

**Substance Abuse
Treatment –
Enhancing Client
Readiness and Linkages**

January 2010

ACKNOWLEDGEMENTS

This study was the result of the vision of members of the Comprehensive Planning Committee and the North Central Texas HIV Planning Council. They realize that improving substance users' readiness for treatment is difficult to accomplish, but believe it is very important to pursue in order to improve health and reduce the spread of HIV. It is hoped that this study will improve practice and result in linkage with appropriate resources.

Special thanks to the Chair and Vice Chair of the Comprehensive Planning Committee who provided significant expertise in case management and substance abuse treatment:

Francine Esposito Pratt, MSSW, LMSW-AP, Assistant Professor and Coordinator of Field Education, Social Work Program, Tarleton State University

Randy Parsons, HIV Services Program Director, Division of Addiction Services, MHMR of Tarrant County

Thanks also to the following committee and council members:

Michelle Barefield, Comprehensive Planning Committee

Oliver Calderon, Comprehensive Planning Committee

Don Clyburn, Comprehensive Planning Committee

Stacey Davis, Comprehensive Planning Committee

Steve Dutton, Comprehensive Planning Committee

David Henderson, Comprehensive Planning Committee

Ray Moore, Comprehensive Planning Committee

Sylvia Alonzo Rawlings, Planning Council Chair

Casey Rashaw, Comprehensive Planning Committee

Lydia Rosenbaum, Comprehensive Planning Committee

Service Delivery Agency Council (SDAC)

Steven Stellner, Comprehensive Planning Committee, Vice Chair Planning Council

Ron Stinson, Comprehensive Planning Committee

Staff of the Tarrant County Public Health Administrative Agency

And the dedicated staff:

Jamie Schield, Planning Coordinator

Gil Flores, Assistant Planning Coordinator

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY (separate document).....	(i)
ACKNOWLEDGEMENTS	i
I. BACKGROUND	1
II. SUBSTANCE ABUSE TREATMENT CONTINUUM OF CARE	3
III. READINESS FOR SUBSTANCE ABUSE TREATMENT	7
IV. CASE MANAGERS' ROLE WITH SUBSTANCE ABUSING CLIENTS.....	8
V. BARRIERS TO SUBSTANCE ABUSE TREATMENT.....	11
VI. SPECIAL POPULATIONS.....	12
VII. MODEL PROGRAMS, REGIONAL ADVOCACY, AND STATEWIDE INITIATIVES	13
VIII. RECOMMENDATIONS AND ISSUES FOR FURTHER STUDY	16

APPENDICES

- A. KEY INFORMANTS
- B. DEFINITIONS OF SUBSTANCE USE, ABUSE, DEPENDENCE
- C. SUBSTANCE ABUSE TREATMENT CONTINUUM OF CARE
- D. NORTH CENTRAL TEXAS PLANNING COUNCIL SUBSTANCE
ABUSE TREATMENT RESOURCE INVENTORY PROVIDER SURVEY
- E. DEFINITION OF ACRONYMS

I. Background

Introduction

Substance abuse exacts a severe physical and emotional toll on any individual, but complications are compounded for people living with HIV/AIDS (PLWHA). Among other issues, substance abuse impacts PLWHA health, treatment adherence, and maintenance in HIV medical care. The North Central Texas HIV Planning Council (Planning Council) identified a significant number of substance using clients in the region. It was felt that only a small percentage of substance using PLWHA were acknowledging their addiction and seeking treatment. Findings during this study confirmed the Planning Council's concerns:

- A medical case manager estimated that 60% to 75% of the 900 patients at her agency smoke marijuana. Actual drug screens of 25 patients conducted at this agency found three (12%) had positive reports, and 23 (92%) tested positive for some drug in the past three years.
- Providers report increasing PLWHA addiction to prescription pain killers.
- HIV Early Intervention (HEI) case managers,¹ who work only with substance abusers, report 65% to 80% of their clients use crack, 15% to 25% use IV methamphetamine, 5% to 10% use heroin. There are few alcoholics in this group.

Goals, Objectives and Methodology

Goal

The overarching goal of this study was to develop strategies to increase PLWHA readiness for substance abuse treatment and support them in accessing treatment as early as possible in their addiction.

Objectives

- Improve substance abuse screening, particularly among HIV case managers.
- Identify strategies to encourage PLWHA readiness for substance abuse treatment and professional skills necessary to support accessing treatment.
- Determine the adequacy of the substance abuse treatment continuum of care in the region.
- Review current substance abuse screening and referral practices within the North Central Texas system and other best practices for HIV+ clients.
- Define and recommend enhancements to substance abuse identification, screenings and assessments by HIV case management staff.
- Identify characteristics of a responsive referral system;
- Examine treatment options for the region including a detailed provider inventory;
- Determine substance abuse providers' practices related to HIV assessment, screening and linkage with medical care;

¹ HEI case managers provide intensive case management to HIV positive substance abusers, supporting them in accessing substance abuse treatment, HIV medical care and other service needs.

- Provide relevant recommendations for further study, including the mental health and substance abuse connection.

Methodology

This study was conducted in two parts. The first part provided background and quantitative information. The second phase expanded the results through additional key informant interviews and a substance abuse provider resource inventory obtained through personal contact with the agencies. The complete methodology included:

- Literature review and model program evaluation, examining national and regional programs.
- Fifteen key informant interviews to evaluate current services, discuss and refine model programs, identify statewide and regional initiatives and potential partnerships. (Refer to Appendix A for a list of key informants.)
- Consumer focus groups with PLWHA recently accessing substance abuse treatment in the region.
 - Two were conducted in the Ft. Worth area.
 - One was attempted in Wichita Falls, but only one person attended. Therefore, interviews were conducted with the two medical case managers and one key informant was added.
- One case manager focus group to determine current intake, identification and referral approaches as well as suggestions for process improvement.
- Detailed inventory of substance abuse treatment providers which included telephone contact with all programs.
- In conjunction with the resource inventory, completion of a short provider telephone survey to identify PLWHA treated, HIV risk factor screening practices, linkages with HIV counseling and testing and HIV medical care.
- Review of Substance Abuse and Mental Health Services Administration (SAMHSA) and HIV program funding in the region for opportunities to expand and enhance substance abuse treatment services to best meet the needs of targeted populations, including in care and out of care consumers.

