DUAL DIAGNOSIS SUBSTANCE ABUSE IN VANCOUVER MENTAL HEALTH BOARDING HOMES: A NEED ASSESSMENT SURVEY

by

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February 1990

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ABSTRACT

This study explores the dual diagnosis substance abuse phenomenon within the context of Vancouver area mental health boarding homes. The target population consisted of thirty-nine mental health boarding homes used by Greater Vancouver Mental Health Services, Mental Health Residential Services. An attempt was made to survey directors (n=37), staff (n=unknown), and residents (n=422), to: estimate the prevalence of dual diagnosis substance abuse within these homes; look for associations between substance use/abuse and the demographic characteristics of staff, directors, and residents; examine boarding home policies; and to establish what, if any, services should be developed. Questionnaires were completed by twenty-nine directors (78%), twenty staff members (% unknown), and ten residents (3%), from twenty-nine boarding homes with a total resident population of 358. Results indicated that one hundred and fifteen residents (32%) consumed alcohol, and 57 residents (16%) had consumed alcohol during a specified two week period.

Only eight residents (2%) out of a potential 358 (from four different facilities) reportedly had substance related problems during the specified two week period. However, substance abuse was identified in eleven facilities (38%), without reference to the two week time limitation. Further, staff and directors from fifteen facilities (52%) had at some time tried to get help for a resident with a substance abuse problem. Thus, while very few residents reportedly had dual diagnosis substance abuse problems, a considerably greater number of boarding homes reportedly had problems related to dual diagnosis substance abuse.
Twenty-four directors (86%) and thirteen staff (68%) were interested in receiving a workshop on dual diagnosis substance abuse. It is the recommendation of this author that a drug education program/workshop for boarding home directors and staff be developed through the Greater Vancouver Mental Health Services "dual diagnosis program."
DEFINITION OF TERMS

(1) In accordance with the World Health Organization's (1986) definition of drug and alcohol abuse, for the purposes of this project substance use will be considered substance abuse when it causes "problems related to health (physical and mental), behavior, family, work, money, [or] the law" (p.6), and when it is "hazardous (e.g., any use of alcohol or amphetamines by a driver of a vehicle may put him or her at risk of an accident), or dysfunctional (e.g., interfering with responsibilities as parent or worker), or harmful (e.g., producing damage to health)" (p.8).

(2) The term mental health boarding home has been used to refer to all of the mental health community residential living facilities used by the Mental Health Residential Services division of Greater Vancouver Mental Health Services. These facilities include "boarding homes," "group homes," "half-way houses," "three-quarter-way houses," and the like.

(3) The term boarding home director has been used to refer to all persons who are directly responsible for the management and operation of boarding homes, whether they be "directors," "supervisors," "coordinators," "managers," "people in charge," "operators," or in some cases, "owners."
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I. GENERAL INTRODUCTION

Many mentally ill people who in the not so distant past would have been confined to large psychiatric institutions have been "freed" from those oppressive walls of cold stone to live in "the community." However, this attempt to "normalize" people with psychiatric problems has not been without its problems. While many people were "deinstitutionalized," the community support services that should have been developed to help make the transition into the community a relatively smooth one were largely neglected. Given the highly competitive nature of our "liberal" democratic society, it is not surprising that many deinstitutionalized people began to experience the same problems that have been experienced by other unemployed, stigmatized, and socially oppressed groups.

Recently, there has been increasing attention paid to the seemingly high incidence of drug and alcohol abuse by persons with psychiatric problems. In fact, the new label of "dual diagnosis" substance abuse has been coined to specifically refer to people with both psychiatric and substance abuse problems. There is a need for studies focusing on substance abuse and psychiatric problems in Canada, as the vast majority of North American studies in this area have been conducted in the United States, and there is a shortage of information specific to Canada. Exploring the prevalence of dual diagnosis substance abuse within boarding homes will help establish what future directions in Canadian health policy should be.

Political trends indicate that we are likely to see a period of increased "neoconservatism," with decentralization of social and health services and a shift towards privatization. Economic restraint is likely to continue. There has been a
shift away from Keynesian economics and Beveridge's social ideas, which established and reinforced the government's responsibility and ethical obligation to end unemployment and provide a wide range of health and social expenditures, to the contemporary preoccupation with inflation that has established and reinforced the government's responsibility and fiscal obligation to reduce its health and social expenditures. The recently reelected Conservative government has renewed its commitment to reducing the national deficit by further reducing government expenditures. Social goals and economic goals are no longer seen as mutually reinforcing but, rather, as almost mutually exclusive. In response to this increasing concern about inflation and decreasing concern about unemployment, Lightman (1986, p.25) says that:

All social and economic policy in any society is built upon fundamental value choices. The frequently-cited argument of economic necessity - that we have no choice but to cut back government spending in the social and health areas in order to conquer inflation and to concomitantly reduce the deficit - is fallacious. It is not a statement of any objective fact or reality, but rather reflects a particular constellation of presumed social priorities.

During the past decade we have moved towards an increasingly conservative political climate. The Meech Lake Accord, with its proposed redistribution of power from the federal to the provincial government is a clear example of the federal government's commitment to decentralization. The Free Trade Agreement that has recently relaxed the north south trade barriers between Canada and the United States clearly delineates government's close alliance with business interests. There is a trend towards privatization and against universality which seems sure
to continue. As inflation continues to raise the costs of services supported by tax dollars, we can expect that services for the mentally ill will feel their "funding freeze." Because community based services are expensive, because the demand for services will drive up costs, and because there will be an unwillingness to use scarce resources for "marginal" people, not only are services for dual diagnosis clients likely to suffer from economic "restraint," but the continued policy of deinstitutionalization itself will be met with stiff resistance, and if it continues at all it will be under funded.

Already, in the United States many bureaucrats, politicians, and health care "professionals" have championed a movement towards "reinstitutionalization." In a disconcerting but revealing statement, Cronklin (1985, p.52) says:

I am getting an increasing sense of something ugly spreading through our land. It is a mean-spirited attitude toward poor people, and it is essentially based on the belief that they are responsible for their plight - and that if they were only willing to pull themselves up by their bootstraps - whatever that means - they could. When top officials of the U.S. government, including President Reagan himself, say these people really prefer to live in the streets and to eat in soup kitchens, it lends an air of legitimacy to those feelings.

As it happens, the area of "substance abuse" is currently in political favor in British Columbia, and the Social Credit government has designated several million dollars to enhance services for persons with psychiatric and substance abuse problems. The Social Credit party is a staunch supporter of privatization and is closely aligned with the interests of "big business," so it is unlikely that its
commitment to providing funding in this dual diagnosis area will continue. Research in this area is extremely timely.

Of further note, it is hoped that the findings of this study will be published, and will increase the awareness of Canadian health professionals concerning the significance of this dual diagnosis problem. This research will also reinforce the importance of revising university social work curricula, and providing in service training to help social workers develop knowledge and skills in the area of dual diagnosis substance abuse.
II. KNOWLEDGE BUILDING FUNCTIONS AND RATIONALE FOR THE
SELECTION OF ISSUES

The primary function of this project concerns exploration and mapping (Crane, 1988), and includes the following processes:

1. Exploring findings in the literature to identify relevant issues regarding dual diagnosis substance abuse.
2. Estimating the prevalence of dual diagnosis substance abuse in Vancouver area mental health boarding homes.
3. Exploring a variety of variables, such as demographic characteristics, to test the strength of associations between these factors and the prevalence of substance use and/or abuse in mental health boarding homes.
4. Exploring the responses of boarding home directors and staff to substance use and/or abuse by residents, and boarding home policies as they relate to this issue.
5. Mapping out alternatives and policy directions based on the research findings.

Our general knowledge about dual diagnosis substance abuse will be increased by the information generated in this study. The more we know about dual diagnosis substance abuse the more likely it will be that our response to this phenomenon will be effective, appropriate, and in the clients' best interests. Furthermore, we will be able to ascertain if mental health boarding homes offer a suitable forum for the development of treatment and/or preventative services.
If mental health boarding home residents do have substance abuse problems, then existing services can be utilized, or new services can be developed to reduce the prevalence of these problems. While there may be a greater prevalence of dual diagnosis substance abuse among "street" people or "homeless" people, it is very difficult to initiate programs with persons who cannot be found or contacted. Services could be quite effective with boarding home residents, as they are a "captive" audience, in the sense that they can be identified, located, and approached with relative ease. Of course, one must be sensitive to the client's rights (to refuse services), and not take the "captive audience" notion too literally.

On the other hand, it is just as important to determine that mental health boarding home residents do not have substance abuse problems as it is to determine that they do. If residents of mental health boarding homes do not have substance abuse problems it provides us with some valuable information concerning the effectiveness of contemporary mental health residential services. Are mental health boarding homes meeting the needs and/or demands of dual diagnosis substance abusing persons? And if not, then why not? The area of dual diagnosis substance abuse is in its infancy, and studies such as this are needed to provide new information and stimulate further thought. The generation of new diagnostic labels, and creation of new service "industries" is a serious business, and is not always in the "consumer’s" best interests. Only through careful attention to the issues at hand can we truly be sensitive to the needs of people with both psychiatric and substance abuse problems. This study will not only add to our knowledge about dual diagnosis substance abuse, but by so doing
will also help to protect dual diagnosis substance abusers against the "professional abuse" that can result from professionals applying generalized solutions to individual problems.

The rationale for this study is largely derived from a recent Vancouver based study by Kroeker (1988), which surveyed the perceptions and practices of both community mental health and alcohol and drug abuse professionals, concerning dual diagnosis substance abuse treatment services. Kroeker found from Mental Health discharge statistics that 18.7% of persons discharged in 1986 had a primary diagnosis and history of substance abuse, while 16.8% of those discharged in 1987 had a primary diagnosis and/or history of substance abuse. Furthermore, Mental Health emergency services estimated that 90% of cases coming to their attention involved alcohol or other drug abuse as part of the precipitating event. Kroeker found that Alcohol and Drug Program (ADP) directors estimated that while only about 15% of their assessments involved specific diagnosis of mental disturbances, many more of their clients had some level of mental disturbance that interfered with treatment. ADP counsellors did not think that mentally disturbed people were suitable ADP clients. On the other hand, Mental Health program directors and staff thought that about 75% of their 'cases' involved substance abuse. Differences were found between the responses of treatment staff and directors. Mental Health treatment staff specified a lower prevalence rate of dual diagnosis substance abuse in assessment and caseloads (3-10%, with only one estimate of 20%) than did their directors (5-35%, with a median of about 20%). Similarly, program directors of both ADP and GVMHS consistently reported higher levels of exchange of information for their units than
did the treatment staff. Both ADP and Mental Health Program staff indicated that they did not generally provide education, orientation, therapy or supportive follow-up for clients whose 'secondary' diagnosis was other than their program's primary focus.

While there was a general consensus that existing services were not adequately meeting the needs of dual diagnosis substance abusers, there was a great deal of dissension over the exact kinds of services that should be developed. Eighty-five percent of the program directors and ADP staff felt that a separate service should be developed, while most of the Mental Health program staff thought that services should be developed within existing programs. However, all of the respondents in Kroeker's study supported and/or emphasized the need to have staff with expertise in both problem areas, and for relevant training to be offered to the various units, teams, clinics, half-way houses and boarding homes in both systems. While the development of special residential facilities was not a strongly supported treatment option, a number of respondents did support the idea of integrating substance abuse and mental health elements in existing residential facilities, such as mental health boarding homes.

Drawing on the findings of Kroeker, I plan to further explore the phenomenon of dual diagnosis substance abuse, within the context of mental health boarding homes, to establish if there is both the need and/or the demand for new treatment services in facilities of this kind in Vancouver. However, as the vast majority of studies on dual diagnosis substance abuse have focused either on groups of deinstitutionalized 'homeless' or hospitalized acute care patients, a study
of dual diagnosis substance abuse would be incomplete without an overview of
deinstitutionalization and homelessness. Accordingly, the following section provides
a brief historical overview of the treatment of persons with psychiatric problems
in the United States and Canada. This overview sets the stage for a summary
of findings on dual diagnosis substance abuse. As mentioned above, these findings
are primarily from studies of "homeless people" or hospitalized acute care
psychiatric patients. Particular attention will be paid to the latter of these two
types of studies, as it is from similar hospital facilities that the majority of
mental health boarding home residents have come.
III. OUTLINE OF THE PROBLEM AREA

A. HISTORICAL OVERVIEW

By the early 1900's concern for the treatment of children and "neurotics" had evolved, and the disciplines of social work and psychology became interested in the mentally disturbed (Elpers, 1987). Further interest in mental health was generated by the large amount of psychiatric casualties in the armed forces during the First World War (Guest, 1985). Similarly, the use of forward aid stations during the Second World War to try and restore psychiatric casualties to combat readiness encouraged a new "treatment" oriented approach by mental health professionals.

Pressure to deinstitutionalize psychiatric patients came from a myriad of different sources. The civil liberties movement fought for an end to involuntary commitment, advocated for less restrictive treatment settings, and initiated lawsuits which defined the right to refuse treatment. This increased emphasis on "patients' rights" created a backlash of resistance among many mental health professionals, which is nicely characterized in the following statement by Shwed (1980, pp. 196-197):

In an age of consumerism, trusted professional groups have come under suspicion. This increasing distrust has contributed to the climate for legislation placing the actions of professionals under surveillance, replete with rigid auditing procedures, and requirements to document and justify standards of practice. So deep is the mistrust among certain segments of society that traditional mechanisms for monitoring
standards of practice have been viewed with suspicion.

Given the medical profession's history of autonomy and power, and the hobbling effect that close scrutiny can have, it is not surprising that some physicians have reacted strongly to the suggestion that they be held accountable by persons outside of the medical fraternity. However, neither is it surprising that "the professions" have been eyed with suspicion, especially in the area of mental health, where professionals once supported the maintenance of institutions that have been compared to Nazi concentration camps, and where "treatments," in any other context would have been condemned as unconscionable tortures. Deutsch (1949, p.449) surveyed over two dozen state hospitals in the United States and found:

scenes that rivalled the horrors of the Nazi concentration camps - hundreds of naked mental patients herded into huge, barnlike, filth-infested wards, in all degrees of deterioration, untended and untreated, stripped of every vestige of human decency, many in states of semi-starvation.

