Date of admission and discharge are recorded and group notes are recorded each time that a consumer attends groups.

Procedure

Group notes are recorded in the CalimTrak EHR system for each participant. The participant's date of program entry and discharge is also recorded in this system. The Continuing Care Coordinator obtained data on preadmission, primary, and program-specific data from the Low Intensity Treatment Program. This included pre-admission data, discharge information and aftercare follow-up information. The reports that have been maintained by Fellowship House staff were obtained via email, condensed into the aforementioned groups, and maintained via an Excel and SPSS spreadsheet. The data obtained was existing data and was analyzed in order to determine the needs of the program. All data was provided as anonymous data so individual participants were not identifiable from the data. A downfall of using pre-existing data is that the information and surveys were not created with research in mind and the data was not intended for that purpose. The aftercare follow-up survey used did not provided questions or answers that were meant for coding and analyzing. Clarification was necessary from administrative members of the agency concerning the meanings and purposes of questions and answers on the survey.

Data Analysis

Logistic regression was used in order to identify which variables correlate with maintaining sobriety once in community independent living. This analysis allows for improvement of the program and suggestions for changes that may assist with clients' ongoing sobriety once the program has been completed. Logistic regression models were used to look at independent variables including days in treatment, number of groups attended, living situation at admission, co-occurring disorder presence, and legal status at admission to determine predictors of success after program completion. The logistic regressions were competed for pre-admission,

secondary, and program-specific variables to determine if there were any predictive factors for successful or unsuccessful discharge. With better understanding of success predictors, program improvements can be made (Reed, 2012). This method of evaluating the program may increase the chance for client success after transitioning to independent living.

Backward elimination logistic regressions were performed to identify which pre-admission, program-specific, and secondary variables most accounted for positive and negative program outcome within the treatment program.

Pre-admission variables are those that impact the client prior to admission into the low intensity treatment program. This includes race, gender, and prior placement type. The dependent variable was type of discharge from the program; meaning those clients discharged in good-standing as compared to those with other than good-standing discharges.

Summary

The study was completed on the Fellowship House, Inc. Low Intensity Transitional Apartment Program and the variables that are related to the outcomes at three month follow-up were determined, allowing for recommendations to the program at adjusting variables and increasing success of clients of the program attaining independent living.

CHAPTER IV. RESULTS

This chapter includes the results of the data analysis for the evaluation of this program. A description of the participants, statistical procedures and results of said analysis are discussed. The findings of each research question will also be summarized within this chapter.

Participants

The participants included consumers (n = 107) who had been residents at the Fellowship House, Inc. Low Intensity Treatment Program and were discharged from March 2012 until May 2013. Consumers (85 or 79%) responded to aftercare follow-up surveys at three months after discharge. The participants were all adults ages 19 or older. The participants were both male (n = 68, 63.6%) and female (n = 39, 36.4%) and all had a primary diagnosis of a substance use disorder as an admission requirement for participating in the program. Of the study sample, 52.3% self-identified as Caucasian and 47.7% identified as African American. Three of the consumers who were discharged from the program have since died and no aftercare surveys were completed for them. The dependent variables were identified as the type of discharge from the program and independent living status. Consumers who were successful completers of the program are those who were discharged into independent living into the community and were identified as *Successful* (n = 67, 62.6%). Unsuccessful completers were not discharged from the program in good standing, meaning that they had unfulfilled obligations, disciplinary issues while in treatment, or were deemed inappropriate for the treatment setting. This group was identified as *Unsuccessful* (n = 40, 37.4%).

Variables

Pre-admission variables are those that impacted the consumer prior to admission to the treatment program. The pre-admission variables included race and gender and prior placement.

Prior placement type indicated where the consumer lived immediately prior to entering into the program. Secondary variables are those that impacted the consumer outside of the program.

These included whether or not the consumer was involved in the legal system and whether or not the consumer has a co-occurring disorder (meaning that consumer has a substance use disorder in addition to at least one other Axis I diagnosis), and the consumer's prior placement type.

Program-specific variables are those that impacted the consumer while living in the treatment program. These include the number of groups that the consumer attended and number of days that he or she was in treatment (length of stay). Frequencies and descriptive statistics were run for preadmission, secondary variables and program-specific variables as well (see Tables 2, 3, and 4).

Result for Logistic Results

Backward elimination logistic regressions were performed to identify which pre-admission, program-specific, and secondary variables most accounted for positive and negative program outcome within the treatment program. The chi-square and Wald tests were used to determine if each variable was significant. These results from three logistic regressions are summarized in Table 1.

Table 1

Summary of Logistic Regression Models

Model	Discharge	Independent Living	Income
Full Model			
Model χ^2	6.502	20.113 **	31.856 ***
% Classified Correctly	68.2%	67.1	81.5
Nagelkerke R ²	.08	.291	.477
Variables	<i>B (Odds ratio)</i>	<i>B (Odds ratio)</i>	<i>B (Odds ratio)</i>
Pre-Admission			
Race	-.616 (.540)	.896 (2.45)	-.420 (.657)
Gender	-.535 (.586)	.489 (1.631)	.795 (2.215)
Prior Placement	-.489 (.613)	-1.475 (.229)	-3.161 (.042)
Secondary Variables			
Legal Status	-.442 (.643)	-.607 (.545)	-.372 (.689)
Dual Diagnosis	-.223 (.800)	.357 (1.428)	.711 (2.037)
Program variables			
# of Groups	-.202 (.817)	-.004 (.996)	.258 (1.295) **
Length of Treatment	-.346 (.707)	.006 (1.006) *	.008 (1.008)
Restricted Model			
Model χ^2 * sig	0 (null model)	13.57 ***	-.944 **
% Classified Correctly	62.6%	68.3	74.1
Nagelkerke R ²	.000	.204	.365
		Length of Stay	Number of Groups
		.006 ** (1.006)	.242 ** (1.27)

*p < .05, **p < .01, ***p < .001

Successful Discharge

The majority of consumers who were unsuccessfully discharged were Caucasian consumers and male consumers. Associations for all pre-admission, secondary and program specific variables showed no statistical significance for all 107 consumers with type of discharge examined though. According to the logistic regression results, no variables were retained in the final model. Overall, analysis found that the typical clients who were successfully discharged from the program attended more sessions and had longer treatment stays; however, these results were not significant. There was also no difference on any other variables examined.