Definition of Substance Abuse

Professionals and consumers presented a range of experiences with substance use/abuse resulting in varied definitions of what constitutes substance abuse. Therefore, operational definitions of substance use, abuse and dependence should be developed for the region in order to ensure that everyone is working from the same frame of reference. The DSM-IV² definition of substance abuse is frequently cited and is recommended for use in the region. It states:

² The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. The last major revision was the fourth edition ("DSM-IV"), published in 1994.

- A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
 2. Recurrent substance use in situations in which it is physically hazardous.
 3. Recurrent substance-related legal problems.
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.³
(Refer to Appendix B for additional definitions)

II. Substance Abuse Treatment Continuum of Care

Insured consumers will find the substance abuse continuum of care is readily available throughout the region. Indigent or under-insured consumers confront waits for treatment and limited options.⁴

The Role of the OSAR

Texas Department of State Health Services (DSHS) contracts with regional agencies to manage the residential substance abuse treatment waiting list. These agencies do not provide treatment, but perform outreach, screening, assessment and referral services (OSAR) on a regional basis. DSHS has defined priority populations, and the OSAR complies with these priorities in allocating treatment beds.⁵ Since the OSAR manages only the residential component of treatment, key informants and providers remarked that individuals may not progress seamlessly throughout the continuum.

Gaps in the Continuum of Care are Found Throughout the Region

In compiling the resource inventory, gaps identified during the focus groups and key informant interviews were confirmed. These include:

- Limited services and limited treatment choices for indigent clients.
- The residential treatment option most readily available to PLWHA is the statewide program in Dallas. It targets PLWHA and is not controlled by the OSAR. If indigent or under-insured consumers do not want to access this program, the wait for treatment through the OSAR can be a month or more.
- Waiting time to begin substance abuse treatment is common, with treatment on demand typically not available. Intensive case management provided by the SAMHSA-funded

³ <http://www.medterms.com/script/main/art.asp?articlekey=24405> retrieved November 3, 2009.

⁴ Detailed information about substance abuse treatment programs and providers can be found in the “North Central Texas HIV Planning Council Resource Inventory—Regional Substance Abuse Treatment Services,” accompanying this report.

⁵ DSHS priority populations (in order) are: pregnant injecting drug users; pregnant substance abusers; injecting drug users; parents with children in foster care; honorably discharged veterans; all other substance abusers. http://www.dshs.state.tx.us/sa/training/OSAR_FAQs.pdf Retrieved January 10, 2010.

HIV Early Intervention (HEI) case management team assists in supporting PLWHA awaiting treatment. HEI has an interim services program that included ambulatory detox and supportive outpatient treatment.

- One key informant stated, “People can get referrals right way, but there is a waiting period for treatment. There needs to be treatment immediately.”
- Another said, “Clients needing residential treatment are put on waiting list and referred to outpatient treatment while they are waiting. It is a slow process to make the referral and complete all requirements (of the statewide program or other for residential treatment).”
- Waiting time between phases of treatment, particularly between detox and residential treatment, results in clients lost to treatment. The client may be admitted to detox, discharged without a residential bed, managed with intensive or supportive outpatient (this may last for several weeks), and admitted to residential treatment when a bed becomes available.
 - A consumer stated, “The wait after detox was supposed to have been a few days – you have to keep calling every morning, Monday through Thursday between 8 and 9AM and they put your name on the list. If you miss a day without calling, they take your name off the list.”
 - A case manager says that she makes these calls for her clients if they are unable— to make sure they maintain their position on the waiting list.
- Supportive aftercare services are identified as needed throughout the region. Consumers identified the need for educational or other programs that provide a purpose to their days.
 - If PLWHA receive residential treatment at the statewide program in Dallas, aftercare treatment in their local community will support recovery.
 - Throughout the region, support groups are most frequently used for aftercare.
 - Consumer focus group participants expressed a need for educational, social or other activities as exemplified by the statement, “Once you do something constructive in a day's time, the rest of the day will go pretty good and then you can go chill out and watch television, but you don't want to watch television every day -- day in and day out.”
 - Alcoholic Anonymous/Narcotics Anonymous (AA/NA) support groups were not highly regarded by consumer focus group participants.
- Key informants identified a need for additional dual diagnosis programs for indigent patients suffering from both a mental health disorder and substance abuse.

Regional Substance Abuse Treatment Services

The following is a brief overview of components of the substance abuse treatment continuum of care. This discussion focuses on services available to indigent or under-insured clients. (Appendix C provides additional information about the number of available programs by location.)

Detox

Of 13 detox providers in the region, four are available to indigent/under-insured clients.

- Locations include Abilene, Dallas, Ft. Worth, and Hico.
- The wait for detox at the Ft. Worth organization typically ranges from two to four weeks. Transition from detox to residential treatment typically requires a waiting period.
- PLWHA access to detox and residential treatment is much easier/quicker at the statewide program in Dallas. Reportedly, however, since initiating a smoke-free campus, smokers are reluctant to access this service.
- In the rural areas, detox and residential treatment generally combine seamlessly, with out a waiting period. The rural organizations report more flexibility due to limited demand for services.