In fact, recent lawsuits by ex-psychiatric patients who claim to have suffered permanent memory loss and psychological damage due to their involuntary subjugation in human brainwashing experiments at Montreal's Allan Memorial Institute in the 1950's and 1960's, (Burstow & Weitz, 1988) (where they were subjected to massive doses of mind altering drugs such as d-lysergic diethylamide (LSD), electroshock several times a day for weeks on end, sensory isolation, and forced listening to repetitions of demeaning and degrading messages) indicates this parallel may be even closer than we allow ourselves to believe.
Another example of the horrible living conditions that existed in Canadian psychiatric hospitals is provided by Griffin (1989, p.26), who provides the following account of a survey conducted in 1918:

We discovered many things that shocked us. In the asylum in Saint-John, New Brunswick, for example we found on the top floor a group of patients who were put to bed in coffin like boxes, with hay in the bottom and slats on the top and who were locked in these boxes at night. Two of these boxes were left unlocked for patients who were trusties, and who were given the job of dealing with noisy patients. They accomplished their task through a revolting procedure by urinating through the slat openings on the faces of noisy patients....

While an insistence on accountability can impede service delivery, certainly, given the characteristic helplessness of psychiatric patients, it not only benefits the patients, by protecting their rights, but benefits the profession through the demonstrable legitimization of treatment practices.

Deinstitutionalization is generally thought to consist of three equally important components: preventing institutional admissions, returning patients to the community, and establishing and maintaining responsive residential environments. Unfortunately, only the second of these three goals has been met. Populations in State and county mental hospitals in the U.S. dropped from approximately 560,000 patients in 1955 (about one-half of all patient care episodes), to 160,000 in 1977 (less than ten percent of all patient care episodes), to 125,200 in 1982 (more than a three/fourths reduction from 1955 (Goldman, Adams, & Taube, 1983). In Canada, days of care in psychiatric hospitals dropped from 10,829,594 in 1979-1980, to
6,607,898 in 1982-1983 (Statistics Canada, 1987). While there was an increase from one to two public mental hospitals in British Columbia between 1971 and 1977 (the addition occurred in 1975), there was a decrease from 47 to 42 public mental hospitals in Canada, and there were decreases in the number of patients on the books on December 31 of those respective years in British Columbia (2,989 to 1,953) and Canada (34,244 to 20,281) (Statistics Canada, 1971, 1972, 1973, 1974, 1975, 1976, 1977).

Table 1 shows the extent of the deinstitutionalization movement in British Columbia by reviewing the reduction in inpatient totals at Riverview Hospital between the years 1963 and 1988. There was a reduction from 3,793 patients in 1963, to 638 patients in 1988 (Brooks, personal communication, November 1989). Inpatient totals were calculated as of December 31 of each year, and exclude the geriatric patients. The largest reductions were between the years 1963 and 1964 (503 persons), 1964 and 1965 (507 persons), 1973 and 1974 (393 persons), 1971 and 1972 (258 persons), 1974 and 1975 (241 persons), and 1982 and 1983 (213 persons). While there were slight increases in inpatient totals between the years 1978 and 1979 (38 persons), 1985 and 1986 (20 persons), and 1983 and 1984 (19 persons), there has nonetheless been a steady decrease over the years for which data are available. However, this large reduction in the number of institutionalized patients seems to have occurred in the absence, rather than the proliferation, of alternative living settings and community services (Shwed, 1980; Scull, 1981).

Quine (1981) has identified the same pattern, of moving formerly institutionalized
Table 1.

RIVERVIEW HOSPITAL INPATIENT TOTALS: 1963 - 1988

<table>
<thead>
<tr>
<th>Year</th>
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</tr>
<tr>
<td>1971</td>
<td>2322</td>
<td>1980</td>
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Source: Clinical Records Department, Riverview Hospital (Brooks, personal communication, November 1989).

Inpatient totals do not include geriatric patients.
people into the community without providing the necessary support systems in England. While most studies that have looked at homelessness and the mentally disturbed have been conducted in the United States, Davis (1986) substantiated that the "phenomenon of the new young chronic," and the "lack of fit" between these people and the health care delivery system is also a very real problem in Vancouver. Ironically, just as the need for help increases so too does the availability of help decrease. Many other authors have concluded that existing psychiatric services have largely failed to meet the needs of the "chronically mentally ill young adult" (Bachrach, 1982a; Bachrach, 1982b; Glass, 1982; Goldfinger, Hopkin, & Surber, 1982; Talbott, 1986; Test, 1985), and that many members of this "chronically ill" population have substance abuse problems (Ridgely, Goldman, & Talbott, 1986; Sheets, 1982; Safer, 1987). The apparent inadequacy of existing community services raises some interesting questions, as length of stay in the community is often used as an outcome measure, but the length of time spent in the community is not necessarily an indicator of whether the person's life is improving or deteriorating.

**B. INCIDENCE/PREVALENCE OF THE PROBLEM**

Numerous studies have been conducted to identify the characteristics of the many homeless people who have flooded North American cities. One such study was conducted by the New York Men's Shelter in 1976, which found that of 1,235 men provided with accommodations in a given night, thirty percent had a record of previous psychiatric hospitalization (Reich & Siegel, 1978). Based on interviews with these men, the shelter concluded that nearly fifty percent of them had
overt mental illness, and many had secondary alcohol problems. However, the reliability of these conclusions may not be very high, as the information was based on self reports, (it is probable that some people would be reluctant to volunteer information of this kind), and the people who stay at the New York Men's Shelter are likely not representative of all homeless people.

Lamb and Grant (1982 & 1983) conducted a study of 102 men and 101 women in county jails in the U.S. who had been referred for psychiatric evaluation, and found that 39% had been living on the streets, on the beach, in missions, or in cheap, transient "skid row" hotels at the time of their arrest. Many of the subjects had extensive experience with the criminal justice system and the mental health system, and refused to stay at mental health boarding homes because they wanted their autonomy (this was especially true for the younger people).

In another study, Merricucci, Wermuth, and Sorensen (1988) interviewed the directors of eight psychiatric and substance abuse facilities in San Francisco: one inpatient alcohol abuse unit, one outpatient alcohol abuse unit, one outpatient psychiatric unit, one psychiatric emergency unit, and four inpatient psychiatric units. All of the respondents indicated that they were more frustrated with the problems they faced making referrals than they were with their clients' behavioral and substance abuse problems. The authors conclude that "most psychiatric board-and-care and halfway houses refuse to take patients with a substance abuse problem" (p.620). And in a Vancouver study, Davis (1987) surveyed the demographics and client movement in supervised boarding homes by examining 232 referrals made for boarding home placement, from January 1983
to December 1985. Seventy-three percent of the sample were male, fifty percent were under age thirty-five, fifty-four percent were schizophrenic (the largest single category), twenty percent had organic brain disorders (especially prevalent among older clients with histories of substance abuse), and thirty percent had been evicted from their last place of residence (twenty-four percent from psychiatric boarding homes, and six percent from private accommodations). "Often the reason for eviction had to do with substance abuse or violent behavior" (p. 11). Of the 232 referrals, forty-one percent refused boarding home placement, and twenty-two percent "were turned down by the placement worker as inappropriate for a boarding home. This could have been for a variety of reasons; the client could have [had] an established history of drug abuse or antisocial behavior" (p. 12).

The studies cited above indicate that many people with substance abuse problems are not admitted to community residential facilities, but say nothing about those who are admitted. One would expect that many of the boarding homes would have at least some residents with substance abuse problems. The following studies of dual diagnosis substance abuse by patients in psychiatric acute care hospitals, indicate that the prevalence of dual diagnosis substance abuse is quite high in these settings. Of course, these findings cannot be directly extrapolated to mental health boarding homes, but one would expect there to be, at the very least, a considerable number of referrals to boarding homes involving substance abusing ex-mental patients.

Many authors have reported that substance abuse is a serious problem among people with psychiatric problems, and especially among those with chronic
problems (Ridgely, Goldman, & Talbott, 1986; Safer, 1987; Sheets, Prevost, & Reimhan, 1982). Bean-Bayog (1987) found that ten to fifteen percent of people hospitalized with schizophrenic symptoms had serious drinking problems, and Fischer (in Ridgely, Goldman, & Talbott, 1986) estimated that fifteen percent of patients in a U.S. psychiatric hospital abused drugs; almost one-third of 335 patients who were admitted to the hospital over a three month period said that they had abused drugs at some time; and about one-half of these 335 patients who were under age 30 had abused drugs at some time. The U.S. Department of Health, Education and Welfare found that twenty-two percent of admissions to state mental hospitals in 1964 were diagnosed as alcoholics (Googins, 1984), and Crowley, Chesluk, Dilts, and Hart (1974) determined that drug problems contributed to one-third of fifty consecutive admittances to a psychiatric hospital.

In their study of addictive behaviors, O'Farrell, Connors, and Upper (1983) surveyed 305 of 309 patients hospitalized on ten psychiatric wards at a large Veterans Administration (VA) Medical Center. Four of the patients were dropped from the study due to missing demographic data. Of the 305 subjects, thirty-three percent were found to abuse alcohol, and five percent (numbers are rounded) were found to abuse other drugs. Fowler, Liskow, Vasantkumar, Tanna, and Valkenburg (1977) studied 120 of 124 admissions to the Veterans Administration Hospital in Iowa City. The sample did not include any females, persons of age sixty-five or older, or persons who remained in the hospital for less than four days. Four people were dropped from the study because they left the hospital before the fourth day. The researchers found that forty percent of the alcoholics in the study had a psychiatric diagnosis that was unrelated to
substance abuse.

Trier and Levy (1969) studied 175 psychiatric admissions to the San Mateo County General Hospital from December fourth to December twenty-second, 1967. Five people had been admitted twice and three had been admitted three times, so the sample actually consisted of 164 people. The examining doctor administered a questionnaire, and rated the admissions as: Emergent, or requiring immediate attention; Urgent, or able to wait up to twenty-four hours; and Elective, or able to wait more than twenty-four hours. Information obtained included the manner of arrival, time of arrival, evaluation, and discharge, diagnostic findings, services provided, disposition, and demographic information. Of the 175 admissions, fifty percent of the Emergent cases involved drug or alcohol addiction, forty-seven percent of the Urgent cases involved alcohol or drug addiction, and forty-eight percent of the Elective cases involved alcohol or drug addiction.

Also of interest is a study by Solomon and Davis (1986), involving 550 people who were discharged from two state psychiatric receiving hospitals in Cuyahogo County, Ohio, between July 1980 and March 1981. While only five percent of the sample were given a primary diagnosis of an alcohol disorder at admission, social workers assessed that thirty-five percent had a need for alcohol counselling at discharge. Solomon and Davis (p.66) conclude that "the social worker's assessment [which indicates that there was a high incidence of alcohol abuse] is probably a more accurate estimate of the extent of this problem for they have a sense of the patient's social history." Furthermore, the authors claim that the
new generation of "chronically mentally ill" are largely eighteen to thirty-five years old, and "share with others of their age a high incidence of drug and alcohol abuse." This view of the mentally disturbed substance abuser as a normative member of a dysfunctional (age) group is a significant departure from the biomedical view, which emphasizes innate and incurable disease states; the former view proffers a considerably more optimistic prognosis.

In another interesting study, questionnaires were administered to 503 of 511 consecutive patients admitted to the Orange County Medical Center, Psychiatric Emergency Admitting, during October, 1971 (Atkinson, 1973). Of the 503 psychiatric emergencies studied, drug abuse was implicated in 107 cases (21%), alcohol abuse was implicated in 103 cases (20%), both drug and alcohol abuse were implicated in 60 cases (12%), and some degree of alcohol and/or drug abuse was judged relevant to the psychiatric problem in 270 cases (53%). Hekimian and Gershan (1968) also found a high degree of dual diagnosis substance abuse, in their study of adult drug abusers in a psychiatric inpatient service: fifty percent had schizophrenia.

Many other studies have also found relationships between substance abuse and specific diagnostic categories. For instance, Meyer and Hesselbrock (1984) commented that "antisocial personality disorder" is the diagnoses that is most often linked to substance abuse. Mirin, Weiss, Sollogub, and Michael (1984a, & 1984b) claim that there is a strong relationship between "affective disorders" and substance abuse. And, following their review of the (medical) literature, Ridgely, Goldman, and Talbott (1986) concluded that substance abuse was most often
associated with "schizophrenia," "personality disorders," and "affective disorders."

In a one year study, Bergman and Harris (1985) found that fifty-two percent of sixty-five chronically disturbed people had histories of drug and/or alcohol abuse associated with hospitalization. McKelvy, Kane and Kellison (1987) found that sixty percent of admissions to a psychiatric hospital had a dual diagnosis of substance abuse and mental illness, including both those who met DSM-III criteria for a dual diagnosis and those who did not, but whose substance abuse adversely affected their psychiatric problems nonetheless.

The vast diversity of research findings, indicating that anywhere from ten to sixty percent of psychiatric inpatients have substance abuse problems, is due to a number of factors, such as geographical differences, employment opportunities, availability of housing, total community resources, variations in operational definitions of "abuse" and "mental illness," and sample selection criteria. Nonetheless, it is clear that significant numbers of people with psychiatric problems have substance abuse problems as well, which is a conclusion further strengthened by evidence that actual incidents are substantially underdiagnosed (Safer, 1986). Given that considerable numbers of psychiatric acute care hospital patients have dual diagnosis substance abuse problems, and most Greater Vancouver Mental Health Services boarding home referrals involve persons who have just been discharged from either Riverview Hospital or one of the regions acute care facilities, one would expect a considerable number of these referrals to have dual diagnosis substance abuse problems as well.
C. SOCIETAL AWARENESS

There is a growing awareness in Canada that the popular trend towards deinstitutionalization is not without its problems. Canadians frequently refer to the lack of community based services for the mentally ill, and while it is true that many Canadians do not want these services developed in their own neighborhoods, there seems to be a general agreement that something must be done. Most of the attention has been focused on the "homeless," who were once thought to be almost exclusively deinstitutionalized psychiatric patients with nowhere to go, and no one to help them. Canadians' concern over the plight of the mentally ill homeless may be fueled as much by their embarrassment as it is by their altruism, and public concern has recently focused more and more on the increasing numbers of "normal" Canadians who have joined the ranks of the homeless. Our hearts go out to the single mother, struggling against overwhelming odds with her three young, ever so cute and wide eyed children, but we are less likely to rush to the aid of an unkempt, shiftless young adult "ex-mental patient."

Canadian society has traditionally given mixed messages about drug use, and as Klerman (1970) points out, it was not until the white middle class society began to be affected by drug abuse that public concern became mobilized. Klerman (p.313) calls the contemporary practice of condoning and sanctioning drug use for therapeutic use only, (and even then only under professional supervision), a "Pharmacological 'Calvinism' that says if a drug makes you feel good it must be bad." He further claims that the response of the public derives as much from
fear of social change as for real concerns for the health and safety of drug users, whose drug use challenges the dominant value system. Klerman's analysis, which came "hot on the heels" of the social and political rebellion of North American youth during the 1960's, is in many respects a product of its time, but even today, with our emphasis on "participation," health, exercise, and anti-drug campaigns, there is a constant push and pull between health concerns and the economic contributions of large tobacco and alcohol manufacturers and distributors. Ironically, even the emphasis on good health has been fueled by concerns over the rising costs of health care. Nonetheless, it is clear that Canadian society has a decidedly negative view of drug use outside of certain limited contexts, and there is little doubt that the ingestion of large amounts or prolonged use of many drugs (whether they are "therapeutic" or not) causes physical and social problems. Whether or not we accept the view that for people with psychiatric problems, "drug use is synonymous with abuse," it is clear that the abuse of drugs is a problem, regardless of who the abuser is. Thus, the apparently significant amount of substance abuse among certain populations of people with psychiatric problems, is a problem that demands our attention if deinstitutionalization is to realize its full potential.