Comparative information on each variable is provided in Table 2.

Table 2

A Comparison of Successful and Unsuccessful Discharged Participants

		Successful Discharge (n = 67)	Unsuccessful Discharge (n = 40)	
Pre-admission Variables				Chi-square
Race	Caucasian	32 (47.8%)	24 (60.0%)	2.79
	African American	35 (52.2%)	16 (40.0%)	
Gender	Male	40 (59.7%)	28 (70.0%)	1.11
	Female	27 (40.3%)	12 (30.0%)	
Prior Placement Type	Treatment Facility	61 (91.0%)	38 (95.0%)	2.5
	Independent	3 (4.5%)	2 (5.0%)	
	Other	3 (4.5%)	0 (0.0%)	

Table 2 (continued)

		Successful	Unsuccessful	
		Discharge	Discharge	
Secondary Variables				
Legal Involvement	Yes	35 (52.2%)	15 (37.5%)	3.86
	No	32 (47.8%)	25 (62.5%)	
Co-occurring	Yes	32 (47.8%)	18 (45.0%)	0.73
	No	35 (52.2%)	22 (55.0%)	
Program-Specific Variables		Mean/SD	Mean/SD	t-score
Length of Stay		179.47 / 158.16	125.97 / 95.58	11.67***
Number of Groups		16.17 / 18.34	11.38 / 12.45	8.89***

*p < .05, **p < .01, ***p < .001

Independent Living

For the Independent Living variable, if consumers answered the living situation question on the Aftercare survey with any answer that “In my own place,” the consumer was coded as dependent rather than independent. In order to address research question 2, a backwards logistic regression model was run with *Independent Living* as the dependent variable and *Group Attendance* and *Treatment Length* as the covariates and found that, there was a significance of $p = .003$ for *Days in Treatment* when one predictor was retained. It is apparent that the probability of a consumer living independently at three months after discharge is lower if said consumer spent less than 198 days in the treatment program. Those consumers who stayed less than 60 days (approximately 2 months) had extremely low probability of being independent when contacted from 3 month aftercare follow-up. The odds ratio (see Table 1) was 1.006; therefore,

the odds of living independently increase as consumers stay longer in treatment. Table 3 illustrates that significant of the *Treatment Length* variable and provides a comparative analysis of the individual and program-specific variables in relation to independent living status three months after discharge.

Table 3

A Comparison of Independent and Dependent Discharged Participants at Three Months

Follow-up

		Independent (n = 36)	Dependent (n = 46)	
Pre-admission Variables				Chi-square
Race	Caucasian	14 (38.9%)	26 (56.5%)	2.51
	African American	22 (61.1%)	20 (43.5%)	
Gender	Male	23 (63.9%)	30 (65.2%)	.016
	Female	13 (36.1%)	16 (34.8%)	
Prior Placement Type	Treatment Facility	33 (91.7%)	44 (95.6%)	.696
	Independent	2 (5.5%)	1(2.2%)	
	Other	1(2.8%)	1(2.2%)	
Secondary Variables				
Legal Involvement	Yes	13 (36.1%)	24 (52.2%)	2.255
	No	23 (63.9%)	22 (47.8%)	
Co-occurring	Yes	18 (50.0%)	22 (47.8%)	0.04
	No	18 (50.0%)	24 (52.2%)	

(table continues)

Table 3 (continued)

Program-Specific Variables	Mean/SD	Mean/SD	t-score
Length of Stay	179.47/ 158.16	107.39/ 88.66	-3.30***
Number of Groups	15.85/ 16.66	9.72/ 12.45	-1.87

*p<.05, **p<.01, ***p<.001

Income

For the income variable, consumers who reported during the Aftercare survey that they were employed or disabled were coded as having income. Those consumers who indicated that they were unemployed or students were coded as having no income. When the variables *Length of Stay* and *Number of Groups* were run with *Income* as the dependent variable, there was a significance of $p = .002$ for the variable the variable retained. The significant odds ratio of 1.27 indicates that the odds of obtaining steady income three months after discharge from the program is increased if the consumer attended more group sessions while in treatment (see Table 1). Table 4 shows a comparative analysis of individual and program-specific variables in relation to obtainment of income three months after discharge from the program. The results of independent samples t-tests for both program-specific variables are significant for income, but in the backward logistic regression, the variable concerning number of groups attended is retained. Consumers who attended 40–53 groups while in treatment had an extremely high probability of having income when they were contacted for aftercare follow up. Conversely, those consumers who attended no documented groups had an extremely low probability of have income during the same follow-up.

Table 4

*A Comparison of Discharged Participants at Three Months Follow-up with Income and No**Income*

		Income (n =60)	No Income (n =21)	
Pre-admission Variables				Chi-square
Race	Caucasian	30 (50.0%)	10 (47.6%)	.035
	African American	30 (50.0%)	11 (52.4%)	
Gender	Male	36 (60.0%)	16 (76.2%)	1.77
	Female	24 (40.0%)	5 (23.8%)	
Prior Placement Type	Treatment Facility	55 (91.7%)	21 (100%)	1.865
	Independent	3 (5.0%)	0 (0%)	
	Other	2 (3.3%)	0 (0%)	
Secondary Variables				
Legal Involvement	Yes	26 (43.3%)	11 (52.4%)	1.29
	No	34 (56.7%)	10 (47.6%)	
Co-occurring	Yes	31 (51.7%)	8 (38.1%)	1.15
	No	29 (48.3%)	13 (61.9%)	
Program-Specific Variables		Mean/SD	Mean/SD	t-score
Length of Stay		179.68/ 146.38	68.86/ 52.21	-3.201**
Number of Groups		15.09/ 15.90	3.86/ 3.14	-3.135**

*p < .05, **p < .01, ***p < .001

Summary of Findings

Associations for all pre-admission, secondary and program specific variables showed no statistical significance for all 107 consumers when *Discharge Type* was examined. According to the logistic regression results, no variables were retained in the final model. When *Independent Living* was analyzed, there was a significance of $p = .003$ for the variable *Days in Treatment* when the variable *Number of Groups* was removed, meaning that the number of days that a consumer spends in the program may serve as a predictor the consumer having stable housing three months after being discharged. When the variables *Length of Stay* and *Number of Groups* were run with *Income* as the dependent variable, there was a significance of $p = .002$ for the variable *Number of Groups* when the variable *Days in Treatment* was removed meaning that the number of groups that a consumer attends while in the program may serve as a predictor for whether or not that consumer has income three months after discharge.