Residential Treatment

While 14 regional programs offer short term (under 30 days) residential treatment, six are available to indigent or under-insured clients. One of these provides treatment for different populations at three locations in Ft. Worth.

- Three require intake and bed allocation to be performed by the regional OSAR, with Regions 2 and 3 represented.
- Two providers have short term residential programs dedicated to treatment of criminal justice prisoners or parolees.

Extended or long-term residential treatment is offered by 16 organizations and treatment duration ranges from 60 days to 18 months or more. Ten of these providers accept indigent or under-insured clients.

- The statewide program for PLWHA is 60 days in duration.
- One rural program is supported by private payment, but also provides reduced rate or indigent care as part of its mission.
- Three “public” programs focus on criminal justice patients. Two of these also accommodate a limited number of other clients.
- Two no-cost programs are 12 months or more in duration, and they require clients to commit to their model and timeframe.
- Two are work-based programs in which participants must be physically able to work.
- One treats adolescents only, and is a statewide resource for adolescent treatment.

Partial Hospitalization

Eleven programs offer partial hospitalization programs. This approach is more common for insured or privately paying patients, with eight requiring insurance,

- Only one program was identified in Ft. Worth, with nine in rural town and one in a suburban area.
- One rural provider combines private payment with scholarships for indigent patients who have local housing.

Intensive Outpatient Treatment

Intensive outpatient (IOP) is a widely available treatment modality. Programs are typically several hours for at least three days per week. Individual, group and family therapy are usually included.

Outpatient Treatment

A variety of outpatient treatment options are available at 26 organizations with 37 locations. These include individual counseling, group therapy and family therapy.

Aftercare

All organizations offering residential treatment provide aftercare services to those who complete the program. In most cases, aftercare involves support groups offered free of charge. Reportedly, most PLWHA completing the statewide program in Dallas prefer to find aftercare services closer to their home in order to avoid the commute.

PLWHA-specific support groups are available at Serenity House and AIDS Outreach Center (AOC), but other PLWHA aftercare support groups may be needed.

Methadone Maintenance

Four organizations with six locations offer methadone maintenance. Three do not have reduced payment, but one states they will take anyone with an opioid addiction.

- Four locations are in Ft. Worth, one is in Wichita Falls and one is in Haltom City.

Clean and Sober Housing

Five organizations provide clean and sober housing. This is in addition to two residential treatment programs that are 12 to 18 months in duration.

- One organization requires private payment and is able to access state support through Texas Workforce Commission.
- One Ft. Worth organization provides a variety of housing options for PLWHA.

Substance Abuse Treatment Services and PLWHA

Treatment of PLWHA

During the resource inventory telephone survey⁶, agency representatives were asked to estimate the percentage of their clients who are HIV positive.

- Eight (24%) organizations report not being able to estimate that percentage with several reporting that they do ask clients their HIV status.

⁶ Refer to Appendix D for survey form

- Outpatient programs are less likely to identify HIV status than residential or other inpatient programs.
- Six agencies (18%) report 1% or less of their clients are HIV positive.
- Fourteen (41%) organizations estimate that less than 5% of their clients are HIV positive.
- A large public Ft. Worth organization reports between 5% and 10% of its clients are PLWHA.
- An adolescent residential program has not had an HIV positive youth in the last eight years.
- The organization with the statewide program PLWHA allocates 19 beds to this dedicated unit, which is 16% of its bed complement.

HIV Risk Factor Assessment

The Health Resources and Services Administration (HRSA) identified substance abuse treatment providers as a key point of entry to HIV medical care. Key points of entry afford access to people with HIV risk factors who would benefit from HIV counseling and testing (C&T) as well as those who know their status but may not be receiving HIV medical care.

Substance abuse providers were asked if they assess their clients' HIV risk factors, provide counseling and testing services (C&T), and include HIV status in the medical history. Over 85% report assessing clients for HIV risk factors.

- Nearly two thirds of substance abuse providers offer C&T services through a community organization that delivers the service at the provider's site. Typically these community organizations come to the substance abuse treatment location on scheduled dates, but are also available "on call" if testing is required.
- Eighteen percent refer to an agency for counseling and testing. This is often the case in rural areas.
- Ten percent of the representatives did not know if or how counseling and testing was conducted.
- More than three quarters of substance abuse treatment providers include HIV status in their health histories. However, in some of these cases, the administrator answering questions responded positively based on the assumption that the program physician would include this information.
 - One large Ft. Worth agency reported that HIV status is confidential so they do not ask about it. If the client volunteers they follow up to ensure access to HIV medical care.

III. Readiness for Substance Abuse Treatment

Consumer Perspective

Consumers were asked how to motivate/encourage someone to begin treatment. The most frequent answer from consumer focus group participants was that a person must "hit bottom" before accessing substance abuse treatment. Internal motivation is considered critical to beginning treatment and maintaining recovery. "Sick and tired of being sick and tired" was a common expression used across consumer groups.

Other reasons given for moving into treatment included financial (“tired of my money disappearing”) and family.

Provider Perspective

During the case manager focus group, participant comments illustrated the difficulty they face in moving clients to treatment and the frustration in seeing them relapse. Enhanced skills, adequate time with clients and case manager support to avoid burnout were identified case manager needs.

- One case manager stated, “That is my biggest problem – helping them understand they have a problem, they need the help ... It's got to be when they hit it. Until they're ready, they will come out and start using again. They will go to treatment for 60 days and come back, be clean for a week or two and then be right back in it.”

Case managers suggested linking substance use with medications/medical care may be the most effective motivator.