Dual diagnosis substance abuse is considered by many mental health professionals and non-professionals to be a significant problem that confounds the effects of clinical intervention and primary care. Furthermore, the areas of substance abuse prevention and treatment are currently politically popular in British Columbia, and while this interest may be fairly short-lived, at least for the present, money is being designated for the development of programs in this area. Thus, there is a
beginning awareness of the dual diagnosis substance abuse problem within the mental health and political spheres, but it is not an area that has yet obtained a high degree of societal awareness. Interestingly, the obverse seems to be true regarding substance abuse "in general," with professionals and politicians struggling to keep pace with ordinary Canadians who are speaking out against the potential dangers of drug use and abuse. Furthermore, it may be questioned if mental health professionals are becoming aware of the "dual diagnosis problem," or are creating the problem by differentiating between drug abusers with and drug abusers without psychiatric problems.

D. PROBLEMATICS (CURRENT ISSUES)

A current issue that confronts mental health professionals concerns the difficulty of identifying substance abusers among persons with psychiatric problems. As previously mentioned, substance abuse is often underdiagnosed. It is hardly surprising that misdiagnosis often occurs, as the symptoms of mental disturbances are often very difficult to distinguish from those symptoms caused by drug intoxication or withdrawal (Salzman, 1981). D-lysergic diethylamide (LSD), for instance, can induce a prolonged "schizophrenic" or briefer "schizophreniform" reaction, and phencyclidine (PCP) induced states resemble "acute paranoid schizophrenia" so much that, especially during the early years of PCP overuse, many people were admitted to hospitals with misdiagnoses of acute paranoid schizophrenia (Cohen 1985). Similarly, people experiencing an acute amphetamine psychosis are often misdiagnosed as "paranoid," "schizophrenic," or "emotionally labile hypomanics with paranoid ideation" (Ellinwood, 1976; Tinklenberg, 1976). It
is also easy to confuse psychiatric problems with the symptoms associated with chronic opiate intoxication (Meyer & Hesselbrock, 1984) and withdrawal (Dackis & Gold, 1984), cocaine use (Cohen, 1985), repeated use of tetrahydrocannabinial (cannabis) (Cohen, 1985), and alcohol abuse and withdrawal (Cohen, 1985; Mirin, Weiss, Sollogub, & Michael, 1984).

In fact, most psychoactive drugs are similar in both structure and action to the human brain's neurotransmitters (Bridgeman, 1988). Mescaline is similar in structure to norepinephrine, and both effect noradrenergic synapses. Psilocin and LSD are molecular expansions of the serotonin molecule, and morphine and heroin are biochemically similar to the brain's enkephalins. "Some aspects of mental illness can be looked on not as disturbances of the rational machine but as drug-induced altered states of consciousness" (Bridgeman, p.436). It is not surprising that it is often difficult to detect cases of substance abuse, and mental health boarding home directors and staff are not immune to this problem. Are boarding home directors and staff able to identify substance abuse by residents when/if it occurs? Have they received any training to assist them at this task? While the detection of drug abuse can be difficult in almost any situation, it becomes even more so when the abuser also has identified psychiatric problems, as there is the possibility that unusual behaviors associated with substance abuse will be attributed to the individual's psychiatric problems.

In addition to the diagnostic problems caused by the similarities between many mental disturbances and drug induced states, problems occur due to the co-ingestion of prescribed and unprescribed drugs. The widespread use of alcoholic
beverages in our society, and our increasing reliance on chemotherapies in the
treatment of mental disturbances, makes the co-ingestion of psychoactive drugs
and alcohol especially likely. Furthermore, alcohol use is not only exacerbated by
some psychiatric conditions, but can lead to conditions that result in psychoactive
drug prescription (Preskorn & Goodwin, 1987). According to Preskorn and
Goodwin (p.123), "interactions between alcohol and psychoactive drugs can fall
into three basic categories:

1. additive - separate effects of the drugs summate when taken together.
2. synergistic (potentiation) - observed effects are greater than the expected
   sum of each drug's individual effects.
3. And, antagonistic - effects of one drug neutralize the effects of the other."

Persons with psychiatric problems are part of a highly medicated group. Thus,
the interactive effects of coingested prescription and nonprescription drugs and the
possible exacerbation of psychiatric symptomology has led to speculation that even
small amounts of substance use may be abusive, for people with psychiatric
problems. Kroeker (personal communication, March, 1989) suggested that many of
the Vancouver area mental health boarding homes may permit residents to
consume alcohol at Christmas parties and other special functions. If alcohol is
allowed at special functions, and if, due to the interactive effects described above
and the similarities between various drug induced states and psychiatric
symptomologies, we conclude that substance use and substance abuse are
synonymous terms, then it would logically follow that boarding home operators
are condoning if not encouraging substance abuse by residents. This logic, of
course, rests on the premise that substance use and substance abuse are
The next section summarizes several studies that suggest the biomedical disease model is the theoretical model most often used in the mental health field today. These summaries are followed by a discussion of the illegitimacy of the biomedical disease model, as it relates to dual diagnosis substance abuse, and the link between this study and the area of social work is made clear.

E. CONNECTION TO SOCIAL WORK

Kovess and Lafleche (1988) administered a survey questionnaire to thirty seven mental health professionals in two outpatient clinics of Montreal’s Douglas Hospital, and had an admirable 82% response rate. Six out of seven social workers responded, eight out of eight psychologists responded, seven out of eleven nurses responded, five out of seven psychiatrists responded, and four out of four "others" responded. Based on their findings, the authors concluded that the model these professionals used corresponded to the medical model, with treatment centered around individual therapy. The respondents spent very little time addressing their clients' social, political, or economic concerns, but rather, seemed to identify the "problem" as existing primarily within the individual.

In another study, Pekarik and Finney-Owen (1987) used The National Directory of Mental Health to identify 144 mental health outpatient service agencies in Kansas, Nebraska, and Missouri, and then randomly selected 36 agencies in cities with populations of 50,000 or greater, and 14 in areas with populations of
49,999 or less. This distribution was selected to correspond with the national ratio of urban-to-rural agencies (approximately 75% of mental health outpatient community services are in urban areas). Thirty seven of the fifty agencies selected responded (an 86% response rate), returning a total of 173 questionnaires (56% of the total number mailed out). Based on their findings, the authors concluded that therapists overestimated the length of treatment received by three times, based on U.S. Community Mental Health Center (CMHC) averages established by the National Institute of Mental Health (NIMH) in 1982. Therapists also preferred longer treatment periods than their clients did, with 77% preferring eleven or more visits, and nearly one third preferring twenty one or more visits, compared to surveys of public clinic clients which indicate that about three-fourths of clients expect treatment to last less than ten visits, and NIMH’s 1981 figures indicating that the CMHC average is five visits. Similarly, the authors concluded that therapists underestimated dropout rates, perceived the therapy process as more positive than it actually was, and did not attribute client dropout to the same factors that clients attributed it to (therapists were more likely to emphasize client "resistance" and less likely to emphasize clients’ dislike of the therapist or therapy).

Of course, there are limitations to the generalizations one can make about an area population on the basis of national surveys. All that can be determined is the extent to which the local population compares to national averages. It is possible that the therapists in Pekaric and Finney-Owen’s study actually did have longer treatment sessions, and lower dropout rates than the national average. Similarly, the local clients might actually have preferred longer treatment periods.
than the national average. Nonetheless, this study does indicate that these professionals, too, relied on the medical model. The biomedical model is firmly entrenched in the North American mental health treatment system, despite the apparent popularity (at a theoretical level at least) of "interactional" intervention models. Given the current climate of political conservatism, the biomedical model is likely to continue dominating the mental health field, and influencing the future direction of mental health community programs. Despite the prevalence of the biomedical disease model in the fields of mental health and substance abuse, the literature suggests that, for mentally disturbed populations, substance abuse results more from 'problems of living' than it does from physiological aberrations. Substance abuse may result from people preferring to self-medicate with drugs rather than accept the label of "mental illness" (Bergman & Harris, 1985), or from people seeking some relief from distressing psychiatric symptoms or trying to retain some control over their own lives (Lamb, 1982), or from people attempting to escape loneliness by joining drug subculture peer groups (Bergman & Harris). Regardless of the specific cause of an individual's substance abuse, as long as we view dual diagnosis substance abuse as a social problem, then no professionals will be better suited to the task of addressing the problem than social workers.

Social workers are uniquely well suited to the task of bridging the gap between mental health and drug and alcohol abuse professionals. Through their professional commitment to social change and well developed skills as process facilitators, they can work together to better meet the needs of dual diagnosis substance abusers. "The goals of mental health and substance abuse treatment
are complementary and serious attempts to address this dual diagnosis population must employ concomitant programming" (Ridgely, Osher, & Talbott, 1987). As a United States Government statistician said, separating these services was very much a political expedient, but the concerns of the patients are often poorly met through this kind of expediency (Sheehan, 1975).

The connection of this study to social work is, I think, self evident. Many social workers are employed in the area of mental health, and whether they are working in hospital or community settings, they are in direct contact with dual diagnosis substance abusers, and so have a vested interest in exploring issues relevant to this problem area. In addition, services for mentally ill substance abusers are still relatively undeveloped (Bachrach, 1987), which provides social workers with an excellent opportunity to be innovators in the development of new treatment strategies, and to carve a solid niche for the social work profession in this area through the accumulation of knowledge and the development of expertise.

The preponderance of the biomedical model in the mental health field makes it especially important that we explore and emphasize the cultural, economic, political, and social factors associated with dual diagnosis substance abuse. Thus, the term "to carve a niche" for social work does not imply that we have a "vested interest" in riding the biomedical wave and capitalizing on the "new industry" of dual diagnosis substance abuse. Rather, we have an interest in fighting for consumers' rights and social change, and in focusing attention on the "problems of living" that reinforce drug abuse for people with, as well as
without, psychiatric problems. What are the explanatory models of directors, staff, and residents of mental health boarding homes? These models are likely to be closely aligned with those of each boarding homes' professional and financial affiliates, and are likely to influence attitudes towards, and behaviors in response to, dual diagnosis substance abuse. Attitudes concerning the inherently abusive nature of substance use, are likely to be closely linked to respondents' explanatory models, as are peoples' perceptions regarding the prevalence of "substance abuse" in mental health boarding homes. It is imperative that boarding home directors, staff, and residents not only have access to information delineating the microbiological facets of "mental illness" and dual diagnosis substance abuse, but that they also have access to information delineating the individual, political, economic, social, and cultural facets of "psychiatric problems" and dual diagnosis "coping mechanisms."

The next section outlines some treatment strategies for dual diagnosis substance abusers. Two studies, outlining one highly successful and one moderately successful treatment program are reviewed. While these programs did not specifically target mental health boarding home residents, their treatment strategies can be extrapolated to a wide range of treatment locales, including boarding homes, and provide useful ideas regarding possible components of future services.
F. TREATMENT STRATEGIES

There are many different approaches to treating dual diagnosis substance abusers. One approach operates on the premise that the treatment of associated psychopathology must be secondary to the modification of drug consuming behaviors (Meyer & Hesselbrock, 1984). This view purports that, while primary drug abuse counseling and rehabilitation is not adequate by itself, by first treating substance abuse it is possible to stabilize peoples' disorganized thinking enough that they can continue with psychotherapy and medication (O'Brien, Woody, & McLellan, 1984). Another approach operates on the premise that dwelling on cause-effect relationships only complicates the issue, and that in most cases the two diagnoses are so enmeshed and mutually reinforcing that, in order for clients to respond positively, the substance abuse and psychiatric issues must be addressed concomitantly (McKelvy, Kane, & Kellison, 1987). Solomon and Davis (1986, p.73) espouse this second approach when they say that: "alcoholism and mental health professionals need to work together to develop programs for this [dual diagnosis substance abuse] population." And Rounsaville, Dolinsky, Babor, and Meyer (1987, p.512) state that "in devising the alcoholics' treatment plan, the poorer prognosis conferred by coexisting psychiatric disorders underscores the value of offering adjunctive treatments." While the use of "adjunctive" treatments presupposes the subordination of one treatment to another, the preference for a concomitant treatment approach is clear. Both of these approaches commonly operate within the parameters of the biomedical model, and are thus differentiated from a third approach, which operates on the premise that cultural, social, economic, and political factors are the primary source of
peoples' psychiatric and substance abuse problems (Glen & Kunnes, 1973).

Hellerstein and Meehan (1987) reported that an outpatient dual diagnosis schizophrenia and substance abuse treatment group they began in 1984, for people with histories of multiple hospitalizations and poor compliance with outpatient follow-up, was successful in reducing the number of days per year of hospitalization for the group participants. People were referred to this open-ended group from both inpatient and outpatient psychiatric and substance abuse treatment facilities. The group, which consisted of ten initial members, met once every week and consisted of three phases:

1. **Engagement** involved identifying mutual problems, such as psychotic symptoms, chronic suicidality, and drug abuse.

2. **Interpersonal skill development** involved learning to listen and respond to each other.

3. **Problem solving** involved working on family issues, use of time, housing, and work problems.

During each of these phases there was continued "psychoeducation" about drug abuse, psychosis, and psychotropic medications. While 100% attendance, abstinence from nonprescription substance use, and compliance with psychotropic medications were not mandatory, the group leaders did insist that all participants express a desire to decrease their substance abuse. Participants were also encouraged to attend self-help groups, such as Alcoholics Anonymous. Hellerstein and Meehan found that, for the original ten members, there was a reduction from 382 days per year of hospitalization for the year prior to joining the group (with a mean
and standard deviation of 38.2 +/- 21.4), to 78 days per year of hospitalization for the first year of the group (with a mean and standard deviation of 7.8 +/- 9.9). Just as the aforementioned treatment group involved "psychoeducation about drug abuse," so too do Ridgely, Osher, and Talbott (1987) conclude, following their review of the literature, that despite the formats of substance abuse programs, almost all involve drug/alcohol education.