CHAPTER V. DISCUSSION

The Fellowship House, Inc. Low Intensity Treatment Program serves those who have substance use disorders and have not been successful in an outpatient setting. These consumers have completed substance abuse assessments and it has been determined that although they are no longer using substances, they still require a structured environment in order to maintain sobriety. The overall goal of this treatment program is to provide housing and support until each individual is ready and better prepared to move to a more independent setting within the community with the least amount of support and dependence on the treatment center and treatment services as possible. Programs such as these are not common in Alabama and across the United States; in addition, program evaluations on these types of programs is also not common. For this reason, it was beneficial to see what program variables may have been effective towards helping clients meet program goals in order that the program could make improvements. Analyzing program-specific variables would also allow for suggestion for ongoing development of similar programs. In addition, the information may be able to identify client individual characteristics that are linked to success in the program, with the possibility of addressing these in the program. Based on this, the current study focused on a pre-existing questionnaire that included past residents who have successfully completed the program and transitioned to independent living and residents that have been discharged but did not successfully complete that program.

Discussion of Program-Specific Variables

In transitional living programs such as the program at Fellowship House, Inc., it is extremely important to concentrate on transition into the community as the primary goal. Becoming a part of the community as a whole involved maintaining a support system and developing a feeling of belonging in areas where the consumer may have once inflicted damage. This integration is a central feature of successful completion of this program. Ideally, at the point of completion the consumer would have obtained steady income, a strong social network of positive support, and independent living. More importantly, the program administrators would hope that successful completers have learned and retained information in the program that would assist with maintaining the independence and sobriety that they left the program with and continue to be productive members of their communities.

The primary focus of the current study was consideration of the variables that contribute to the success or lack of success of this program which specifically focuses on increasing sobriety and independent living of adults with substance use disorders and co-occurring disorders. Based on these goals, the primary questions of this particular study looked at the differences in relation to successful completers of the Fellowship House, Inc.'s Low Intensity Transitional Apartment Program and unsuccessful completers of the same program, past consumers who maintained stable housing three months after leaving the program, and past consumers who possessed employment or other legal income three months after leaving the program. Of the 107 consumers included in this study, 67 of those were discharged successfully into the community and 40 consumers were discharged unsuccessfully. Many times, unsuccessful consumers may be discharged from institutions without proper case management linkage to services available in the communities in which they plan to live (Feldman, Trauer,

Newton, & Cheung, 2003; Hamden, Newton, McCauley-Elsom, & Cross, 2011; Moxham & Pegg, 2000). For this reason, having a larger percentage of those who complete the program successfully rather than unsuccessfully is positive for this program.

When considering pre-admission and secondary variables, it was anticipated that these variables would not have an impact on the consumer's and program's outcome. Pre-admission variables are those that impacted the consumer prior to admission to the transitional living program. The pre-admission variables included race and gender. Prior placement type indicated where the consumer lived immediately prior to entering into the program. Secondary variables are those that impacted the consumer outside of the program such as whether or not the consumer was involved in the legal system and whether or not the consumer has a co-occurring disorder; meaning that consumer has a substance use disorder in addition to at least one other Axis I diagnosis, and the consumer's prior placement type. In theory, the treatment program cannot have an impact on these variables as they impact the consumer outside of the program's control; however, services provided within the program assist with addressing legal and mental health needs. Nevertheless, if one of these variables were found to have a negative impact on the program outcome, there is not much that the program could change that would impact these variables. The study looked at each variable previously mentioned in order to examine what may work for the program and what may not in terms of successful completion of the program. The study also addresses areas in which the program can improve at meeting the program goals.

Successful Completion

In addition to investigating pre-admission and secondary variables, it is necessary to assess the impact of program-specific variable and their link to successful completion of the program. In regard to the program examined in the current study, program-specific variables

were found to have a no significant impact on whether or not consumers were successfully discharged.

Other studies have suggested that mental health diagnosis is not associated with length of stay, while other programs have suggested that specific diagnoses such as major depression and psychosis correlate with longer stays in residential placements (Gigantesco, de Girolamo, Santone, Miglio, & Picardi, 2009). Research in mental health has shown that community living depends largely on including daily living activities coupled with social supports (Mirza, Gossett, Chan, Buford, & Hammel, 2008).

Independent Living

Program-specific variables included the days that the consumer participated in treatment in the program and the number of therapy groups that they participated in while in treatment. Since program-specific variables were significantly successful at impacting program outcomes, then the program should be able to make adjustments and improvements in those areas. The research determined that the length of stay contributed significantly to maintenance of independent housing three months after discharge.

Treatment programs such as the Fellowship House Low Intensity Treatment Program have goals of improving consumer independence and increasing their abilities to function in the community. Treatment programs need to improve their emphasis on factors of independent living as a focus of rehabilitation. This not only assists with meeting program goals, but also benefits the consumers more by assisting with fostering stability on ongoing recovery (Reed, 2012). Based on previous research, independent living, social supports, and daily activities need to be addressed in treatment planning. Focus on these areas may improve consumer progress within programs that have goals of improving consumer independence and maintaining

community living. As for consumers with co-occurring disorders, social support as well as development of daily living skills impact and are impacted by severity of psychiatric symptoms. Consumers with significant social impairments have more difficulty with achieving independence (Wagner, Almeida, Wagner, & Dias, 2006). Empowerment and encouragement in the area of independence for consumers support with improved management of mental illness and substance abuse. This in turn also results in increased social activities.