- A case manager who recently moved from a large AIDS services organization (ASO) to an HIV medical clinic stated, “Clients tend to be a lot more honest (in a medical clinic). When you ask, ‘Tell me what you are using because it might affect which medications the doctor prescribes,’ they typically own up to it. In three and a half years ___ (ASO), I probably had four people come to me and say ‘OK, I need help.’ The rest say they use occasionally but it is not a problem. At ___ (clinic) I have found 60% to 75% admit using.
 - Other suggestions included linking it to their finances or establishing a contract to reduce substance use.
 - One rural case manager has clients keep a financial diary of how they spend money so they can see the actual cost of drug/alcohol use.

IV. Case Managers’ Roles with Substance Abusing Clients

HIV Case Manager’s Role in Substance Abuse Screening

Case Managers Roles are Diverse

- Case managers attending the focus group represented a wide range of roles and funding sources. They each may provide case management for the specific services their agency provides. The result is that consumers have multiple case managers.
 - Although some duplication may be necessary based on funding source requirements, a unified case plan with a “lead” case manager will support efficient and effective care.
- Case manager focus group participants’ case loads range from 25 to 200 clients.
 - Case managers at one large organization report 200 clients in their care loads. They evaluate substance use on intake and annually during the recertification process. They report spending much of their time making social services referrals.

- No uniform acuity system is used for HIV case management, although one is currently being developed and implemented
- HIV case manager turnover is high.
 - Consumers stated that their case managers change often, and this was confirmed with case managers during their focus group.

Case Managers are Willing to Increase Their Role in Substance Abuse Screening

- All case managers in this study expressed a willingness to increase their roles in substance abuse screening.
- They acknowledged a need for tools and training to do it effectively.
- Key informants expanded on this:
 - “Train case managers in universal screening tool, then refer to professional or other agency for complete assessment. Case managers need to develop skills and have confidence to confront clients and resolve issues.”
 - “Case managers need to be better trained in what they are dealing with so they have a better understanding to identify problems, understand the extent of the problem, and realistic expectations for outcomes.”

Substance Abuse Screening Tools

- The Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) were reviewed during the case manager focus group. The participants indicated a willingness to use them with appropriate training.

The most frequent comment about the SAMISS was that it appears very sensitive.

- One case manager focus group participant is currently using the SAMISS. She was not trained on how to administer it.
 - She stated that SAMISS is “too sensitive. If clients admit to one thing they need a referral. I then must document why a referral is not being made.”
- In Abilene the case manager uses SAMISS as a “conversation starter.”
- AOC case managers reported use of a tool that combines assessment and client satisfaction.

Enhancing Case Managers’ Interviewing Skills

- Some of the case managers feel that there is a “wall or barrier” when substance abuse issues are brought up.
- They indicated an interest in developing motivational interviewing and other skills to help reduce substance use or improve clients’ readiness for treatment.
- Although all case managers will benefit from the training, their case loads will impact implementation.

Resource Inventory is a Tool for Case Managers

During Phase I of this project, several participants in the case manager focus group demonstrated limited knowledge of substance abuse treatment programs in the region, particularly outpatient programs. Remarks included:

- “(There is) not much in the way of outpatient counseling and partial day treatment, and none for people who are HIV+.”
- One case manager at a large agency was not familiar with outpatient substance abuse treatment options, asking, “What are our current outpatient substance abuse treatment services (in the region)?”
- One case manager stated, “None of the residential treatment programs for women allow children to remain with their mothers.” A program with this configuration was identified as a need. The resource inventory identified one Ft. Worth program with this configuration.

The substance abuse treatment resource inventory should aid case managers in making appropriate referrals to substance abuse treatment providers.

HEI Case Managers

HIV Early Intervention (HEI) case managers are licensed chemical dependency counselors (LCDC) that provide intensive case management using a hands-on approach.

- The HEI program incorporates counseling with case management. HEI case managers reported splitting their time equally between these two functions.
- Approximately two-thirds of an HEI case manager’s time is spent in direct activities with clients including conducting assessments, supporting client access to substance abuse treatment, follow-up after treatment, working with other agencies to secure or maintain housing, ensuring clients access medical care, supporting treatment adherence including attending medical appointments and maintaining medication regimens, accessing psychiatric and mental health services as necessary. They also personally provide transportation to and from appointments.
- HEI case managers currently work with “hard core” substance users. Functional addicts as well as chronically homeless are populations with a need for treatment that they typically don’t see. One HEI case manager estimated they could increase their case load by 75% if these clients accessed their services.

HEI case managers are funded by a SAMHSA grant, and they must use the Behavioral Health Integrated Provider System (BHIPS) for documentation. This system does not communicate with the HIV data system, ARIES, resulting in the need for duplicate documentation. This is time consuming and may limit communication.

HEI is an excellent resource for HIV case managers, providing an important link to substance abuse treatment. Once an HIV case manager identifies a substance using client willing to access treatment, the case is immediately referred to HEI.

- Every quarter four or five referred clients do not complete intake with HEI.

Key informants suggested expanding the HEI role to provide HIV case manager training. It was felt this would increase the level of expertise across the system, promote uniformity in screening, and support appropriate referrals from HIV case managers to HEI.

- A case manager suggested HEI case managers should become leaders of multidisciplinary client treatment teams, combining all services and resources to optimize care and treatment.

V. Barriers to Substance Abuse Treatment

The most significant barrier to substance abuse treatment is client readiness. Once this is overcome, the care system should ideally make accessing care easy. Unfortunately, this is often not the case. The following barriers may result in the client returning to substance use and not accessing treatment:

Waits for Treatment. Waits for residential treatment can be up to four weeks. A client's resolve to access treatment may diminish during the waiting period, and he/she is lost to treatment.

Limited Service Integration and Collaboration. Programs and services reportedly operate in "silos," limiting providers' information about and understanding of consumers.