In an Oregon study, Stark and Kane (1985) found that providing people with detailed information about the proposed treatment (psychotherapy for substance abusers), during initial intake procedures, increased the likelihood that they would return for treatment. Clients were divided into four groups. One group received general information about psychotherapy. Another group received specific information about psychotherapy for substance abuse. The third group was given information about the drug used, and acted as a control to determine if it was simply the attention that the clients received, rather than the specific content of the information exchanged, that effected rates of return. The last group, which received the standard information gathering (versus information giving) intake, also served as a control group. Stark and Kane found that there was a significant difference between the groups for clients that returned at least once (chi square=8.62, p<.05). However, the effects were shortlived. No significant difference was noted between the four conditions after 90 days (chi square=.18).

It seems that, while initially, being given accurate information about what to expect is important, subsequently, the level of satisfaction with the treatment experience is the prime determinant of the length of treatment. Clients were
included as active members of the treatment process during initial interviews, and may have been relegated to a secondary role during subsequent encounters, due to the "therapist driven" formats of many conventional treatment programs. Both of the preceding studies indicate that involving the consumer in the treatment process is important if program goals are to be achieved. We can extrapolate this conclusion to mental health boarding homes, and ensure that treatment or preventative dual diagnosis substance abuse services incorporate a high level of consumer involvement and maintain open lines of communication.

The literature reviewed in this chapter formed the background for the development of the present study, which investigates the occurrence of dual diagnosis substance abuse within the context of mental health boarding homes. Specific research questions will be outlined in the next chapter.
IV. THE RESEARCH PROBLEM

Following from the literature review, this chapter details the research questions that have been formulated for this study. Five specific questions have been identified, and each one will be presented in turn. Various elements of the questions will be identified, and question formulation will be linked to the literature reviewed in the preceding chapters.

1) How prevalent is dual diagnosis substance abuse in community mental health boarding homes? The literature indicates that there is a significant dual diagnosis problem among the "young adult chronic" population. Many of these people are transient and homeless, and either refuse to enter mental health boarding homes or do not meet the entrance criteria that have been established by the boarding homes themselves. However, these studies have focused on persons who do not live in boarding homes, rather than those who do. The literature suggests that dual diagnosis substance abuse is quite prevalent in psychiatric acute care hospital settings. The majority of Vancouver area mental health boarding home client referrals involve persons who have just been discharged from such facilities. Thus, one would expect that some of these dual diagnosis substance abusers would end up in mental health boarding homes. How many of the boarding home residents have histories of drug and/or alcohol abuse? How many currently have substance abuse problems? How many have had drug or alcohol related problems in the past two weeks? What types of substances are commonly abused? These and other questions will be explored.
(2) Is there a relationship between the demographic characteristics of mental health boarding home residents and dual diagnosis substance abuse? The literature indicates that there are associations between both the incidence and prevalence of dual diagnosis substance abuse and both peoples' age and psychiatric diagnoses. The high incidence of dual diagnosis substance abuse among the "homeless" suggests that dual diagnosis substance abusers are both unemployed and highly transient. What is the average age and gender of residents in different boarding homes? What level of education is common? Are these people employed? What are the identified primary diagnoses of the boarding home residents? This study explores the above characteristics and maps out associations between them and dual diagnosis substance abuse.

(3) Is there a relationship between the demographic characteristics of the staff and directors of mental health boarding homes and their perceptions of the dual diagnosis substance abuse problem? Do age, gender, job position, and level of education affect the way people view the problem, and consequently affect the responses of individuals, and policies of boarding homes? Peoples' "explanatory models" effect their perceptions, which in turn effect their actions. A review of the literature unearths large variations between the findings of different researchers. These variations are due, in part, to different operationalizations and, thus, different interpretations of data. While a review of literature focusing on associations between individual and group characteristics and emotions, cognitions, and behaviors has not been included here, (as it does not relate directly to dual diagnosis substance abuse), this study will explore the demographic characteristics of boarding home directors and staff, and map out relevant associations. It is
believed that information regarding the demographic characteristics of caregivers will provide useful insights into the mental health boarding home infrastructure.

(4) **How do mental health boarding homes respond to residents' substance abuse problems?** The literature indicates that many community mental health and substance abuse services are not currently designed to meet either the substance abuse or the psychiatric problems of this dual diagnosis population, and that most services are based on the precepts of the biomedical disease model. Do mental health boarding home staff and directors refer substance abusing residents to outside agencies, and if so, where? Do they have inhome dual diagnosis substance abuse treatment services, and if so, what? Is alcohol consumption allowed in boarding homes regularly, at special functions and parties, or not at all? Do the boarding homes have established policies concerning substance use and/or abuse by residents? These and other related questions remain unanswered.

(5) **Should special services be offered in response to residents' dual diagnosis substance abuse problems?** Services could be offered to both clients and staff. Would recreational services, regular drug and alcohol free social outings, job training and employment opportunities, drug education programs and substance abuse counselling, or self-help and support groups be useful treatment approaches? Do staff recognize a need for, and have an interest in attending a special workshop focusing on secondary diagnosis substance abuse and related issues? Would they like to have a self-help group, or a drug education program offered jointly by the mental health and drug and alcohol programs, available within their boarding homes? It is hoped that this study will, in conjunction with
information extracted from the literature, result in some concrete recommendations for the development of new programs to help people with psychiatric problems stop or minimize their use of drugs and/or alcohol.
V. RESEARCH METHOD

A. RESEARCH DESIGN

This study involved a naturalistic design, according to the guidelines of Reid and Smith (1981), as I had no control over the subject’s perceptions or practices in relation to dual diagnosis substance abuse, or over the prevalence, frequency, severity, or types of substance use and/or abuse. There was no direct manipulation of experimental conditions. Rather, this study involved: estimating the prevalence of substance use and/or abuse in mental health boarding homes; identifying certain specified features, such as demographic characteristics and boarding home policies, and mapping out relevant associations; and lastly, mapping out suitable alternatives and policy directions.

The study followed a dimensional (Crane, 1988) conceptual model. Thus, attempts were made to examine a global concept (dual diagnosis substance abuse) within a specific context (mental health boarding homes). Considerable amounts of data were gathered using survey questionnaires. The questionnaire items were determined from information gathered through personal interviews with service providers in the field, and by examining the literature. Findings that are specific to dual diagnosis substance abuse, within the context of mental health boarding homes, are largely unavailable, so connections were made between available studies and the issues at hand. And finally, a "map" was developed, outlining the principle sub-areas of the dual diagnosis phenomenon.
B. RESEARCH SAMPLE

Due to the small size of the population (thirty-nine boarding homes, minus two pretest facilities) all of the units in the population were initially contacted, eventually resulting in a sample size of twenty-nine facilities (78%). These homes had from two to forty-seven residents, totaling 358 residents across all twenty-nine homes. The sample consisted of a fairly heterogeneous group, as many of the boarding homes are run by different agencies and cater to different client groups. It was hoped that not only the staff and directors of the boarding homes would participate in the study, but that the residents would also ‘stand up and be counted.’ There were a number of reasons for surveying all three of these groups: first, to increase the sample’s heterogeneity, and provide a more comprehensive picture of ‘the way it is;’ second, to increase the chance that residents, staff and directors would support any subsequent policy recommendations, by including them in the planning process, and thereby instilling in them a sense of ownership in the project; and finally, to circumvent the all too common practice of not including the actual service consumer in decisions that determine what services they need. As previously mentioned, a pretest of two boarding homes was conducted to test the survey instruments.

C. SURVEY INSTRUMENTS

Data was collected from the staff, directors, and residents of boarding homes using survey questionnaires. I had intended to personally visit the boarding homes to administer questionnaires to residents, and collect the director and staff
questionnaires that had previously been mailed to the boarding home directors (along with introductory letters). However, in four cases, completed questionnaires were returned to me in the mail (I was unable to visit these facilities). Both quantitative and qualitative data were gathered. The quantitative data were generated by a series of closed ended questions designed to gather factual data concerning the prevalence of and response to dual diagnosis substance abuse. The qualitative data were generated by a series of open ended questions designed to elicit the respondents' perceptions of and attitudes towards dual diagnosis substance abuse. The survey questionnaires were designed specifically with the target population in mind, and were pretested prior to full scale application. This was done to enhance internal validity.

It was assumed that the use of mailed questionnaires would minimize the amount of time needed to survey people, and reduce project costs and interviewer bias. The questions asked (and the ways that they were asked) were standardized from one respondent to the next, although some adjustments were made to ensure a good fit between questionnaires and the "director," "staff," and "resident" groups. Careful attention was paid to constructing simple and easily understood questions, to maximize the consistency of interpretations. It was hoped that some (limited) clarification could be obtained, if necessary, while personally visiting the facilities to collect director and staff questionnaires. Additionally, an attempt was made to personally administer resident questionnaires, not only to increase the response rate, but also to both provide and receive clarifications where appropriate. It was hoped that obtaining data from the three respondent groups would reduce problems of bias.
In an attempt to increase the response rate, which is generally recognized as a significant problem with mailed questionnaires, a number of measures were adopted. As mentioned above, the residents' questionnaires were not mailed, but were distributed directly by the researcher, who was (in some cases) present while they were completed, and personally collected them upon completion. Directors were telephoned following their receipt of the mailed questionnaires, and this is believed to have increased the rate of response for directors considerably. Also the questionnaires were printed on colored paper with an attractive and easy to use layout. Questions were worded politely and included clear concise instructions. And, not only was University of British Columbia (U.B.C.) School of Social Work letterhead stationery used, but letters of endorsement from Greater Vancouver Mental Health Services (GVMHS) and Alcohol and Drug Programs (ADP) were included as well.

D. DATA ANALYSIS

Frequency distributions, Pearson's correlation coefficients, Spearman's correlation coefficients, phi coefficients, Cramer's V, and chi-square tests of significance were tabulated using the U.B.C. Computing Centre's SPSS:x statistical analysis program. The phi coefficient is a useful measure of association for use with two dichotomous variables, as it can be given a proportional reduction in error (PRE) interpretation. Cramer's V was used to measure associations between nominal data with more than four categories, because as a chi-square based measure it also can be used to determine levels of significance. Spearman's rho was selected for use with fully ordered ordinal data, as it can identify both positive and
negative relationships, and be given a PRE interpretation. Pearson's $r$ was used for interval level data not only because it can be given a PRE interpretation, but also because its mathematical similarity to both phi and Spearman's rho makes comparisons between them possible.

The relationships between substance use and/or abuse and gender, age, boarding home admittance policies, boarding home size, average length of stay, psychiatric diagnoses, and prescribed medications were analyzed, as were the relationships between the abuse of alcohol and the abuse of other drugs, and the boarding homes' response to residents' substance use and/or abuse and their professed support for various programs. In addition, frequency distributions were examined to estimate the incidence and prevalence of dual diagnosis substance abuse in the various homes, and the degree of support evidenced for the various in-home or out-of-home treatment services.

E. METHODOLOGICAL DIFFICULTIES IN RESEARCHING THIS TOPIC

The greatest methodological problem of this study concerns the quality of estimates. An attempt was made to increase the reliability of data by including three groups of respondents: directors, staff, and residents. It was assumed that surveying all three groups would cause the individual biases and inaccuracies of individual respondents and collective interest groups to balance each other out. In like fashion, it was hoped that selection bias would not be a problem, as attempts were made to survey the entire population of Vancouver area mental health boarding homes.
The identified population of boarding homes were contracted services run by fairly small independent agencies (fourteen homes operated under the auspices of larger umbrella organizations), so the staff and directors did not face as many formal restrictions regarding the release of information, as they would have in many larger human service organizations.

Nonetheless, there were a number of factors that threatened to jeopardise the reliability of the data. First, there were some issues arising from the method of data collection: mailed survey questionnaires often generate low response rates, and the researcher is unable to clarify problems of interpretation, and explore inconsistencies as they occur. These problems threatened the accuracy and efficiency of prevalence estimates. A number of measures were adopted to increase the rate of response, and the quality of estimates.† And yet, despite these precautionary measures, very few residents (3%) participated in the study. Thus, attempts to increase the accuracy of estimates by reducing selection bias were not entirely successful. Further, respondents were self-selected, rather than randomly selected. Accordingly, resident reports have been used as descriptive data, and attempts have not been made to generalize findings based on these reports to the entire population of residents.

While the rate of response for staff is not known (information detailing the total number of staff members employed in the identified population of boarding homes was not available), there was a very high response rate from directors (78%),

†Refer to the "Survey Instruments" section of this chapter for a more detailed discussion of the problems associated with mailed questionnaires, and subsequent measures adopted to improve their efficiency.
and thus, facilities. And while the effects of individual bias, agency bias, and selection bias, can never be entirely annulled, neither the efficiency of survey methods, nor the accuracy of the estimates are any more problematic than is usual for studies of this kind. Of course, this study was not entirely free from the objective bias of the researcher. However, by avoiding the use of research assistants and interviewers, other than the primary researcher, there was a high level of consistency in the evaluation of data from different sources. Furthermore, closed-ended and open-ended questions were used, so that I could benefit from the objectivity of the former and the subjectivity of the latter. Of course, the survey sample may not be representative of mental health boarding homes in other areas or municipalities, and so caution must be exercised when making generalizations to other populations.
VI. RESEARCH FINDINGS

A. PRETEST AND SUBSEQUENT QUESTIONNAIRE REVISIONS

Following receipt of a letter of approval from the University of British Columbia Ethical Review Committee (Appendix 1), a pretest of two boarding homes selected randomly from the population of Vancouver area mental health boarding homes was conducted to test the survey instruments. This section outlines the pretest, and details some of the ensuing questionnaire revisions. These revisions have been included here rather than simply making vague references to unspecified "changes" to accentuate the value of conducting a pretest. This section does not contain results of the primary study; these are detailed in the ensuing sections. The resident populations of these pilot homes were fourteen and twenty, respectively. Only two homes were selected for the pretest due to the small number of homes in the population (n=39), and the assumption that modifications to the survey instruments subsequent to the pretest would be such that the pretest sample could not be included in the larger study. Indeed, a number of revisions were made to the survey instruments.

According to the guidelines of the U.B.C. Ethical Review Committee, introductory letters (Appendices 2, 3, and 4) were mailed to the two boarding homes, along with questionnaires for the directors and staff. The directors were telephoned approximately one week following their receipt of the mailed packages, and arrangements were made to visit the two facilities, both to collect the mailed questionnaires and to personally administer the resident questionnaires. It was at
the point of telephone contact that the first difficulties ensued! The directors of both facilities indicated that the residents in their respective boarding homes were elderly persons who did not abuse drugs or alcohol, and that, therefore, this study was not applicable to their homes. Nonetheless, one of the directors immediately agreed to participate, by completing "at least part" of the director questionnaire. And while the other director was not quite as amicable, and berated the entire study as a "waste of taxpayers' money," upon further consideration, he/she too agreed to participate (perhaps I should clarify now, as I did then, that this study was funded entirely by the researcher, who received no monies from the public purse).