Studies that have been done on similar programs have stated that a consumer's length of stay is often a predictor of success of consumers in these programs. For this reason, it is often assumed that if a consumer stays longer in a program, that they are more successful because the program is successful at treating their issues and improving their independence. Length of stay in a residential program is a consistent predictor of improved program outcome even after a year past the consumer's discharge although prolonged length of stays in residential treatment programs have also been found to create a disconnect in social supports (McGuire, Rosenheck, & Kaspro, 2011). This study showed that longer stays in this particular program had no effect on whether or not the consumers had successful or unsuccessful discharges.

Income

The research also determined that the number of groups that consumers attended contributed significantly to acquirement or maintenance of income. Based on this evidence, the program should begin to focus more on increasing group attendance while consumers are in the program and on increasing the length of stay for consumers. There is limited usefulness of group attendance as a predictor because there were no specific indicators of which groups consumers participated in.

There is also a lack of consistency and uniformity in what services any of the consumers receive. The range for groups attended by consumers while in treatment varied from 0 recorded groups to 237 recorded groups. In a treatment program, all consumers should be participating in some type of documented treatment activities. Although low-intensity is designed to be less structured than higher intensity programs, there must still be some sort of structure. The finding showing the predictive nature of group attendance on income at three month follow-up also reveals the need to know more about the nature of the groups that consumers attended. Specific groups aimed at independent living and/or income may have had a specific impact.

Recommendations

Based on the outcome of this study, it is recommended that this program provide individualized treatment planning for each consumer. Although the program states a focus on individualization of treatment goals and objectives for each consumer, there appears to be a lack of specific goals and the direction that each consumer was headed in. There is also not a clear understanding of the steps intended for transitioning to independent living.

The consumers who participate in this program are often the same consumers who utilize more emergency room services, psychiatric services, homeless, and other costly services. These needs have continued to increase since the large push towards deinstitutionalization and movement towards usage of community-based services (Dixon & Goldman, 2004; Hamden, et al., 2001; Sawyer, 2005). The variety of addictive drugs and factors surrounding drug use and level of success and transition into successful community living is considered to be a positive outcome, especially in the case of consumers with co-occurring disorders. There are still areas in which the program requires improvement and ongoing evaluation can assist with determining

how programs can improve. This is a crucial element of treatment evaluation and program enhancement.

Treatment Planning

Within these treatment plans should be a focus on building social supports and increasing community involvement. Program administrators may also want to identify discharge barriers at the day of discharge in order to determine which treatment goals were reach at the end of program participation. Although a focus on social connectedness may be discussed within residential treatment activities, information about these activities were not included in the follow-up survey. Guidelines for increased effectiveness of independent community living focus on inclusion of social supports, skill building, inclusion of an accurate diagnosis, allowing for encouragement and support from the staff and the consumer's identified support system, and heavy focus on the consumer's goals and where they are within their treatment (Hero & Drury, 2007; Test & Stein, 2000).

Utilization of individualized treatment planning using the guidelines provided by Test and Stein (2000) and by Hero and Drury (2007) would be useful to the program in meeting the goals that they have identified for the program. Treatment planning should include consideration of psychopharmacology and psychosocial components which will assist in identifying applicable therapeutic interventions to promote stabilization and thereafter, ongoing recovery (Sharfstein, 2009). This also requires identification of each consumer's specific needs and individualized treatment goals and objectives addressing unambiguous needs and discharge barriers.

Residential treatment programs and specialty care models provide the opportunity for the consumer to the treatment provider to focus on the treatment of each individual's often difficult-to-treatment disorders (Sharfstein, 2009). There should also be a level of collaboration and

formation of treatment teams that not only include treatment staff from the agency and the identified consumer, but their identified social supports and individuals from other agencies where the consumer may be receiving services.

In addition to individualized treatment plans, it is suggested that an improved evaluation could be produced with additional data. In order to determine what variables impact successful discharge from this program, there needs to be inclusions of all variables that could be impacting a consumer's successful discharge from the program.

Increase Consumer Group Attendance

Each consumer should receive a core set of treatment services that are mandatory and adequately documented. Although it was reported that many different services were available to each consumer, there was evidence that many of the consumers examined did not participate in or receive many of the services offered. For example, according to the orientation manual, each residential consumer is required to attend Continuing Care Alumni Group and other weekly groups as assigned by the Case Manager. Although this may be a requirement, it is clear that the consumers do not always comply with this requirement. Essentially, a consumer can be a resident in the program without being an active participant in the therapeutic treatment program because they may only participate intermittently as they see fit. Treatment and recovery support services are essential in improving independent living skills and it is assumed that attendance in groups is critical for consumer progress; however, without this data and consistent group attendance by the consumers of this program, that statement cannot be authenticated. More information and additional assessment of other aspects of this program along with additional assessment of other programs will benefit the service providers in meeting treatment goals.

Improve Surveys and Follow-up

Ongoing assessment of these types of programs with additional variables will improve the impact that the findings of the evaluations have on the success of the programs. Fellowship House administration reports that it assesses current consumer's opinions of the program and possible issues with the program monthly throughout the treatment period. It may be helpful for the program to conduct an exit interview in which the consumer is able to say what they think was most helpful or least helpful to them during their tenure in the program and for the consumer to be able to note services that they felt that they needed but were not able to get while in the program. Essentially, this would acknowledge whether or not the consumer accomplished any of their own identified goals while in the program. It is helpful to get the consumers' perspectives of the program and their definitions of success. It is advantageous to ensure that the consumers' feel that they have met their personal goals and are ready for independent community living and that they are contributing to the overall wellbeing of the program.

The program should consider creating an emailed format for the follow-up survey in an effort to gather more responses. Many of the phone numbers that consumers provide may be no longer in service for various reasons. Generally, people keep email addresses longer than they keep phone numbers and the digital age requires that the program change with the time in order to collect more accurate data. In addition, the program should consider a major revision of the data collection process in order to get specific program participation data that can be used for program improvement purposes.

Limitations

This study did not include a large sample of participants and a significant amount of these were discharged unsuccessfully from the program having not completed the goals of the program

and being transitioned into independent living. Due to this insufficient data, it was difficult to determine variables that contributed to successful discharge as there were a low percentage of participants that were discharged successfully.