- Consumers have multiple case managers, in some cases up to five or more.
 - "Clients have too many case managers and communication between them is difficult and time consuming."
- Multiple case managers may have different priorities for the same client. "Need to define who is the lead person, so someone is responsible for coordinating care."
- Tarrant County providers have at least three different data systems in use depending on funding source. These include:
 1. AIDS Regional Information and Evaluation System (ARIES) – the Texas HIV/AIDS reporting database,
 2. Homeless Management Information System (HMIS),
 3. BHIPS used by HEI case managers.
- DSHS also has different divisions working on similar issues resulting in different requirements and approaches, i.e. HIV vs. substance abuse and mental health.

Placing Client in First Available Treatment Due to waiting lists and gaps in the treatment continuum, clients may receive treatment from the "first available" program, not the program that best meets their needs.

- Program requirements or quotas limit access for various groups, i.e. ex-offender, minority-specific.
- In one consumer focus group, participants agreed that a widely available program "treats you like you are in middle school." Most would not use or recommend this program.
- The HIV statewide program reportedly recently enacted a smoking ban on its campus.

Transportation to outpatient services and aftercare is a barrier, particularly evening support or therapy groups.

- This is a significant barrier in Abilene and other rural areas.

Substance Use May Negatively Impact Entitlements/Benefits. Consumers do not mention their substance abuse at agencies where it might affect their benefits or entitlements such as housing, groceries, and other services.

Limited substance abuse treatment services are available for undocumented immigrants.

- Deportation fears cause undocumented immigrants to avoid substance abuse treatment.

VI. Special Populations

Dual Diagnosis

A dual diagnosis refers to a person who has both mental health and substance abuse diagnoses. This is a common condition among PLWHA.

- A key informant estimated that 50% of clients at a local HIV housing agency have a dual diagnosis and may also be mentally challenged.

While key informants report few specific treatment resources for this population, the resource inventory found nearly one third of substance abuse treatment providers offer services for clients with dual diagnosis. Of these, half are for clients with private insurance, and one is the statewide program for adolescents. The remaining four agencies include: (1) large Ft. Worth provider, (2) provider with three locations that focuses on the incarcerated, (3) outpatient rural service provider with five locations, (4) new rural residential program that accepts both private and indigent clients.

- One HEI case manager estimates the 75% of her typical caseload has co-occurring mental health disorders and half of these are “serious psychiatric disorders.” She reports that appropriate mental health services are limited.
- A homeless services representative also identified a need for dual diagnosis treatment.
- Mental disorders are under-reported because “not everyone gets a diagnosis” but according to several case managers “you can see it's there.” Depression and bipolar are reportedly most common.
- Hispanic substance abusers often are depressed. According to a bilingual case manager, “Hispanics tend to be depressed due to their situation. They are coming from under-developed countries and leaving their families. This is why they drink or have drugs to forget.”

Homeless

Homelessness places PLWHA at risk for substance use and/or relapse.

- Consumer focus group participants stated that without stable housing after residential treatment, there is a high risk of either turning to old friends for shelter or returning to the streets. Both result in relapse.

- Case managers report homeless clients begin the substance abuse treatment process, and then disappear. “HIV homeless need so much support. If one thing goes wrong, they tend to give up.

Services for the homeless are reportedly very good in Ft. Worth. Samaritan House provides a range of housing options specifically for PLWHA. Directions Home and Project Lifeline are new initiatives for the homeless.

The Union Gospel Mission offers a range of services. A six month stay is typical. They conduct a thorough intake that includes a substance abuse assessment. As necessary they refer to Recovery Resource Project Hope which is located on site.

Recently Released from Incarceration

Nearly one-third of the substance abuse treatment providers have programs for current or ex-offenders. Some of these programs are dedicated to this population with options for both state and federal prisoners. Judges may remand offenders to substance abuse treatment in lieu of incarceration.

- One HEI case manager estimates that 10% to 15% of new referrals have been in jail or prison in the last year. These clients often are referred due to an issue with their parole officer.
- The majority of the consumer focus group participants had been incarcerated in the past.
- In Abilene, it was stated that no transitional services are available for people coming out of prison with substance abuse problems.
- The Wichita Falls consumer stated that it is easier to get drugs in prison than on the outside. He stated that the threat of a lifetime in prison caused him to get clean.

Monolingual Spanish Speaking Population

- Two monolingual Spanish groups were identified on the resource inventory, one in Ft. Worth and another in Arlington. However, ten organizations report Spanish language is available.
- No HEI case manager speaks Spanish. LCDCs that are bilingual are difficult to recruit.

VII. Model Programs, Regional Advocacy, and Statewide Initiatives

Model Programs

SAMHSA INSight Project

- This recently completed five year SAMHSA grant screening over 80,000 Harris County Hospital District emergency and clinic patients using a shortened version of the SBIRT tool. Clients with a positive screen were referred to assessment and appropriate intervention. Motivational interviewing was used to support the patient in reducing substance use or accessing substance abuse treatment.
- A key finding was the positive impact of motivational interviewing on substance use and readiness for treatment.
- A wide range of personnel were trained in motivational interviewing, and paraprofessional staff reportedly became very skilled and effective.

Strengths Based Case Management

- This study compared the impact on client readiness for substance abuse treatment of five sessions of strengths based case management with one session of motivational interviewing or no specific intervention. Results found that five sessions of strengths based case management was more effective than one session of motivational interviewing, and both were more effective than no intervention. It recommended case manager training in strengths based intervention and/or motivational interviewing in order to promote client readiness for substance abuse treatment.