Both of the pretest facilities were large old wooden homes that blended inconspicuously into their environs; both had clearly defined lines of authority, with traditional staff/resident role expectations. The residents of the first home I visited had been informed of my intentions by the director, and were all gathered in the living room awaiting my arrival. I told the gathered residents about my study and, after stressing the voluntary nature of their participation, invited them to contribute their own views and expertise. My oratory was met, for the most part, with seemingly blank stares. Only two of the assembled residents (all were elderly and two were over the age of ninety) made any comments: one resident remarked that she "[did not] think that there [was] anything wrong with having a drink sometimes;" and the other resident asked me if I "could come back later to play cards?" Both comments were appropriate, if somewhat brief. The residents in the second home had not convened as a single group, though many were sitting in scattered groups of two or three in
the large grassy backyard. Two residents who had been conversing together agreed to fill out questionnaires with me; none of the other residents showed any interest. I also met personally with the director and one staff member from this home, and the director of the other home. None of the respondents answered the questionnaire questions very thoroughly. Thus, the information gained through oral discourse was invaluable.

A number of revisions were made to the survey questionnaires following the pretest. I should clarify at this point that the question numbers cited in this section refer to the pretest questionnaires (Appendices 5, 6 and 7) rather than to the revised questionnaires (Appendices 8, 9 and 10) used in the actual study. The first question on the director and staff questionnaires, which asked for the date, was left unanswered in all cases. Though it certainly had not been intended as such, both the director and staff respondents from one of the homes believed that this question had been designed to test their awareness, rather than to simply elicit the date. Consequently, this first question had unfavorably colored the respondents' impressions of the entire questionnaire. Furthermore, due to the relatively short time span of the data collection in this study, the approximate date of completion for any given questionnaire was easily determined without reference to the exact date. This question was deleted from the questionnaires.

Question number five of the director questionnaire which enquired after residents' average length of stay, was also left unanswered. Interval level data does increase the researcher's flexibility during data analysis. However, nominal data is better than no data. Thus, in a later version, respondents were asked to check
the appropriate category rather than fill in the blanks. This change may have reduced the range of responses considerably.

Question number six of the director questionnaire was not answered by either of the directors, but the director of one of the homes did provide some interesting comments. This director stated that diagnoses were "just labels, and [she didn't] like labels." The staff respondent from this same home proffered a similar sentiment. I had not intended that this question indicate that either I or the respondent supported the routine use of popular diagnostic labels. Rather, I had hoped to establish if there was a relationship between diagnoses and substance use or abuse, and between diagnoses and residency in mental health boarding homes. In response to the director's comments, I added a diagnoses are not seen as relevant category. In addition, the director who made the preceding comment was not familiar with the terms unipolar affective disorder or bipolar affective disorder, so the more common terms: depression (though not entirely synonymous with the term it replaced), and manic depression, were used.

Question number seven of the director questionnaire also caused some confusion. At least two of the respondents were unable to distinguish between major and minor tranquilizers. Consequently, these two categories were synthesized into a single category. Despite these revisions, it appears that some respondents still found the medication categories confusing.

Numerous changes were made to question twenty of the director questionnaire and question thirteen of the staff questionnaire. First, the subheading: what is
your job title, was deleted completely. None of the respondents answered this question, and the use of distinct director, staff, and resident questionnaires rendered this question somewhat redundant. However, "staff" could have been cooks, cleaners, nurses, or "aides." Also, rather than asking respondents for their date of birth, I asked a less sensitive question: what is your age? and included four age categories to choose from. Thus, while the range of responses was narrowed, the response rate was increased. Additionally, the subcategory that inquired after respondents years of schooling was changed from an interval to a dichotomous yes/no answer format. A work experience category was added both in recognition of the intrinsic value of practical experience, and to reduce the level of intimidation experienced by those respondents without formal academic credentials.

Just as many changes were made to the director and staff questionnaires, so too were many changes made to the resident questionnaire. Perhaps the most glaring oversight was the overall length of the resident questionnaire; the resident questionnaire was longer than either the director or the staff questionnaires, and the two pretest resident respondents clearly found the length unwieldy.

Question five was deleted entirely. Neither of the two pretest respondents were able to answer this question about their psychiatric diagnoses. Furthermore, neither the director nor the staff who participated in the pretest thought it was a suitable question, both because they thought it highly unlikely that the residents would know the answer, and because they thought it might cause them some undue apprehension. Question seven was substantially altered, by asking
respondents to simply indicate if they used any medications at all rather than indicating which of a specified list of medications they used.

Questions fifteen, sixteen, and seventeen, which dealt with boarding home policies, were deleted entirely, as they were also included on the director (questions seventeen, nineteen, and ten) and staff (questions five, twelve, and four) questionnaires. Like its counterpart on the director and staff questionnaires, the subsection of question nineteen that asked respondents for their date of birth was changed from an interval to an ordinal level format, by including a list of numeric ranges for respondents to choose from. The subsection that asked respondents what level of education they had completed was similarly changed.

The formats of a number of additional questions on director, staff, and resident questionnaires were also altered, either by switching from interval to ordinal, or ordinal to nominal levels of data collection, or by switching from a horizontal to a vertical layout, or by including directional arrows to guide respondents to the appropriate categories. The pretest segment of this study was clearly invaluable, and resulted in extensive changes that improved the quality and relevancy of the survey questionnaires.

The following section is essentially an "introduction to the results." This introductory section includes a general description of the survey sample, that is, the members of the total surveyed "population" that actually participated in the study. Following this introductory section, the research results will be examined in more detail, with specific reference to the identified research questions.
B. PRELIMINARY DESCRIPTION OF THE SURVEY SAMPLE

As mentioned in the previous section, two Vancouver area mental health boarding homes were surveyed in a pretest. Due to the extensive changes that were subsequently made to the survey questionnaires, the two pretest facilities were excluded from the main study. Thus, the main study involved a sample size of thirty-seven boarding homes, and twenty-nine (78%) of these thirty-seven facilities participated in the study. While there was one director participant from each of the twenty-nine homes, three of the directors completed questionnaires intended for staff members. Accordingly, questions that were only included on director questionnaires were not answered by these three respondents.

Out of the thirty-seven boarding homes, eight (22%) homes declined to participate for a variety of different reasons. For instance, the coordinator of one group of four homes stated that the persons living in the facilities were tenants with self-contained apartments, rather than residents of conventional (staffed) boarding homes. These four facilities did not have any staff members, and the coordinator's role involved liaison between the tenants and the umbrella organization rather than on-site participation. Though a survey of these facilities would have provided useful information, they were dropped from the study at the coordinator's request (thus, it can be seen that the coordinator's role did indeed involve direct manipulation of the tenant's interests).

The director of another facility refused to participate because "[his/her spouse had] asked [him/her] to scale down [his/her] duties," and he/she simply did not
have the time to get involved. However, this director's insistence that I approach neither the staff nor the residents of the facility suggests that his/her refusal may have involved more than temporal concerns. Indeed, personal communications with the (now retired) director of the Mental Health Residential Services, indicated that the residents of this particular facility were among those most likely to have dual diagnosis substance abuse problems. A similar reason for not participating was expressed by the director of another facility, who said: "I'm a working operator so I have to look after the residents. I haven't had the time [to complete the questionnaire]." In addition to temporal concerns, the director of another facility cited a lack of substance use by residents as the reason for not participating in the study. And finally, the last director who refused to participate did so for quite a different reason: in this case it was not the director but, rather, the residents, who decided at a weekly house meeting that they would not participate. In this latter case, the residents were not only consulted regarding their participation as individuals, but were also consulted regarding the boarding home director's participation.

It became apparent very early in the study (indeed, during the pretest) that very few residents would agree to participate. However, it should be noted that in many cases it was the directors, and not the residents, who determined that residents would not participate. The following comment was by one such director, who decided for the residents: "It's the age group. We had one person in the last six months who was a street person who did have problems ... no, I don't think it would do any good [to survey residents]. They are mostly in their own little worlds and like to be left alone. We have one fellow [who might be able
to answer a questionnaire], but he's too paranoid and grandiose to be of much use." It is not the accuracy of the preceding statement that is at issue here, but rather, it is the simple fact that no effort was made to consult the residents. Thus, we cannot fall back on the often used conclusion that low resident response rates are due to "non-compliance."

There were 358 residents in the twenty-nine homes surveyed in this study, and sixty-four in the eight homes that were not surveyed, equalling a total resident population of 422.† Only ten residents (3%) completed questionnaires. Furthermore, the ten residents who did participate were concentrated in four facilities: one resident from each of two facilities, two from a third facility, and six from a fourth facility. With one exception, those residents who did agree to participate were from facilities where a high degree of resident autonomy was encouraged (and expected). This is not surprising, as these residents were not only likely to have been among the most cognisant, but were also most likely to have been given the opportunity to participate. Additionally, these persons who are encouraged (or allowed) to make their own decisions are more likely to be accustomed to, and comfortable about, taking control over their lives, and are less likely to be intimidated by someone like myself.

Unlike residents, twenty staff members, from twelve facilities, participated in the study. While it is clear that I initially overestimated the number of staff

†These figures do not include the two pretest facilities. The reference to sixty-four residents in non-participating facilities is an estimate, based on figures obtained from Greater Vancouver Mental Health Services, Mental Health Residential Services. These figures were found lacking with respect to three other facilities, so the true number of residents in these eight non-participating homes at the time of the study is not known.
members likely to be employed in mental health boarding homes, it is not clear exactly how many staff were employed in these facilities at the time of this study. In fact, several facilities did not have any clearly defined staff positions, either because they were small family run operations, or because of their emphasis on independent living. Additionally, many of the staff members were employed as cooks, or cleaners, who either did not have the expertise or the motivation to participate in the study. Thus, it remains difficult to establish just what the response rate for staff members was.

One thing is clear concerning the response rate: the enthusiasm of directors was a key determinant of the support generated in boarding homes. As mentioned previously, it was the directors who decided, in seven out of eight cases, that their respective facilities were not to be included in the study. In like fashion, the directors of many of the participating facilities had a strong influence on whether or not the staff and/or residents of the various homes became involved. Of course, the staff and/or residents of some facilities refused to participate despite the directors’ enthusiasm, but without the directors’ support they were not even given the opportunity to decide the issue for themselves. While it is true some consumer driven facilities did involve residents in the decision making process, these were the exception rather than the rule.

The next five sections present results that are specifically related to the five main research questions. Each of these five questions is considered separately. The

†My initial estimates were based on staffing models in group homes for physically disabled and mentally handicapped adolescents, which are not congruent with those of the mental health boarding homes surveyed in this study.
Accordingly, the first results to be reviewed are those relating directly to the prevalence/incidence of dual diagnosis substance abuse in mental health boarding homes. Responses by directors, staff, and residents are considered. It is important to note that the participating sample of residents is too small, and too unrepresentative of the population† of residents, to provide statistically meaningful answers. Thus, resident responses have been included at the end of each section, as descriptive points of interest.

C. PREVALENCE/INCIDENCE OF SUBSTANCE USE AND/OR ABUSE

The first purpose of this study was to estimate the extent of dual diagnosis substance abuse in Vancouver area mental health boarding homes. Twenty-two (76%) of the twenty-nine directors, and fifteen (75%) of the twenty staff members, from twenty-three (79%) different facilities (95% confidence interval for the population percent=64%-94%)‡ reported that at least one resident consumed alcohol. The total number of residents who, according to directors' reports, consumed alcohol was 115 (32%) (95% confidence interval for the population percent=27%-37%). Ten directors (34%) and four staff members (20%), from eleven (41%) different facilities (95% confidence interval for the population percent=22%-60%), reported that at least one resident used marijuana. According to director's reports (n=27), a total of fourteen residents (4%) used marijuana

†The resident group was not a random sample, but was self selected. Thus, external validity is likely quite low.
‡Although confidence intervals have been included here, it is important to remember that the research sample was not randomly selected. Thus, the representativeness of the sample to the population is unknown.
(95% confidence interval for the population percent = 0%-11%), although one additional director who did not report any cases of marijuana use did indicate that he/she suspected, but could not prove that a number of residents did use that substance. Data was missing in two cases. One director (3%) reported that one resident used opiates; there were no staff reports of opiate use. One staff member (1%) reported that there was an occasional LSD user, although this was not corroborated by the director of the same facility. On the other hand, both the director and the staff member from another facility substantiated the presence of an amphetamine user among the residents. There was no barbiturate or PCP use reported. One director identified the use of inhalants by a resident; inhalant use was not reported by any of the staff members. Three directors and two staff members reported that substances other than the ones listed in the questionnaires were also used. Only one of these two staff members was from a facility whose director had similarly reported the use of drugs in the other category. Thus, the use of "other" drugs was reported in four (14%) different facilities (95% confidence interval for the population percent = 1%-27%). Of course, individual respondents were responsible for determining specifically which other substances warranted mentioning, and it is probable that opinions varied greatly in this respect. Substances that were mentioned in the other category included: antihistamines, antiemetics, cough syrup, Midol, and Gravol. The total number of residents who, according to directors' reports, used "other" drugs was three (.8%). Data was missing in one case. Figure 1 shows the total number of residents who used any of the specified substances, according to directors' reports. It is clear that alcohol is the most frequently used substance, and aside from some marijuana, very few residents use illicit "street" drugs.
Figure 1.

PREVALENCE OF SUBSTANCE USE IN MENTAL HEALTH BOARDING HOMES

Number of Residents

<table>
<thead>
<tr>
<th>Substances</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
</tr>
<tr>
<td>Opiates</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td>LSD</td>
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<tr>
<td>Amphet</td>
<td></td>
</tr>
<tr>
<td>Bath</td>
<td></td>
</tr>
<tr>
<td>Herbal</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Data are for all residents (n=358) but two cases are missing for "marijuana" and one is missing for "other."
While I had not included cigarettes or coffee in the specified list of substances, two respondents commented specifically about one or the other of these two drugs. One staff member included the following comments:

Incidentally, coffee and cigarettes (‘minor’ (?) drugs) are mega-consumed by these people - but the cigarette smoking especially seems to be one of life's few pleasures for these people - hard to watch the chain smokers without wanting to gag yourself - staff will usually gently caution against too many cigarettes, and only allow decaffeinated coffee to be served in the house after 10:00 o'clock.

The other respondent, a director, provided the following rationale for the high prevalence of cigarette use by residents:

I could count the number [of residents] who don't smoke on one hand. You can look at it in light of Marxist philosophy. They own the means of production, control the time of production, and determine the level of production. Cigarettes are a form of currency, and a status symbol. They are a social medium ... a way of initiating conversations with others.