There were a lower number of participants for three month follow-up. Fellowship House staff reported that this was partly due to incomplete aftercare follow-up consent forms, meaning that staff or designated interns could not legally contact past consumers or their family members for follow-up. Most research studies expect to lose around 20% of participants in each follow-up. This number is higher for the population identified in this study. Historically, longitudinal studies for drug users and homeless are difficult to complete because of the unreliability of the participants (Lankenau, Sanders, Hathazi, & Bloom, 2010). Retaining participant contact for follow-up is crucial though, especially considering that the participants who are unable to be contacted may be cases where the participant has relapsed or has not been successful in community living and has therefor been unable to maintain a phone number, familial relationships, or housing preventing follow-up. For this reason, many studies that are not specifically geared towards this population, hesitate to allow individuals with substance use disorders to be participants in the study.

The information provided in the follow-ups was self-reported or family reported. Many individuals may fabricate information in order to make themselves or their family member be seen in a more positive light. There is no proof that those consumers who reported being independent actually had their own homes, etc.

There is a lack of consistency in services provided by the agency. The orientation manual that outlines services offered and activities that are mandatory; yet, those rules are clearly not always followed. Some of the consumers did not participate in groups. Although that

is one of the factors that could be evaluated during the study, one may assume that there are other mandated and offered services that consumers did not participate in. A standard must be set and maintained.

The data examined and analyzed was pre-existing data. The primary downfall of using pre-existing data is that the information and surveys were not created with research in mind and the data was not intended for that purpose. The aftercare follow-up survey used did not provided questions or answers that were meant for coding and analyzing. Clarification was necessary from administrative members of the agency concerning the meanings and purposes of questions and answers on the survey. In addition, the number of each type of group attended (therapeutic, educational, recovery specific) would provide valuable information about the program; however, this information was not available. Simply using the overall number of groups may not adequately help to understand program effects and analysis of this variable is very limited due to this fact.

Lastly, it is important to give emphasis to the fact that this study was conducted on one program that is located in only one state. For this reason, there are limits of generalizability. Programs such as the Fellowship House, Inc. Low Intensity Transitional Apartment Program are not common and this study will impact similar programs. Additional research within transitional living programs for adults with substance use disorders and co-occurring disorders would be beneficial in determining what variables positively and negatively impact successful discharge.

In conclusion, the outcome of the study has identified the possible importance of increased group attendance and treatment length as factors for ongoing independence at three months after discharge. Identifying the consumers' goals and assigning groups and activities that are in line with those, while also retaining the consumers in treatment long enough to accomplish

those goals and create a strong foundation, is key. This will allow for positive outcomes within the treatment program. Assisting the consumer with developing and maintaining adequate supports and coping mechanisms through groups as a part of treatment is central in the ongoing success of stabilization and independence maintenance in the community for consumers.

Discharge and transition to independent living can be stressful for consumers whether or not the discharge is successful or unsuccessful. This stress can be lessened by enduring relationships in the community and ongoing contact with staff and recovering individuals (McCea & Spravka, 2008). The primary focus of the overall study was to determine if any variable contributed to successful discharge and whether or not the variables specific to the program contributed to the outcome variables of *Independent Living* and *Income*. The results suggested that the program specific variables *Length of Stay* and *Group Attendance* were predictors of *Independent Living* and *Income* respectively.

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APPENDIX A
PROGRAM ORIENTATION MANUAL

Low Intensity Transitional Apartment Orientation Manual

"Recovery begins as the individual, personal responsibility for one's own needs"

The purpose of the Low Intensity Transitional Apartment Program is to help individuals that suffer from substance dependence/abuse or dual-diagnosis to maintain sobriety while living in a semi-independent setting, while also developing and maintaining independent living skills sufficient to return to mainstream society.

- I. **Recovery begins as the individual gains personal responsibility for his/her own needs:**
 - a. All clients should utilize their opportunity as a transitional apartment client to develop a budgeting plan. There is an apartment budgeting group held the last Thursday of each month in the apartment office at 4pm and a residential budgeting group held the second Monday of each Month at 2pm.
 - b. Rent is based on a sliding scale that will not exceed \$400.00 monthly/\$200.00 bi-weekly/\$100.00 weekly. Individuals with documented income of under \$1,000.00/ monthly will be considered on a sliding fee scale.
 - c. Apartments are to be kept clean at all times (i.e. dishes washed, bathrooms and common areas cleaned). A community vacuum is kept in the apartment office (Magnolia # 4). Routine inspections are conducted.
 - d. Smoking is not permitted inside the apartments.
 - e. Each person is responsible for their own personal items such as toiletries and food. If clients do not have the means to supply their own food, they may receive one food box each month from FH. Clients may also receive an indigent kit with a case manager's approval.
 - f. Be considerate of the overall living area and personal space. No excessive accumulation of items. Absolutely no cast-off items will be brought in from the street.
 - g. All roommates are responsible for utility bills that exceed \$125.00. FH recommends that clients keep thermostats at 72 degrees to maintain a manageable power bill.
 - h. If you are discharged and do not take your belongings, they will be packed and stored for up to 48hrs in accordance with the FH storage policy. Staff will only pack items that are visible in client's personal area. *FELLOWSHIP HOUSE ACCEPTS NO PERSONAL RESPONSIBILITY FOR YOUR BELONGINGS.*
 - i. You are responsible to participate in night watch duty as scheduled. Missing night watch will result in a \$30.00 charge on the first occasion, two-day restriction and a \$30.00 charge on the second occasion, and discharge on the third occasion. Clients have a responsibility to communicate properly with Placement Coordinator, Apartment Case Manager, and lead staff member during their night watch shift, when duties cannot be performed.
 - j. It is your responsibility to report all personal medications, whether prescribed by a physician or purchased over-the-counter, to staff on duty at the time you obtain medication. Clients are also responsible for informing staff immediately after emergency room/hospitalization or routine doctor's visits by presenting discharge documents and any prescriptions received.
- II. **Residents are responsible for maintaining the therapeutic environment of their aftercare apartment.**
 - a. Visiting hours are allowed in the apartments between the following limits:
 1. Visiting hours are Monday-Friday 3-8pm and Saturday and Sunday 10am-8pm. Visitors are not allowed to be in the bedroom areas of the apartments.
 2. Sexual activity is not permitted in the apartments.