Regional Advocacy

Tarrant County Challenge

Tarrant County Challenge (TCC) is an important advocacy and professional education resource for the Planning Council. TCC administration is interested in partnering with and supporting the Planning Council's efforts to increase PLWHA readiness and access to substance abuse treatment. TCC provides:

- A detailed understanding of legislative changes affecting substance abuse treatment at the regional, state and national level. They were integrally involved in changes to Texas Medicaid which impacts covered substance abuse treatment services for Medicaid recipients.
- Regional analysis of substance abuse treatment and updates about treatment providers.
- Skilled staff available for training on a contract basis.

Statewide Initiatives

Four DSHS initiatives support enhancing and expanding HIV case managers' roles in working with substance using clients. These include:

1. Texas HIV Case Manager Project and Expert Case Management Panel striving to enhance the HIV case management function. In differentiating the roles of medical and non-medical case managers, the State evaluated the HIV case management system. The statewide goals provide a framework for local evaluation of the HIV case management function. They include:
 - Ensuring easy access into the system for clients.
 - Matching client needs with the appropriate level of case management.
 - Ensuring that services which fall under medical case management are readily available in every region and are implemented in a consistent manner by qualified staff.
 - Ensuring that coordination occurs among all the agencies clients access, including those outside of the HIV care system.

DSHS HIV/STD Prevention and Care Branch manager is supportive of the Planning Council establishing innovative approaches to HIV case management. As this occurs, instituting appropriate evaluation measures with implementation will promote process improvement as well as communication with other state and national organizations.

2. Encouraging implementation of the SAMISS screening tool among HIV case managers in order to standardize and enhance substance abuse screening. Initiatives include:
 - Train the trainer program for Eligible Metropolitan Areas/Transitional Grant Areas (EMA/TGAs) interested in using the SAMISS. This will be available locally to administrative agency and planning council staff as well as subcontracting providers such as case management agencies.
 - Online availability of the SAMISS tool and calculation of the SAMISS score.
3. HEI case manager program and statewide residential substance abuse treatment for PLWHA.
 - Regional HEI case managers are considered a critical resource for PLWHA seeking substance abuse treatment. HIV case managers typically contact the HEI case managers when a client is ready to seek substance abuse treatment, and the HEI case manager provides intensive case management services. (Refer to page 10 for detailed information.)
 - Homeward Bound, located in Dallas is the statewide residential substance abuse treatment program for PLWHA. North Central Texas residents benefit from relatively close proximity to this resource. (Refer to Resource Inventory for more detailed information and program requirements.)
4. Texas Drug Demand Reduction Comprehensive Strategy

Five of nine objectives presented to State leadership in January 2009 will be addressed by expanding the role and knowledge of North Central Texas HIV case managers.

 - Build partnerships—reduce fragmentation and duplication of efforts.
 - Outcomes measurement—invest for results—not just how many receive services, but how many benefit from services.
 - Create a foundation for guidelines at the local level.
 - Match people to appropriate and effective services.
 - Develop a strong work force.

Increasing Texas Medicaid Funding for Substance Abuse Treatment⁷

Texas Medicaid SBIRT Reimbursement⁸

- Beginning November 2009, SBIRT became a benefit of Texas Medicaid, targeting patients ages 10 to 20 who present at hospital emergency rooms. With appropriate referral, Medicaid will pay for up to three 45 minute counseling/motivational interviewing sessions. After these sessions, a referral to mental health or substance abuse treatment may be made.
- One of six brief screening tools must be used in the emergency room to qualify for Medicaid funding. These include ASSIST, CRAFFT, DAST, DUDIT, CAGE, binge drinking questionnaire. (Refer to Appendix E for Definition of Acronyms)

⁷ <http://www.dshs.state.tx.us/council/agendas/110409/8-SubstanceAbuseBenefit.pdf> Retrieved January 10, 2010.

⁸ <http://www.tmhp.com/homepage%20File%20Library/screening.pdf>. Retrieved January 10, 2010.

Medicaid Funding for Adults with Substance Abuse Disorders

In 2009, the Texas Legislature authorized the Health and Human Services Commission (HHSC) to implement a comprehensive substance abuse treatment benefit for adults receiving Medicaid who have a substance abuse disorder. This benefit targets adults, with implementation planned for September 2010.

- The Legislative Budget Board's 2009 *Texas State Government Effectiveness and Efficiency* report found that less than a quarter of adults with a diagnosis of substance abuse received treatment in 2006. The report also found that individuals with substance abuse disorder have twice the medical expenses of those without a substance abuse disorder and that these costs can be better managed with treatment. In calling for development of the benefits, the Texas Legislature assumed the treatment of substance abuse problems will result in a savings to the Medicaid program, offsetting any cost associated with the new benefit.
- The new benefits require approval by the Federal Center for Medicare and Medicaid Services (CMS). If approved by CMS, the proposed comprehensive Medicaid substance abuse treatment services will include:
 - Detoxification,
 - Limited residential treatment,
 - Outpatient detoxification,
 - Medication assisted treatment,
 - Specialized residential services for women,
 - Outpatient chemical dependency counseling.
- These benefits will be provided through fee-for-service Medicaid, as well as Primary Care Case Management (PCCM) and Medicaid managed care health plans.

VIII. Recommendations and Issues for Further Study

The following recommendations may be prioritized over a three year planning cycle. In considering these recommendations, it is hoped that many of the required actions will dovetail with other Planning Council initiatives.

The Planning Council must also be aware that recommendations increasing service access must be supported by service availability. This may impact priority setting and allocations as well as linkage with non-funded providers.

1. Develop operational definitions of substance use, abuse and dependence for the region in order to ensure that all providers are operating from the same frame of reference.
2. Per case managers' suggestions, develop an educational program for mid-level or low-level substance users at the HIV medical care clinics addressing the physical and emotional toll of drugs and alcohol on their health.