While the above rationale does make sense (of course, cigarettes also seem to be physiologically addictive), I question the legitimacy of the statement that "these people" like to smoke (unless the term was used to refer to the residents of one specific facility, rather than to persons with psychiatric problems, in general). Personal observations in acute care (hospital) psychiatric settings indicate that very many psychiatric patients smoke cigarettes, but observations in community mental health boarding homes indicate that very many ex-psychiatric patients do not smoke. Certainly, in some boarding homes virtually every resident smokes
cigarettes, but it is equally true that in other boarding homes virtually every resident does not smoke. The prevalence of cigarette use may be a product of the environment (for example, high stress levels and inactivity in acute care psychiatric hospitals, or anti-smoking policies in boarding homes). On the other hand, high levels of cigarette use may be associated with other variables (such as age, ethnic background, or alcohol consumption) that influence the selection of environments (by the individual or by others). As such, the environment may be a product of cigarette use. In any case, very few respondents included cigarettes or coffee as viable substances for the purposes of this study ... nor was it intended that they do so.

In order to explore the immediacy of residents' substance use, respondents were asked to indicate how many residents had consumed illicit street drugs or alcohol during the two week period prior to the questionnaire's completion.† Based on directors' reports, three boarding homes (12%) had at least one resident who had used illicit drugs during the past two weeks (95% confidence interval for the population percent=0%-25%). Data was missing in three cases (n=26). Illicit drug use was not reported by any of the staff members, despite the fact that three of them were from a facility whose director had identified illicit drug use by two residents. There is a clear discrepancy between the director and staff reports for that facility.

There was considerably more alcohol use during the specified two week period. The directors (n=27) of fourteen (52%) different facilities (95% confidence interval

†For the purpose of this discussion, the phrase the past two weeks refers to the two week period directly preceding the completion of any given questionnaire.
for the population percent=33%-71%), and seven staff members (n=20, 35%), reported that at least one resident had consumed alcohol one to five times during the past two weeks. Directors' reports were missing in two cases. While seven of the directors indicated that three or more residents had consumed alcohol one to five times during the past two weeks, according to the staff reports, there were not more than two residents in any given facility who had consumed alcohol that frequently. In one home, all three staff respondents reported that only two residents had consumed alcohol, while the director of that same facility indicated that six residents had consumed alcohol. And yet, while there is a clear discrepancy between reports by directors and staff, one reason that director reports were not substantiated by staff members is because, in four out of seven cases, the facilities with reportedly more than two drinkers did not have any staff members (thus, none completed questionnaires). Based on directors' reports, a combined total of fifty-four residents (16%) consumed alcohol one to five times during the past two weeks (95% confidence interval for the population percent=12%-20%). Data were missing for eighteen residents from two facilities (n=340).

Two directors indicated that at least one resident had consumed alcohol six to ten times during the past two weeks; there were no reported cases of residents consuming alcohol more than ten times during a two week period. It is difficult to determine if the three residents who reportedly consumed alcohol six to ten times, did so on six to ten different days, or drank repeatedly on a fewer number of separate occasions. Similarly, it is not clear exactly how much alcohol was consumed on any given occasion. Thus, it can not be ascertained that the
consumption was of an abusive nature, based on the specified World Health Organization guidelines. A combined total of fifty-seven residents (17%) consumed alcohol at some level during the specified two week period† (95% confidence interval for the population percent = 13%-21%),

While three residents had (according to directors’ reports) used illicit street drugs during the past two weeks, only two residents had abused illicit drugs. As one would expect, the director who reported that residents abused illicit drugs had also reported that residents used illicit drugs. And yet, this director stated that there were two residents who had abused illicit drugs during the past two weeks, while only one resident had used illicit drugs during the same time period. Thus, one of the residents seems to have abused drugs without using them! It is possible that this respondent was referring to three different people: one that had used drugs, and two that had abused drugs. Thus, the conflict may have involved the interpretation rather than the report (of course, it may simply have been an error). The strongest relationship between reports of drug use and drug abuse was between drug abuse and marijuana use (Phi = .32). There do not appear to be any significant relationships between the use and abuse of any specific drug.

Only a slightly higher incidence of alcohol abuse was reported. Two directors indicated that one resident in their respective facilities had abused alcohol during

†Staff reports have not been included here, as their inclusion would have resulted in a certain amount of overlap; some residents would have been counted twice. However, one case of staff reported alcohol use could have been safely added, as the director from the same facility reported that no one had used alcohol, thus alleviating the chance of duplication.
the past two weeks, and two directors indicated that two residents had abused alcohol during the same time period. Thus, there were reportedly six (2%) residents (95% confidence interval for the population percent = 0%-7%), who had abused alcohol (n = 358), from four (14%) different facilities (95% confidence interval for the population percent = 1%-27%). Questionnaires were also received from two staff members from each of two different homes where alcohol abuse had, according to director reports, occurred. In one of these two facilities, one staff member indicated that one resident had abused alcohol, while the other staff member reported that none of the residents had abused alcohol during the specified two week period; the director, on the other hand, stated that two residents abused alcohol. In the other facility, neither of the staff members reported that any alcohol abuse had occurred, though the director had indicated that one of the residents had abused alcohol. Thus, there are discrepancies between reports by directors and staff once again, with more directors reporting that more residents use and/or abuse substances. With alcohol abuse and drug abuse categories combined into a substance abuse category, eight (2%) residents (95% confidence interval for the population percent = 0%-7%), from four facilities (14%) had reportedly abused substances.

Associations between the use of various different substances could not be made, as reports by directors and staff did not identify individual users, but rather, referred either to the presence or absence of substance use/abuse, or the total number of substance users/abusers. However, it can be determined that all reported cases of "drug" use were from facilities that also had reported cases of alcohol use. There was a significant relationship between facilities that had
reported cases of marijuana use and reported cases of alcohol use, according to directors' reports (Chi-Square, with the Yates correction < .05). There was also a significant relationship between the estimated prevalence of monthly alcohol use and yearly marijuana use (\(\rho = .65, \text{sig} < .01\)). The only significant relationship between substance use and substance abuse was between weekly alcohol use and drug abuse (\(\rho = .58, \text{sig} < .01\)). Surprisingly, this association was between alcohol use and drug abuse, rather than between alcohol use and alcohol abuse. Of course, it is not surprising to find that reported drug abusers also consume alcohol. Although not statistically significant at the 95% level, negative associations were noted between weekly alcohol use and the "alcohol," "drug," and "substance" abuse variables. Frequent consumption does not appear to be a good indicator of abuse.

A cursory examination of the data suggests that there are very few substance abuse problems in Vancouver area mental health boarding homes. However, several factors suggest that the prevalence of substance abuse may have been underreported. First, directors' reports indicate that at least fifty-seven residents, from sixteen different facilities consumed at least some level of alcohol during the two week period directly preceding the completion of questionnaires. Directors' reports further indicate that 115 residents (32%) consumed at least some level of alcohol during the year. Figure 2 shows a large discrepancy between the number of people who consumed alcohol during a two week period, and during a one year period, and the number who abused alcohol during a two week period.†

†If staff responses are added to the directors' reports, controlling for possible duplications by only selecting staff responses from facilities whose director did not
Figure 2.

SUBSTANCE USE VERSUS SUBSTANCE ABUSE

Number of Residents

Reports of alcohol abuse during a two week period and use during a one year period (n=356)

Reports of Abuse, and Use of Alcohol During Different Time Periods
Furthermore, as previously mentioned, one of the facilities that had a "reputation" for housing residents with substance abuse problems was not included in the study. And while the director of one additional facility with a similar reputation did complete a questionnaire, I was strongly discouraged from either visiting the facility or surveying the staff or residents. In both these cases, it is possible that the prevalence of substance abuse in the facilities influenced the respective directors' decisions to limit the information I received.

In addition, the internal validity of reports of substance abuse may have been adversely affected by internal or external pressure to present the facilities in a favourable light. Several directors expressed concern that Greater Vancouver Mental Health Services (GVMHS) might have access to their responses. All of the facilities that were surveyed rely heavily on GVMHS for their funding,† and are therefore very concerned about meeting that agency's contract demands. Similarly, the private owners or umbrella organizations that control and are administratively responsible for the various facilities, have formal or informal regulations governing the daily operations of their boarding homes. For instance, the Mental Patients' Association has a formal list of *house rules*. The first two rules are:

1. No alcohol (in the house or immediate vicinity) nor arriving home intoxicated.
2. No abuse of non prescription drugs.

† (cont'd) identify any cases of substance use, the number of residents who reportedly use alcohol increases slightly to 121 (34%).
† While the bulk of agency operating expenses are covered by GVMHS "contract" money, the generation of additional funds for "nonessential" things through private fundraising is also commonplace.
The Coast Foundation Society also has a formal, documented policy regarding the consumption of alcoholic beverages. The following information outlining some suggested changes to this policy was circulated to the "Management Committee" in September of 1989:

Coast Foundation Society promotes the maintenance of a healthy lifestyle. Individuals should be aware that a mixture of alcohol and medication may have adverse affects. Therefore:

1. As a general rule, alcoholic beverages will not be consumed in Community Care Homes, in the Clubhouse/Administration, and in the public areas of the apartment buildings. Upon approval by the appropriate division manager or designate, there may be special events where alcohol is present.

2. No supervised outings should be planned specifically for the consumption of alcoholic beverages. Coast employees will not drink alcoholic beverages during their scheduled working hours.

The directors and/or staff members of some facilities may have sacrificed accuracy for efficacy, in an attempt to present either themselves or their facilities in a favourable light. The comment by one director that he/she "had to check out the politics of the thing" before participating in the study is indicative of this tendency to protect one's personal, or agencies' interests.

Another factor that may have adversely effected the estimates of substance abuse

†It is important to clarify at this point that the two examples of agency policies used here were selected because of their clarity, and not because the directors of either the Mental Patients' Association or the Coast Foundation Society boarding homes purposely provided me with misleading information. On the contrary, respondents from facilities affiliated with these two organizations were, for the most part, among the most enthusiastic and cooperative.
has to do with the survey questionnaires, rather than the respondents. On the original draft of the questionnaires, respondents were asked how many residents had abused substances during a one month period. Following the pretest, the question was simplified. In an attempt to increase the response rate, and the accuracy of responses, respondents were asked to focus on the past two weeks, rather than the past month. While the response rate (for this particular question) and the accuracy of responses may have been increased, the efficiency of the estimates may have been jeopardised. This problem was summed up nicely by one director, who stated that he/she did not "think two weeks [was] long enough, because [they had had] some problems about a month and a half ago, but not during the past two weeks ... in the last month and a half one person drank and got in a fight ... also in the last month and a half [one person took illicit drugs and] got in a fight; the police were called and the [resident was] taken to the hospital."

Another director stated, regarding substance abuse by residents, that:

I don't have that. I used to. There used to be a young girl [here] who was not only a drug addict and alcoholic but also a street person. She took off last year and was raped and almost killed. I don't know if you remember, but a lot of prostitutes were being attacked back then ... I just started operating this [home] in October [1987] and have already had two serious problems [related to substance abuse].

Similarly, the director of another facility stated that they "had a fellow in the home two years ago who caused trouble [fighting with another resident] in the home, so [he] was expelled." Although this same director reported that none of
the current residents used any of the specified substances, he/she included the following comment:

I have one residents [sic] only that drinks when he go home to his mother, who is an alcoholic, deaf [sic] and mute. His brother who he was very close to committed suicide and his father did too and he has tried it as well ... He come home very drunk, sometimes police bring him home very drunk ... If he is drunk he just sleep. But one time he was fighting with one of our residents. He was warned he will stay in Look Out - if he do it again.

Thus, it would seem that despite the fact that this respondent indicated that none of the residents used alcohol, one of the residents, at least, not only used but also abused alcohol on occasion.

Another director who similarly reported that the residents neither used nor abused substances stated that "at one time one guest did get very drunk, we had a bad time." And in two additional cases, although no drug or alcohol abuse was reported, directors indicated that they believed a resident abused prescription drugs. These cases of suspected prescription drug abuse were reported despite the fact that this study did not address the issue of prescription drug use directly; that is an area for future research!

In response to the obvious problems of reliability and validity associated with questionnaires, respondents were encouraged to elaborate on their responses to "closed ended" questions. These supplementary comments indicated that, while a number of facilities had had problems directly related to residents' substance use, these problems had not occurred within the specified two week period.
Respondents from eleven different facilities (38%) reported that residents had abused substances during a period of time exceeding two weeks. For example, one director stated that "there was one fellow [in the home] who [had] signed a contract not to drink, because his drinking was causing problems for the other residents." Another director said that "sometimes people will go out for a few beers and come home drunk when they get their checks." Neither of these directors reported that there had been any substance abuse in the facility during the past two weeks. Certainly, the act of going out for a few drinks does not necessarily constitute abusive behavior, but the potential for substance related problems to occur is probably very high, and the same behavior in another facility might result in expulsion for substance abuse. In another slightly different example, a staff member from one facility indicated that, while there were not any substance abusers in the facility, he/she had "experienced substance abuse at [another facility], when he/she was employed there ... especially [with] marijuana." And yet, the director of the specified other facility (the name has been withheld to maintain confidentiality) reported that there were not any cases of substance abuse.

Thirteen directors (45%) and seven staff (35%) from fifteen different facilities (52%) reported that they had tried to get help for a resident with a substance abuse problem; and yet ten of these directors and one of these staff members, from eleven different facilities, had not reported any cases of substance abuse. Similarly, there were no reports of current substance abuse in eight of the eleven facilities where past cases of abuse were reported. Only 20% of the respondents (from 27% of the facilities) who had indicated that they had tried to get help
for a resident with a substance abuse problem, indicated that a resident had had substance abuse problems within the past two weeks. **Figure 3** compares the number of boarding homes where substance abuse occurred during the specified two week period (four facilities), the number where it occurred during a longer, one year time period (eleven facilities), and the number of boarding homes where attempts were made to get help for a resident with a substance abuse problem (fifteen facilities). There is a clear discrepancy between these different reports. Nonetheless, there appear to be statistically significant relationships, between staff and director's attempts to help residents with substance abuse problems and reports of alcohol use (Chi-Square<.02, following the Yates correction), and reports of marijuana use (Chi-Square<.01, following the Yates correction). Furthermore, there was also a fairly significant relationship between staff and director's attempts to help residents with substance abuse problems, and their reports that at least one resident abused substances (Chi-Square=.07, following the Yates correction). When directors' reports were viewed in isolation, the significance levels dropped considerably. Only the relationship between attempts to get help and reports of marijuana use retained a high level of significance (Chi-Square<.05, following the Yates correction).