- 3. No fraternization between clients that are involved in any aspect of the FH program. Perception of fraternization will be addressed by staff and individualized direction given on these behaviors.
- 4. Visitation from one apartment to another is prohibited.
- b. You may not be away from the apartments more than two nights at a time without approval from Apartment Case Manager. Absence of over two nights is considered AWOL and will result in discharge.
- c. Conduct in the apartments should exhibit a degree of maturity; therefore behaviors such as gambling, fighting, and verbal altercations will not be tolerated, and can result in discharge.
- d. You will not use drugs or alcohol while a resident in the transitional program, nor will you associate with places or people involved in drug/alcohol use.

All residents are subject to random drug and alcohol screening. If a client admits to his/her drug use, staff will assist them on an individualized basis. Refusal to submit a drug or alcohol screening will result in dismissal from the program.

- e. The confidentiality of other clients must be protected.

III. Involvement in the self-help community and continuing care are vital to the development and maintenance of recovery.

- a. Consistent communication is mandatory. You are responsible for meeting with Apartment Case Manager at least twice a month.
- b. Clients will attend and document at least 4 self-meetings weekly, and turn in meeting verification sheet to Apartment Case Manager on a bi-weekly basis.
- c. Client will attend groups as assigned by Apartment Case Manager.
- d. All transitional apartment clients are expected to attend Continuing Care Alumni group on Wednesdays at 6:30pm every week.
- e. A mandatory house meeting is held in the apartment office (Magnolia # 4) the 1st Wednesday of every month at 6:00am. If your employment interferes and you are unable to attend, you must make arrangements to attend the 5:30pm meeting at the FH in the Upper Putt Hut. If client misses house meeting without being excused, disciplinary actions will be taken.
- f. Independent living evaluations are a valuable tool in tracking client's progress. These forms will be available in the monthly house meeting and are due each month immediately after the meeting.
- g. Clients that are not employed or not engaged in outside structure will be expected to attend at least two of the small groups that are offered at the transitional apartments each week.
- h. FH Apartment Community will provide occasional recreational services to assist in client family and community involvement.

Any of these guidelines can be amended at the discretion of the Apartment Case Manager or Administrative Staff.

Client Signature

Date

APPENDIX B
AFTERCARE FOLLOW-UP SURVEY

AFTERCARE FOLLOW-UP SURVEY

Name of organization conducting follow-up: Birmingham Fellowship House

Name of person conducting follow-up: _____

Date completed:_____ Review Period: [] 3 months [] 6 months [] 12 months

Client case number:_____ Client registry number:_____

Type of FSH program last attended: []residential rehab []ac apartments

Type of discharge from last program:[]good standing []disc.[]med.[]other.[]awol

Date of discharge:_____

Follow-up means: []in person []phone []mail/fax

Source of follow-up means: []client []sig. other []other(_____)

What is your legal status?

- None/BOS
- Compliant on Probation, Parole or Alt. sentence/Community Corrections
- Non-compliant on Probation, Parole or Alt. Sentence/ Community Corrections
- Incarcerated – city or county jail
- Incarcerated - state or federal prison

Drug or alcohol use since leaving treatment?

- None
- Less frequent than before treatment
- More frequent than before treatment
- Continuous frequency – no change

What is your living arrangement today?

- In treatment
- Dependent on family/friends
- In my own place
- Other

How long have you been clean and sober?

- Less than 90 days
- 90 days to 6 months
- 6 months or more

What recovery tools are you currently using?

- 12 Step Meetings
- Sponsor
- Recovery Dynamics
- Church
- Other

What is your vocational status?

- Employed
- Disabled
- Unemployed
- Student

COMMENTS:

APPENDIX C

LOW-INTENSITY TREATMENT PROGRAM APPLICATION

APPLICATION FOR SERVICES

Fellowship House is a recovery program designed to assist the individual who suffers from alcoholism and /or drug addiction. We do not align our program with any specific religious viewpoint, but we do adhere to a spiritually based, 12 step approach to recovery, including a strong emphasis on measurable action in recovery. Our goal is to aid the individual in the personal, vocational and spiritual adjustments required for the maintenance of a sober and productive life.

BASIC DEMOGRAPHICS:

DATE _____

NAME _____
LAST FIRST MIDDLE

APT# _____ TELEPHONE _____ EMAIL _____

RACE _____ SEX _____

DATE OF BIRTH ____/____/____ AGE _____

SOCIAL SECURITY NUMBER _____ - _____ - _____

EMPLOYMENT STATUS _____ LONGEST PERIOD OF EMPLOYMENT AT ONE TIME _____

HIGHEST LEVEL OF EDUCATION _____

MARITAL STATUS (circle one): single – married – divorced – separated – living as married

CHILDREN (NAME, GENDER, AND AGE)

EMERGENCY CONTACT

NAME #1 _____ PHONE _____ RELATION _____

NAME #2 _____ PHONE _____ RELATION _____

RECENT TREATMENT OR HOSPITALIZATION _____

HAVE YOU HAD AN ASSESSMENT WITH ANY SUBSTANCE ABUSE PROFESSIONAL? If SO, WHEN AND BY WHOM, AND WHAT DIAGNOSIS WAS GIVEN?

ANY PAST OR CURRENT MEDICAL OR PSYCHIATRIC CONDITIONS?

CURRENT PRESCRIBED MEDICATIONS

ALLERGIES _____

WHAT ARE YOU CURRENTLY DOING TO MANAGE YOUR PHYSICAL HEALTH?

WHAT CAN FSH DO TO ASSIST YOU WITH YOUR PHYSICAL HEALTH?

WHAT ARE YOU CURRENTLY DOING TO MANAGE YOUR MENTAL HEALTH?

WHAT CAN FSH DO TO ASSIST YOU WITH YOUR MENTAL HEALTH?

WHAT ARE YOU DOING TO IMPROVE YOUR SPIRITUAL HEALTH?