3. In conjunction with the reassessment of the medical and non-medical case management roles and responsibilities, consider augmenting the system to include:
 - a. Revised standards of care that clearly differentiate the roles of medical and non-medical case managers.
 - b. Establishing a standardized patient acuity system with associated staffing and fee structure.
 - c. Adding “levels” of case managers with varied education and skills. Consider development of a “professional ladder” for HIV case managers that provides incentives and compensation for achievement. The rungs of the ladder would be focused on key areas of case manager competence.
 - d. Pilot a patient navigator role to support HIV medical, non-medical and/or HEI case managers. This may be the first rung on the professional ladder.
 - e. As changes are made, institute appropriate evaluation measures to support process improvement as well as communication with other state and national organizations.
4. Establish uniform standards for medical and non-medical case management substance abuse screening which will be implemented during intake, recertification and at other times based on client profile.
 - a. Engage case management providers and DSHS in the process of standards development.
 - b. Support DSHS efforts to implement the SAMISS substance abuse and mental health screening tool with all HIV case management providers in the TGA.
 - c. Establish six month and 12 month evaluations of the effectiveness of SAMISS that include: (1) ease of use, (2) accuracy of assessment, (3) ability to engage clients in further assessment and movement to treatment. As appropriate, consider other standardized screening tools after the 12 month evaluation.
5. Provide ongoing case manager education to improve effectiveness in working with substance using/abusing clients. A curriculum may be developed that enhances the skills of both inexperienced and veteran case managers.
 - a. Some training may be mandatory, but others may be skill enrichment, supporting movement up the professional ladder.
 - b. Training plans must include evaluation of the impact of training on case manager skills, both through outcome and process evaluations.
 - c. Draw on regional resources to develop training programs including: AIDS Education and Training Center (AETC), HEI case managers, and Tarrant County Challenge.
6. Identify opportunities to support the HEI case manager program in order to leverage their expertise to train case managers and to lead multidisciplinary treatment teams. Use paraprofessional personnel (patient navigator, peer mentor, sponsor, etc.) to relieve them of time consuming but low-skill tasks they currently provide.
7. Collaborate with funded and non-funded social service providers to improve communication, enhance access to treatment and optimize client outcomes. Include HIV funded organizations, substance abuse treatment providers, mental health therapy and counseling

- services, homeless/housing organizations, HIV medical care providers. The local/regional continuum of substance abuse treatment should be included.
- a. Identify opportunities to (a) increase linkages including developing unified care plans, (b) utilize a multidisciplinary team approach to client treatment (c) develop joint programs, (c) educate providers to enhance screening, referral and treatment for PLWHA, (d) establish shared documentation and data systems.
 - b. Include Tarrant County Challenge in an advisory capacity.
 - c. Develop a detailed strategy to develop and expand this collaboration to ensure its success.
 - d. Ensure compliance with HIPAA and all professional ethical rules and regulations relating to substance abuse and HIV disclosure.
 - e. Educate regional substance abuse treatment providers in order to expand agency personnel's understanding of HIV and improve client treatment. .
8. Encourage development of supportive aftercare services that provide education, socialization, and aftercare group therapy for PLWHA. This may be accomplished in conjunction with funded and non funded providers and services.
9. Although skilled bilingual personnel are in short supply, strive to expand substance abuse treatment options for monolingual Spanish speakers.

APPENDIX A

Key Informants

1. Tamara Allen
Policy Advisor
Adult Mental Health
Mental Health and Substance Abuse
Division
Texas Department of State Health
Services
2. Darlene Carter
Tarrant County MHMR
HEI Clinical Supervisor and Supervisor
of the Ryan White Grant
3. Ann Dills
Case Management Training Specialist
HIV/STD/TB Branch
Texas Department of State Health
Service
4. Terry Dybala
Samaritan House
Lead LCDC
5. Rhonda Evans
Touchstone Ranch Recovery Center
Administrator
6. Susan Gallego
Texas Department of State Health
Services
7. Toni Sue Gibbons
Recovery Resource Council
Integrated Services Case Manager
8. Jennifer Gilley
Executive Director
Tarrant County Challenge
9. Gale Konrad
Tarrant County MHMR
Lead HEI Case Manager
10. Betty McIlroy
Union Gospel Mission
11. Paula McNeely
Tarrant County Preventive Medicine Clinic
Ryan White Medical Case Manager
12. Camille Parrish
Case Manager
Abilene
13. DeWayne Roberson
Wichita Falls
14. Ann Robbins
Manager
HIV/STD Prevention and Care Branch
Texas Department of State Health Services
15. Aurelio Rodriguez (with Felton
Stevens)
Ryan White Planning Council
Manager
Dallas County Health and Human
Services

APPENDIX B

Definitions of Substance Use, Abuse and Addiction

Substance Use

1. The *appropriate* use or ingestion of a substance or drug.⁹
2. Current substance use refers to use of alcohol, tobacco, or other illicit substances on one or more of the past 30 days.¹⁰

Substance Abuse

DSM-IV¹¹ Substance Abuse Criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights).

Alternatively, the symptoms have never met the criteria for substance dependence for this class of substance.¹²

Substance Dependence

DSM-IV Substance Dependence Criteria

Addiction (termed *substance dependence* by the American Psychiatric Association) is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
 - (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect *or*
 - (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:

⁹ <http://medical-dictionary.thefreedictionary.com/substance+use> Retrieved February 16, 2010.

¹⁰ http://www.doh.wa.gov/cfh/mch/mch_assessment/documents/SubstUseAdol08.pdf. Retrieved February 16, 2010.