In summary, while reports from 52% of the facilities indicate that either directors or staff have at some time attempted to get help for residents' substance abuse problems, it can not be denied that there were very few reported cases of substance abuse. The apparently low incidence of substance abuse in mental health boarding homes will not come as a surprise to many persons working in the mental health field. And yet, while substance related
Figure 3. PREVALENCE/INCIDENCE OF SUBSTANCE ABUSE

The data are grouped by boarding homes (N=29), while figures include reports from directors, staff, and residents. A comparison of different reports:

- Failed to help
- Abuse (≤2 weeks)
- Abuse (>2 weeks)

Number of Boarding Homes

Two weeks, more than two weeks, and attempts to help.
problems are likely far greater among the "street people," or tenants of derelict rooming houses in the city's poorer quarters, there are clear indications that *dual diagnosis substance abuse is a problem in at least some Vancouver area mental health boarding homes*. And if even one resident in any given facility has problems related to substance use then it is potentially cause for concern.

*a. Resident Responses*

*Resident reports* regarding the prevalence of substance abuse are considered below. Six of the ten residents indicated that they consumed alcohol on a monthly basis, two reported that they drank alcohol on a yearly basis, and two reported that they never drank alcohol. One of the persons who reportedly consumed alcohol monthly also indicated that he/she used marijuana on a yearly basis. There was no other substance use indicated by the residents. Only one of the resident respondents lived in a facility that strictly forbade alcohol use; not surprisingly, this resident was one of the two people who reportedly never drank alcohol. Residents from facilities that did not allow any level of alcohol use were not as well represented as were residents from facilities that tolerated at least moderate alcohol use.

None of the residents reported that *they* had abused substances, although three of them indicated that at least one other person in their boarding home had. Two of these residents were from the same facility (neither the director nor the third resident who responded from this facility corroborated the reports of substance abuse). Similarly, the other report of substance abuse was not
corroborated either by the five coresidents who responded or the director. It is
difficult to determine if the contradictory reports by residents within the same
facility were due to differences of opinion, or differences in available information.

Self reports of substance abuse are notoriously unreliable. Thus, residents were
asked if they had ever received treatment for substance abuse, if they had ever
tried to get help for substance abuse, and if they had ever been told they had
a substance abuse problem, in an attempt to test (and increase) the internal
validity of prevalence estimates. While none of the residents reportedly had a
substance abuse problem, three reported that they had received treatment for
substance abuse, three reported that they had tried to get help for substance
abuse, and three reported that they had been identified as substance abusers. Not
surprisingly, it was the same three residents (from the same facility), who had
both tried to get treatment for, and been told that they had, substance abuse
problems. However, only two of these residents had actually received treatment;
one of the residents who had received treatment was from a different facility.
Nontheless, if we accept that the three questions: 1) have you received treatment;
2) have you tried to get help; and 3) have you been told you have a problem, are
accurate indicators of substance abuse, then we can speculate that three residents
actually did have substance abuse problems, despite their claims to the contrary.
The key word here, of course, is if.
D. DEMOGRAPHIC CHARACTERISTICS OF RESIDENTS

The second research question that this study posed concerned the demographic characteristics of Vancouver area mental health boarding home residents, and the relationships between these characteristics and the prevalence/incidence of substance use and/or abuse. For instance, are men more likely to abuse substances than women? Information concerning gender was available for a total of 151 male residents (48% of the residents for whom data were available) from nineteen different homes, and 162 female residents (52% of the residents for whom data were available) from twenty different facilities, equalling a combined total of 313 persons (87% of the residents in the sample). Data were missing for forty-five residents from three facilities. Seven homes had no men, six homes had no women, and thirteen homes had both men and women. Figure 4 shows the number of male and female residents in the participating boarding homes. There appears to be a fairly equal balance between the number of men and the number of women residing in mental health boarding homes. This distribution of men and women differs from that reported by Davis (1987), who found that 73% of referrals to boarding homes involved men. Of course, the Davis study did not focus on persons who had been accepted into, and were residing in boarding homes. Perhaps there is a higher rate of referral rejection for men, or a higher turnover of male residents, which would account for the discrepant figures. Based on director's reports, the data from this study do reveal a moderate inverse relationship between the number of males in boarding homes and the residents' average length of stay (Cramer's V = .5), but this relationship is not statistically

†The Davis study is referred to in more detail in Chapter IV.
Figure 4.

RESIDENT GENDER

The Number of Male and Female Boarding Home Residents

Women 162 / 52%

Men 151 / 48%

Data were missing for forty-five residents from three different facilities (N=313)
significant. Data were missing in three cases.

According to director's reports, there appeared to be a positive relationship between the number of men \((n=151)\) in boarding homes and the number of weekly drinkers \((n=12, \rho=.35, p<.05)\), and the number of women \((n=162)\) and the number of yearly drinkers \((n=57, r=.69, p<.01)\). Data were missing in six cases. There was also a fairly strong positive relationship between the number of women in boarding homes and the total number of people in any given facility who consumed alcohol \((r=.72, p<.01)\). Data were missing in four cases. According to these findings, the more men there are in a boarding home the greater the frequency of alcohol consumption, while the more women there are the greater the number of alcohol consumers. No relationship of any import was noted between residents' gender and the prevalence of substance abuse.

Age was another demographic variable that was identified. According to directors' reports, the average age of residents in the different facilities ranged from twenty-five to sixty-five, with a mean of forty-four, standard deviation of thirteen, and median of forty-eight across all facilities for which data were available. Data were missing in four cases. Figure 5 shows the distribution of residents' average age within each of twenty-five facilities.† As can be seen, fourteen \((56\%)\) of the facilities have an average resident age of fifty or less, while eleven \((44\%)\) have an average resident age of fifty-one or more. The strongest correlations between the average age of residents in any given facility and the prevalence of substance use and/or abuse in that facility were between age and monthly alcohol

†The "count" on the horizontal axis of figure 5 represents the number of boarding homes.
AVERAGE RESIDENT AGE

Director Reports of the Average Age of Residents: By Facilities

Average Resident Age

Data are missing from four facilities (n=25)
The displayed curve is the normal curve for the distribution
consumption \((\rho = -.45, \text{sig}<.05)\) and yearly marijuana consumption \((\rho = -.51, \text{sig}<.01)\), and between the average age of residents and the prevalence of marijuana use, with the daily, weekly, monthly, and yearly categories of marijuana use combined into one total number of users category \((r = -.54, p<.05)\). Data were missing in six cases. While neither of these correlations were particularly strong, they do suggest that the consumption of alcohol on a monthly basis and marijuana on a yearly basis tends to decrease as the age of boarding home residents’ increases. There do not appear to be any meaningful relationships between the average age of residents and the prevalence/incidence of substance abuse.

One concern that has been expressed regarding the use of drugs and alcohol by persons with psychiatric problems is that these substances will interact poorly with prescribed medications. Accordingly, this study has examined both the frequency, and the variety of medications used by Vancouver area mental health boarding home residents. Director reports indicated that 102 residents (37\%) used tranquilizers, 133 (49\%) used neuroleptics, forty-nine (18\%) used antidepressants, 38 (14\%) used lithium, 116 (43\%) used antiparkinsonians, 1 (.4\%) used some other medication, and four (2\%) used no medication at all.\(^\dagger\) Data were missing for 85 residents from seven facilities \((n = 273)\). Figure 6 shows how many residents use the specified medications. Neuroleptics, antiparkinsonians and tranquilizers are the most frequently used. A strong relationship seems to exist between yearly alcohol use and the use of tranquilizers \((r = .78, p<.01)\), antidepressants \((r = .65, p<.05)\), and antiparkinsonians \((r = .87, p<.01)\). There does

\(^\dagger\)The medicines used categories are not mutually exclusive, as any single resident could be using a wide variety of different medications.
MEDICATION USE BY RESIDENTS

The Number of Residents Who Take the Specified Drugs: Director Reports

Figure 6.

Medications Taken by Residents

Director reports only. Data is missing in seven cases (n=273).
Medication names have been abbreviated.
not appear to be a significant relationship between medication use and substance abuse.

The literature suggests that dual diagnosis substance abusers are generally a more transient group than their non-substance abusing counterparts.† In an attempt to test the above premise, the residents’ average length of stay in boarding homes was tested against their use and/or abuse of substances. It is hardly surprising that directors only selected the months and years categories, and in no case indicated that residents stayed, on the average, for a period of weeks. The vast majority of facilities (23 of the twenty-six homes for which data were available, or 88%) indicated that the residents stayed, on the average, for a period of one or more years. Data were missing from three facilities.‡

There was some alcohol use in all of the facilities with an average length of stay measured in months (n=3), and 25% of the facilities that had reported cases of marijuana use had an average length of stay measured in months, compared to 6% of those that had not. Nonparametric statistics did not reveal significant relationships between residents’ average length of stay and substance use and/or abuse. In any case, it is difficult to make clear connections between length of stay in boarding homes and drug use and/or abuse, because the average length of stay is not sensitive to the individual’s length of stay. Thus, it is difficult to establish how closely the individual’s length of stay is influenced by

† Refer to the section on homelessness in Chapter III for a discussion of this point.
‡ In all three cases the directors had completed staff, rather than director questionnaires, and the question concerning the average length of stay was not included on the staff questionnaires.
his/her substance use. In retrospect, it is apparent that categories such as: less than one year, one to two years less a day, two to five years, and greater than five years, would have provided more variability in the data.

Another question that this study addressed concerned the size of boarding homes. Is the size of a boarding home, measured by the number of residents living in the facility, related to the occurrence of substance use and/or abuse in that facility? The assumption behind this question was that the relationship between care givers and residents would become less personal as the size of homes increased. While information regarding the size of mental health boarding homes and outcome for residents is not available, the size of hospitals and hospital wards has been found to influence the course of peoples' psychiatric disturbances. Ulman (1967), for instance, found that patients were released from small hospitals more often than from large hospitals, and according to Moos (1974), large wards tend to create pressure towards a more rigid structure, result in less spontaneous relationships and decreased patient independence and responsibility; there is less support from staff and less attention to personal needs on large wards; and the staff on large wards feel an increased need to control and manage the patients. Mishler's (1981) conclusion that the term "hospitalitis" provides a more accurate explanation of peoples' behavior than the term "schizophrenia" may not be too far off the mark.

The minimum number of residents in any given facility was two (there were two homes of this size), the maximum number was forty-seven, the mean was 12.35, the standard deviation was 9.2, and the median was 10. As previously
mentioned, the total number of residents in the twenty-nine participating facilities was 358. **Figure 7** shows the distribution of residents across all twenty-nine facilities. As can be seen, the resident populations follow a normal distribution quite closely, with a limited number of uncharacteristic "outliers."

*Alcohol use* appeared to be the only substance use variable that was related to boarding home size ($r = .6$, $p < .01$). Of course, the more residents there are the greater the chance becomes that there will be substance users in any given facility. Oddly enough, neither marijuana use nor substance *abuse* are related to boarding home size. Thus, the interesting point here is not that there is a positive relationship between boarding home size and alcohol use, but that there are not any observable relationships between boarding home size and either marijuana use or substance *abuse*.

And what of diagnoses? Is the **psychiatric diagnoses** of boarding home residents related to their use, non-use, or abuse of drugs and/or alcohol? According to directors’ reports, 191 residents (68%) had been diagnosed as schizophrenics; 34 (12%) had been diagnosed as manic depressives, 17 (6%) had been diagnosed as depressives, 20 (7%) had been diagnosed as personality disordered, 20 (7%) had been diagnosed as organically disordered, and 20 (7%) had been given some other diagnosis. None of the directors selected the *diagnoses are not seen as relevant* category, although one of them did state that this category was "particularly

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† The study by Davis (1985) reviewed in Chapter III indicated that 54% of his sample of boarding home referrals had a diagnosis of schizophrenia.

‡ The diagnoses included in the *other* category include: mental retardation (seven cases), schizoaffective disorder (four cases), eating disorder/bulimia (two cases), Parkinson's disease (two cases), alcohol syndrome (two cases), and one case each of Alzheimer's disease, cerebral palsy, and multiple sclerosis.
BOARDING HOME SIZE
The Number of Facilities With the Specified Number of Residents

Director Reports

Data is available for all twenty-nine facilities.
The curve is the normal curve for the distribution.
important with people with mood disorders, [because they] can understand what's happenening better." There was reportedly at least one person who had been diagnosed as schizophrenic in every boarding home for which data were available. Data were missing for 76 residents (n=282) from six homes (n=23). Figure 8 shows the number of people who had been given the specified diagnoses. Schizophrenia is considerably more comon than any of the other diagnoses. There seemed to be significant relationships between the following variables: the number of people diagnosed as schizophrenic and the number who consumed alcohol (r=.61, p<.05); the number of people who had been diagnosed manic depressive and the number who consumed alcohol (rho=.55, sig<.01); and the number of people who had been given a diagnosis of personality disorder and the number who consumed alcohol (rho=.42, sig<.05).

It is somewhat paradoxical that depression was the only diagnostic category that seemed to be related to the reported number of people who abused alcohol (rho=.63, sig<.01), while this same diagnostic category was not related to the number of people who used alcohol. While these findings do support those in the literature, the data refer to the total number of residents in a given facility that have been given each of the specified diagnoses. It must be remembered that the relationships between diagnoses and substance use and/or abuse that have been noted here do not apply to individuals, but rather, delineate more general patterns.
DIAGNOSES OF MENTAL HEALTH BOARDING HOME RESIDENTS

The Number of Residents with the Specified Diagnoses

Psychiatric Diagnoses

Director reports only. Data are missing in six cases.
N=282
a. Resident Responses

**Resident responses**, concerning demographic characteristics, are described below. Of the ten residents who participated in the study, five were men and five were women. The same number of females (4) and males (4) consumed alcohol. However, males appeared to consume alcohol more frequently; all four male drinkers drank alcohol on a *monthly* basis, while two of the female drinkers drank alcohol on a *yearly* basis. There appeared to be only a moderate relationship between gender and alcohol consumption, Cramer's $V=.52$). The only resident that reportedly used marijuana was male.

Four of the residents who completed questionnaires, according to their own reports, were under the age of thirty, four were between the ages of thirty-one and forty-nine, one was between the ages of fifty and sixty-four, and one was over the age of sixty-four. Thus, eight of the residents were under the age of fifty. Six of the eight residents who were under the age of fifty consumed alcohol on a *monthly* basis, and they all consumed at least some *level* of alcohol.

On the other hand, neither of the residents over the age of fifty consumed alcohol. There appeared to be a moderate relationship between alcohol use and resident age, with the data listed in ordinal form (Spearman's $r = -.59$, sig.<.05). Additionally, with alcohol use recoded into yes/no categories, and age recoded into 0-49/50-99 categories, there was a very strong relationship between the "age" and "alcohol abuse" variables (Phi=1., Fisher's Exact Test<.05). The one resident who reportedly used marijuana was in the thirty or less age range. According to the reports of this small sample of residents, younger persons are more likely to
use, and thus abuse substances. Of course, as has been previously acknowledged, the small sample of residents who participated in this study are not representative of all Vancouver area boarding home residents, and findings can not be generalized across the respondent/nonrespondent boundaries.