WHAT CAN FSH DO TO ASSIST YOU WITH YOUR SPIRITUAL HEALTH?

WHAT OTHER SUPPORT ARE YOU SEEKING FROM FELLOWSHIP HOUSE?

WHAT IS YOUR LEGAL STATUS:
 none/ End of Sentence
 Compliant on Probation, Parole or Alt Sent/ Community Corrections
 Non-compliant on Probation, Parole or Alt Sent/ Community Corrections

HOW LONG HAVE YOU BEEN CLEAN AND SOBER _____
LONGEST PERIOD OF SOBRIETY _____

WHAT ARE YOU CURRENTLY DOING TO STAY CLEAN & SOBER

WHAT ARE SOME OF YOUR CHALLENGES IN MAINTAINING RECOVERY

RECOVERY/LIVING ENVIRONMENT:

WHAT WAS YOUR LIVING SITUATION BEFORE COMING TO FELLOWSHIP HOUSE?

WHAT WOULD YOU LIKE YOUR LIVING ARRANGEMENT TO BE?

HOW CAN FSH HELP YOU GET THERE?

WHAT ARE YOU DOING TO MANAGE YOUR RECOVERY?

HOW SATISFIED ARE YOU CURRENTLY WITH YOUR RELATIONSHIPS WITH FAMILY, FRIENDS, & YOUR COMMUNITY_____

An individualized team oriented approach to recovery is particularly effective. Please list anyone you would like to authorize regarding your program at FSH (individual consent forms & contact info will be completed prior to contact)

FAMILY/CLOSE FRIENDS:

DOCTORS:

LEGAL ENTITIES:

OTHER:

CONTRACTUAL AGREEMENT

I, _____ UPON BEING ACCEPTED AS A RESIDENT OF FELLOWSHIP HOUSE, INC, DO AGREE TO THE FOLLOWING CONDITIONS:

- A) I WILL HOLD FELLOWSHIP HOUSE, INC., ITS AGENTS, MEMBERS, OR EMPLOYEES FREE FROM ALL LIABILITY FOR LOSSES THROUGH FIRE, THEFT, OR PERSONAL INJURY WHILE I AM A RESIDENT OF THE PROGRAM.
- B) I GRANT PERMISSION FOR A REPRESENTATIVE OF FELLOWSHIP HOUSE, INC. TO INSPECT MY BELONGINGS AND REMOVE THEREFROM ANY PROHIBITED MATERIALS AT ANY TIME (ALCOHOL, DRUGS, WEAPONS, ETC.).
- C) I AGREE TO BE CONTINUOUSLY TESTED FOR ALCOHOL AND DRUGS AS REQUESTED BY THE STAFF.
- D) I UNDERSTAND THAT WHILE A RESIDENT OF FELLOWSHIP HOUSE, INC. I MUST MAINTAIN COMPLETE ABSTINENCE FROM ANY ALCOHOLIC BEVERAGES AND/OR MOOD ALTERING SUBSTANCES.
- E) I ALSO UNDERSTAND SHOULD I BREAK THE AFOREMENTIONED ABSTINENCE AT ANY TIME, IT CAN RESULT IN DISCHARGE/TRANSFER TO ANOTHER LEVEL OF CARE, AND WILL RELIEVE FELLOWSHIP HOUSE, INC AND STAFF OF ITS RESPONSIBILITIES FOR ME AS A RESIDENT OF FELLOWSHIP HOUSE, INC.
- F) I UNDERSTAND THAT IF DISCHARGED AND UNABLE TO TAKE MY BELONGINGS FROM FELLOWSHIP HOUSE, MY PROPERTY WILL BE PACKED AND STORED FOR 48 HOURS. AFTER THAT TIME, ALL BELONGINGS WILL BE DISCARDED. I ALSO UNDERSTAND FELLOWSHIP HOUSE IS NOT RESPONSIBLE FOR ANY BELONGINGS LEFT AFTER DISCHARGE.
- G) I UNDERSTAND THAT THE RULES AND REGULATIONS OF FELLOWSHIP HOUSE, INC. ARE TO BE CONSIDERED A PART OF THIS CONTRACT. IF AT ANY TIME I FAIL TO OBSERVE THESE AND OTHER CONDITIONS IT WILL RESULT IN DISCHARGE.
- H) I UNDERSTAND THAT AT ANY TIME IF I CHOOSE TO DISENGAGE MYSELF FROM RESIDENTIAL TREATMENT AND COMMUNICATE THIS TO THE TREATMENT TEAM, IT WILL RESULT IN DISCHARGE.
- I) FELLOWSHIP HOUSE, INC. IS NOT RESPONSIBLE FOR ANY MEDICAL OR DENTAL EXPENSES NOT COVERED BY EXISTING PAYMENT MECHANISMS.
- J) I AGREE TO PAY RENT/SERVICE FEES AS ESTABLISHED AT INTAKE INTERVIEW AND TO KEEP FH INFORMED PROMPTLY REGARDING CHANGES TO MY INCOME. (MAXIMUM FEE IS \$100/WEEK).
- K) I UNDERSTAND THAT FAILURE TO MEET FINANCIAL RESPONSIBILITIES CAN RESULT IN DISCHARGE/TRANSFER TO ANOTHER LEVEL OF CARE.
- L) AN ADMISSION FEE OF \$35.00 IS REQUESTED AT THE TIME OF ADMISSION TO ANY FELLOWSHIP HOUSE RESIDENTIAL PROGRAM.
- M) I UNDERSTAND THAT NO INFORMATION ABOUT ME WILL BE RELEASED FROM FSH WITHOUT MY WRITTEN PERMISSION **EXCEPT UNDER CERTAIN CIRCUMSTANCES.**
 - 1. If I present a serious danger to myself or another person.
 - 2. If FH staff has good reason to believe that a child, elderly individual or dependent adult is being or has been abused or neglected. (FH must contact the Alabama Department of Human Resources)
 - 3. If a subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosure.
- N) I UNDERSTAND THAT FH STAFF CANNOT PROMISE CONFIDENTIALITY FROM OTHER RESIDENTS

I, _____ GIVE FELLOWSHIP HOUSE INC. PERMISSION TO ENTER MY PERSONAL INFORMATION INTO THE ELECTRONIC ALABAMA SUBSTANCE ABUSE INFORMATION SYSTEM (ASAIS) AND CLAIMTRAK ELECTRONIC RECORD SYSTEM FOR BILLING AND DOCUMENTATION PURPOSES.