¹¹ The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is published by the [American Psychiatric Association](#) and provides diagnostic criteria for [mental disorders](#). The last major revision was the fourth edition ("DSM-IV"), published in 1994.

¹² http://www.dawnfarm.org/pdf/DSM_Abuse_and_dependence_criteria.pdf. Retrieved February 16, 2010.

- (a) The characteristic withdrawal syndrome for the substance *or*
 - (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.
 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
 7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

DSM-IV criteria for substance dependence include several specifiers, one of which outlines whether substance dependence is with physiologic dependence (evidence of tolerance or withdrawal) or without physiologic dependence (no evidence of tolerance or withdrawal). In addition, remission categories are classified into four subtypes: (1) full, (2) early partial, (3) sustained, and (4) sustained partial; on the basis of whether any of the criteria for abuse or dependence have been met and over what time frame. The remission category can also be used for patients receiving agonist therapy (such as methadone maintenance) or for those living in a controlled, drug-free environment.¹³

¹³ http://www.dawnfarm.org/pdf/DSM_Abuse_and_dependence_criteria.pdf. Retrieved February 16, 2010.

APPENDIX C

Substance Abuse Treatment Continuum of Care

Substance Abuse Treatment Providers by Location* and Modality					
Treatment Modality	Total	Fort Worth	Rural	Suburban	Comments
Inpatient Detox	13	3	8	1	9 require insurance/private pay
Short Term Residential	14	2	9	2	8 require insurance/private pay; 3 require intake through OSAR
Extended Residential	15	6	6	3	2 require 12 to 18 month commitment (one Christian) 1 for adolescents only 2 are work programs 1 requires insurance/private pay 1 for incarcerated only
Partial Hospital	11	1	9	0	8 require insurance/private pay
Intensive Outpatient Program	25	5	13	6	9 require insurance/private pay
Outpatient Treatment	37	16	15	4	7 require insurance/private pay 1 for COPS-D only 1 for veterans only
Aftercare	20	5	12	2	Most do not charge but require completion of prescribed program
Methadone Maintenance	6	4	2	0	Most require daily payment rates between \$8 and \$10
Clean and Sober Housing	6	2	2	1	1 requires private pay and completion of treatment
AA/NA/Support Groups	10	4	4	1	Many refer to AA/NA but do not provide
Support Groups for PLWHA	2	2	0	0	
Outpatient Detox	7	0	7	0	5 through one proprietary agency
Total Agencies	33	50	87	20	
Note: Providers with multiple locations identified for each location. Homeward Bound, the statewide program for PLWHA, is not included.					

APPENDIX D

**NORTH CENTRAL TEXAS PLANNING COUNCIL
 SUBSTANCE ABUSE TREATMENT RESOURCE INVENTORY
PROVIDER SURVEY**

Organization _____

Contact Name _____ **Contact Phone** _____

Organization Website _____

Location(s)
 (Identify with number which will coincide with locations in matrix)

1. Services offered.

Service	Location	Waiting Period (for first appt)	Eligibility	PLWHA Specific
Inpatient Detox				
Short Term Residential (<30 Days)				
Extended Residential (>30 Days)				
Intensive Outpatient Treatment				
Outpatient Treatment, Regular				
Monthly Follow-up/After Care				
Methadone Maintenance				
“Clean and Sober” Housing				
AA/NA/Self-Help Groups				
Support Groups for PLWH				
Other				
Other				
Other				

-
2. Overall what percentage of your clients are HIV positive? _____%
3. Do you offer services for people Recently Released from Jail/Prison
 Yes No
4. Do you offer services for Dual Diagnosis? Yes No
5. Other Populations (Gay/Lesbian/Transgender, Minorities) Yes No

Specify: _____

I would like to ask a few questions about your organizations practices related to identifying and linking people living with HIV.

6. Does your facility routinely screen clients/patients for HIV risk factors?
 Yes No Don't Know
7. If patients/clients present with HIV risk factors, does your staff routinely refer to HIV testing?
 Yes No Don't Know
8. How do your patients/clients access HIV testing?
 Refer to HIV counseling and testing (C&T) site
 Perform blood work here and report results to patient/client
 Have relationship with HIV C&T program to provide service at your site
 Other (Specify) _____
 Don't Know
9. Is HIV status included in your health history?
 Yes No Don't Know
10. When you identify a patient/client who has been diagnosed with HIV/AIDS (HIV+ individual), do you screen to determine if he/she is receiving HIV medical care?
 Yes No Don't Know
11. Do you know where to send patients for free HIV medical care?
 Yes No

If yes, where do you refer? _____

12. Other Comments _____

Thank you for your help.

APPENDIX E

DEFINITION OF ACRONYMS

AA/NA	Alcoholic Anonymous/Narcotics Anonymous
AETC	AIDS Education and Training Center
AOC	AIDS Outreach Center
ARIES	AIDS Regional Information and Evaluation System
ASO	AIDS Service Organization
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
BHIPS	Behavioral Health Integrated Provider System
CAGE	Cut down, Annoyed, Guilty, Eye-Opener
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble
C&T	Counseling and testing
DAST	Drug Abuse Screening Test
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUDIT	Drug Use Disorders Identification Test
EMA/TGA	Eligible Metropolitan Area/Transitional Grant Area
HEI	HIV Early Intervention
HHSC	Health and Human Services Commission
HMIS	Homeless Management Information System
HRSA	Health Resources and Services Administration
LCDC	Licensed chemical dependency counselors
OSAR	Outreach, screening, assessment and referral services
PCCM	Primary Care Case Management
Planning Council	North Central Texas HIV Planning Council
PLWHA	People living with HIV/AIDS
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SBIRT	Screening, Brief Intervention, and Referral to Treatment
TCC	Tarrant County Challenge