SIGNATURE OF APPLICANT _____ DATE _____
WITNESS _____ DATE _____

CLIENT PRIVACY
Effective April, 2003

There is a new law that protects you by keeping your medical information private. Read this notice to find out what you need to know.

FOR YOUR PROTECTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You do not need to do anything with this notice unless you have a problem or concerns about this law. This notice is being given to you so you will know about this law.

FELLOWSHIP HOUSE PROMISES TO KEEP YOUR INFORMATION PRIVATE

Your health information is personal. However, there are times when Fellowship House must share information with others to help you get the health care that you need. When this must be done, Fellowship House promises to follow the law so that your information is kept private. This notice tells you how Fellowship House uses and shares information about you and what your rights are under the law. It tells the rules Fellowship House must follow when using or sharing your information.

UNDERSTANDING THE TYPE OF INFORMATION THAT MAY BE SHARED

There are many good reasons for your information to be shared. If you apply for treatment services through another agency, that agency must send information about you to Fellowship House. Information that may be sent to us includes your name, address, birth date, phone number, Social Security number, and health information. When Fellowship House sends claims to the Department of Mental Health Substance Abuse Division for payment, the claims must include your diagnosis and other information.

HOW FELLOWSHIP HOUSE USES AND SHARE HEALTH CARE INFORMATION

Fellowship House contracts with others outside the agency for some services. For example, Fellowship House contracts with the State Department of Mental Health Substance Abuse Division. Fellowship House may need to share some or all of your information with DMH so your treatment cost can be paid. When this is done, Fellowship House requires that company to follow the law and keep all of your information safe. Here are the ways Fellowship House uses and shares your treatment health information. For each category, we will say what we mean and give an example.

For payment: Fellowship House may use and share information about you so that we receive payment. On the claim for, Fellowship House must identify you and say what your diagnosis and treatment are.

For Medical Treatment: Fellowship House may use and share information about you to make sure that you get needed medical treatment or services.

To Other Government Agencies Who Provide Benefits or Services to You: Fellowship House may share information about you to other government agencies that are giving you benefits or services. For example, Fellowship House may be asked to give the Alabama Department of Public Health information so you can receive medical or Alabama Department of Education- Vocational Rehab Services.

To Keep You Informed: Fellowship House may share information about you to the government agencies that license and inspect our facilities. An example is that Alabama Department of Mental Health which inspects state programs.

To Check on Health Care Providers: Fellowship House may share information about you for an approved research project. A review board must approve any research project and its rules to make sure your information is kept private.

As Required By Law: When requested, Fellowship House will share information about you with the U.S. Department of Health and Human Services.

YOUR HEALTH INFORMATION

You have the following rights about health information that Fellowship House has about you.

- You have the right to see a copy of your health information with certain exceptions.
- You have the right to ask Fellowship House to change health information that is incorrect or incomplete. Fellowship House may deny your request in some cases,
- You have the right to ask what items and with whom Fellowship House talk with you about your health in a way or at a place that will help you keep your health information private.
- You have the right to get a paper copy of this notice.

FELLOWSHIP HOUSE REQUIREMENTS

Fellowship House, Inc. is required by law to:

- Keep your information private.
- Give you this notice that tells the rules Fellowship House must follow when using or sharing your information with others.
- Follow the terms of this notice.
- Except for the reasons given in the notice, Fellowship House may not use or share any information about you unless you agree in writing. You may take away your permission at any time, in writing, except for the information that Fellowship House disclosed before you stopped your permission. If you cannot give your permission due to an emergency, Fellowship House may release the information if it is in your best interest. Fellowship House must notify you as soon as possible after releasing the information.
- In the future Fellowship House may change its privacy practices and may apply these changes to all treatment information we have. Should Fellowship House privacy practices change, Fellowship House will inform you of the new notice within 60 days. Fellowship House will also post the new notice on the client bulletin board.

TO FIND OUT MORE

If you have questions or would like to know more, you may see the Director of Treatment Services or the Executive Director.

TO REPORT A PROBLEM

If you believe your privacy rights have been violated, you may:

- File a complaint with Fellowship House, Inc., 1625 12th Avenue south, Birmingham, AL 35205. State Advocacy Office, Department of Mental Health Substance Abuse Division, RSA Union Building, 100 North Union Street, P.O. Box 301410, Montgomery, AL 36130-1410 (1-800-367-0955).
- File a complaint with the Secretary of Health and Human Services by writing to Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, D.C. 20201. For additional information you may call toll-free 1-877-696-6775.
- File a grievance with the United States Office of Civil Rights by calling toll-free 1-800-627-7748

APPENDIX D
LETTER OF APPROVAL



FELLOWSHIP HOUSE INC.
RECOVERY SERVICES

1625 12th Avenue South • Birmingham, AL 35205
205-933-2430 • 205-933-2475 (fax)
www.fshbhm.org

2/22/13

Auburn University Institutional Review Board
c/o Office of Human Subjects
307 Samford Hall
Auburn, AL 36849

Please note that Asha McAdory, Auburn University Graduate Student, has the permission of Fellowship House, Inc. to conduct research at our facilities in Birmingham, Alabama for her program evaluation study.

Ms. McAdory will use previously collected data and information from applications, residential surveys, and follow-up questionnaires. Our interns and continuing care staff will provide de-identified information regarding clients for use in her research. Ms. McAdory's on-site research activities will be finished by January 1, 2014.

Ms. McAdory has agreed not to interfere with the delivery of client services. Ms. McAdory has also agreed to provide my office a copy of the Auburn University IRB-approved, stamped consent document before she reviews the previously collected data, and will also provide a copy of any results.

If there are any questions, please contact my office at 205-933-2430.

Sincerely,

Beth Bachelor
Chief Executive Office
Fellowship House, Inc.