Resident's employment status was another demographic variable that was explored in this study. Three of the ten residents reported that they were employed. All three of the employed residents lived in the same facility, and all three consumed alcohol. Neither the single marijuana user nor the two abstainers were employed. The employment status of residents did not appear to be related to the prevalence/incidence of substance use and/or abuse, for the residents who participated in the study.

A variable that is somewhat similar to employment is education. Does a person's level of education affect his/her use of drugs or alcohol? Perhaps highly educated persons are more likely to be aware of the potential dangers of substance use. Four residents had completed some secondary school, one had graduated from secondary school, one had completed some post secondary school, and three had graduated from a post secondary program. Data was missing in one case (the resident who admitted to marijuana use did not answer this question). The relationship between education and substance use and/or abuse was weak.

The last resident characteristic to be considered here concerns the use of
prescription drugs. Seven of the resident participants took medication,† one did not take medication, and one did not know if he/she took medication. Data was missing in one case. The two people who either did not take medication or did not know if they took medication (one person in each case) consumed alcohol, while five of the residents on medication drank alcohol, and two did not. No strong associations were noted between medication use and either substance use or substance abuse.

E. DEMOGRAPHIC CHARACTERISTICS OF DIRECTORS AND STAFF

The third research question posed in this study concerned the demographic characteristics of the directors and staff members of mental health boarding homes. Do the demographic characteristics of care givers influence their perceptions of the "problem"? As previously noted, individual respondents have very different views concerning the acceptability of moderate levels of alcohol consumption. Is there an observable relationship between the responses people give and their gender? Of the twenty-nine directors who participated in the study, twenty-one (72%) were women and eight (28%) were men. Of the staff members for whom data were available, twelve (63%) were women, and seven (37%) were men. Data was missing in one case. Not only do more women work in Vancouver area mental health boarding homes than men, but an even greater number of women occupy the top positions. Perhaps this is due to the nursing backgrounds of many of these persons, and the preponderance of women in

†Medications identified by residents included Lithium (two cases), Halcion (two cases), Stelazine, Rivotril, and an "anti depressant."
nursing.

In order to measure the strength of the relationships between gender and reports of resident substance use and/or abuse, the interval level data from the prevalence of substance use categories were recoded into ordinal data (0 users = 1, 1-6 users = 2, 7-12 users = 3, 13-20 users = 4, 21 or more users = 5). There appeared to be a significant relationship between the directors' gender and the number of people identified as alcohol users (Cramer's V = .56, Chi-Square < .05). Women identified more alcohol users than did men. Of course ... there were more women than men. Nonetheless, there did not appear to be a significant relationship between directors' gender and the number of cases of substance abuse they reported; nor was there a significant relationship between gender and substance use and/or abuse when both director and staff responses were considered together.

Another demographic variable that was tested in relation to reported cases of substance use and/or abuse, was the respondent's age. One (3%) of the directors was reportedly thirty or less years of age, twenty-four (83%) were in the thirty-one to forty-nine age range, and four (14%) were between the ages of forty-nine and sixty-five (n=29). Five staff members (26%) selected the thirty or less age category, eleven (58%) selected the thirty-one to forty-nine age category, and three (16%) selected the fifty to sixty-four age category. Data was missing in one case (n=19). Only a weak association was found between directors' age and the number of alcohol users they identified (Cramer's V = .32). No noteworthy relationships were noted between the age of directors or staff and the number of
marijuana users and/or substance abusers they identified.

**Education** was another variable that was explored. Does the level of directors' and staff members' education effect their perceptions regarding residents' use and/or abuse of substances? Seventeen (59%) of the directors and eight (42%) of the staff members had a college diploma or university degree; twelve directors (41%) and eleven staff members (58%) reportedly did not have a college diploma or a university degree. Data was missing from one staff member. Tests of association did not reveal any significant relationships between staff and directors' education and substance use and/or abuse.

Two other questions, also designed to elicit the respondents' level of education, or in this case, *training*, were included in the questionnaires. These two questions asked director and staff respondents if they had received any *training* in the areas of *substance abuse*, or *dual diagnosis substance abuse*. Six directors (21%) and five staff members (26%) had, and twenty-three directors (79%) and fourteen staff members (74%) had not reportedly received any training in the area of *substance abuse*. Data was missing from one staff member. Similarly, five directors (17%) and three staff members (16%) had, and twenty-four directors (83%) and sixteen staff members (84%) had not received any training in the area of *dual diagnosis substance abuse*. One director indicated that he/she had received substance abuse training at one of the other boarding homes surveyed in this study. However, the director of this *other* boarding home indicated that he/she had not had any training in either substance abuse or dual diagnosis substance abuse, and in reference to the latter of these two areas, said: it
"would be nice to have this."

A significant relationship was noted between directors who reportedly had received both substance abuse and dual diagnosis substance abuse training (Phi = .67, Chi-Square < .05). Four of the six directors who had, and only one of the twenty-three who had not received training in the area of substance abuse, had also received training in the area of dual diagnosis substance abuse. Similarly, 80% of the directors who had, and only 8% of those who had not received training in the area of dual diagnosis substance abuse, had also received training in the more general area of substance abuse. Though not significant at the 95% level, directors without training in either substance abuse or dual diagnosis substance abuse, reported fewer cases of substance use by residents (Phi = 1). However, there were not any note-worthy relationships between the "training" and "substance abuse" variables.

F. BOARDING HOME POLICIES

The fourth research question concerned boarding home policies as they relate to substance use and abuse. Do Vancouver area mental health boarding homes have policies regulating the use of drugs and alcohol by residents? Forty-four (90%) of the participating forty-nine directors and staff members indicated that their facilities did indeed have policies concerning the use of substances by residents; four respondents (8%) indicated that their facility did not have such a policy, and one (2%) respondent indicated that he/she did not know if the facility had a policy concerning substance use. When only directors'
responses are considered (n=29), it appears that twenty-five (86%) of the facilities have policies concerning substance use and/or abuse, and four (14%) do not.

Seven directors indicated that their "policy" was to totally prohibit substance use by residents; thirteen directors indicated that their policy was to prohibit the use of substances within their facilities; one director stated that the policy was to prohibit drunkenness; and one director said: "[we] try to monitor and as much as possible prevent use, but this is not a prison ... [the facilities] primary function is [that of] a home." While comments delineating the house policy were not included by all residents, from the available data it is reasonable to conclude that at least twenty facilities (69%) had policies that prohibited the use of alcohol or drugs on the premises, and at least twenty-two facilities (76%) had policies that restricted the use of substances on the premises.

The one staff respondent who indicated that he/she did not know if the facility had a policy, was from a facility that did not appear to have substance use of any kind (which helps to explain his/her lack of insight). The director of this same facility, and one additional staff member, indicated that the boarding home did in fact have a substance use policy, which consisted of screening applicants prior to their admission, to ensure that no one who was likely to use or abuse substances was admitted to the facility.

According to directors' reports (n=29), 50% of the facilities that did not have a substance use policy had at least one resident who consumed alcohol, and 50%
did not. None of the policy free homes reported any cases of marijuana use, amphetamine use, or inhalant use. The relationship between the existence of a policy and the prevalence of substance use by residents was not statistically significant, with or without the inclusion of staff reports. Similarly, there did not appear to be a significant relationship between the presence or absence of a boarding home policy concerning substance use, and the incidence of substance abuse. Of course, it is not surprising that the mere existence of a policy is not related to the prevalence/incidence of substance use and/or abuse. It is the exact nature of the policy that counts.

One way that boarding home policies were further explored was by asking respondents what their response to substance use and/or abuse was when (or if) it occurred. Table 2 lists the reported likelihood that directors and staff would respond any of a specified number of ways to alcohol consumption by residents. The perceived appropriateness of the specified responses is considered by respondents in relation to alcohol consumption in the boarding home, outside of the boarding home, and in either location. Twelve directors (41%) and eight staff (40%) said that they would not do anything about residents drinking alcohol outside of the home. This point of view was summed up nicely by one director, who said:

> When a resident leaves the home for whatever purpose [he/she is] then governed by the laws of the community - if a resident’s behavior impacts upon the home or other residents then intervention by staff is expected.

Another director expressed a similar sentiment when he/she said:
### DIRECTOR AND STAFF RESPONSES TO ALCOHOL CONSUMPTION BY RESIDENTS

Responses to Drinking In-Home, Out-of-Home, and in Either Location

<table>
<thead>
<tr>
<th>Response To Drinking</th>
<th>Location Of Drinking</th>
<th>Director</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would Not Do Anything</td>
<td>In-Home</td>
<td>12 (41%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>5 (17%)</td>
<td></td>
</tr>
<tr>
<td>Ask to Stop</td>
<td>In-Home</td>
<td>2 (7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>8 (28%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Refer To Mental Health</td>
<td>In-Home</td>
<td>6 (21%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>5 (17%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Refer To Substance Abuse</td>
<td>In-Home</td>
<td>2 (7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td>1 (3%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>4 (14%)</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>Refer To Self Help</td>
<td>In-Home</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td>2 (7%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>3 (10%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Evict</td>
<td>In-Home</td>
<td>6 (21%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td>1 (3%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>2 (7%)</td>
<td>7 (35%)</td>
</tr>
<tr>
<td>Control Money</td>
<td>In-Home</td>
<td>2 (7%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>4 (14%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Other</td>
<td>In-Home</td>
<td>5 (17%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td></td>
<td>Out-of-Home</td>
<td>2 (7%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td></td>
<td>Either Location</td>
<td>9 (31%)</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

Numbers refer to the number of respondents who would reportedly respond the specified ways in the specified circumstances.

Director n = 29, Staff n = 20
As long as it is not abused I feel residents have the right to go have a drink. They are adults and have the right to make their own decisions as long as it does not create violent/abusive behavior towards themselves or others.

Another director, who also stressed the result rather than the act of drinking, stated that "there are happy drunks and angry drunks. Angry drunks are sent to their room." Also, concerning drinking outside of the home, another director said: "it is not my business - but if it [became] a problem with budgeting or health I would help them in those areas."

On the other hand, six directors (21%) and four staff members (20%) indicated that they would evict residents for drinking alcohol in the home, one director (3%) said that he/she would evict residents for drinking alcohol outside of the home, and two directors (7%) and seven staff members (35%) reported that they would evict residents for drinking alcohol either in the home or outside of the home. However, some of the respondents who indicated that they would evict residents for drinking, qualified their choice by stating that drinking would only result in eviction "if [the] behavior continued," or if a "contract had been broken," or "as a last resort." Figure 9 shows the boarding homes' responses to substance use by residents. In addition to the "in-home," "out-of-home," and "both in-home and out-of-home" categories, a "neither" category was added to show how many respondents reportedly would not respond in the specified manner regardless of where the drinking took place. As can be seen, none of the directors would do nothing about residents drinking within their facilities. Thus, we can assume that all of the directors would do something about alcohol
BOARDING HOME RESPONSE TO SUBSTANCE USE BY RESIDENTS

Do Directors Respond the Specified Ways?

Number of Boarding Homes

Categories are not mutually exclusive
N=29
consumption within their facilities. But what would they do? The highest selected response to "in the home" drinking was *asking residents to stop*, and yet only seven directors selected this response. As Figure 9 clearly depicts, the vast majority of directors indicated that they would not respond in any of the specified ways, regardless of where the drinking took place. For instance, twenty-three directors (79%) would not refer residents to a self help group, twenty-three (79%) would not control residents money, and twenty-two (76%) would not refer residents to a substance abuse counsellor. Not surprisingly, many directors (55%) selected the "other" category.

Several respondents selected the *other* category simply as a means of elaborating on, or qualifying another selection. However, some respondents truly did specify responses that were decidedly different from those that were specified in the questionnaires. For instance, in one facility when residents' substance use is "overdone," they are asked to sign a contract restricting or prohibiting further consumption. Several other facilities review the boarding home policy with residents who drink alcohol or consume drugs.

As would be expected, the prevalence of substance use in any given facility is closely linked to the likely response of the director and staff members of that facility. Eleven of the twelve facilities that do not do anything about residents drinking alcohol outside of the home, and all five facilities that do not do anything about residents drinking alcohol either inside *or* outside the home, have at least one resident who consumes alcohol.
Significant relationships were noted between facilities that reportedly had at least one alcohol consuming resident, and facilities that either did nothing about residents' alcohol consumption (Phi = .51, Chi-Square < .05), or facilities that referred residents who drank to mental health counsellors (Phi = .51, Chi-Square < .05).† At least one resident consumed alcohol in 94% of the facilities that reportedly would not do anything about alcohol consumption by residents, compared to 50% of the facilities that reportedly would do something (unspecified) about alcohol consumption by residents. Coincidentally, the crosstabulation distributions for facilities that referred clients to mental health counsellors for drinking alcohol was exactly the opposite of that mentioned above in relation to facilities that did not do anything about residents consuming alcohol; there was an inverse relationship between referrals to mental health counsellors and reports that there was at least one alcohol user in any given facility.

Another aspect of boarding home policies concerning substance use involves the facilities admittance practices. Certainly, there are not likely to be substance abuse problems in facilities to which substance using persons are routinely denied access. Of course, it does not necessarily follow that there are likely to be substance abuse problems in facilities that do accept substance using applicants. Only one director (4%) indicated that he/she never admitted people with histories of substance abuse into the facility ("if the abuse [was] current.") Thus, while additional comments by this respondent suggested that people with histories of substance abuse probably were never knowingly admitted into the facility, his/her

†The response variables were recoded into yes/no values (rather than differentiating between substance use in the home, out of the home, and in or out of the home).
qualifying statement also suggests that the term history of substance abuse quite possibly meant different things to different people. Another respondent had this to say about admitting people with histories of substance abuse into the facility: "This boarding home does not accept clients with a recent history of drug or alcohol abuse. It is extremely difficult to deal with straight psychiatric problems, and even harder to deal with compounded problems."

Seven (25%) directors indicated that they rarely accepted applicants with histories of substance abuse. Eleven (39%) directors indicated that they sometimes accepted applicants with histories of substance abuse, with one of them stating that this decision depended "on [the] time elapsed since [the] substance abuse." Four (14%) directors indicated that they often admitted people with histories of substance abuse into their facilities. And finally, only five (18%) directors reported that a history of substance abuse did not influence their decision to accept or reject applicants to their facilities. Data was missing in one case.

Tests of association were conducted between the boarding home referral acceptance policies and the prevalence/incidence of substance use and/or abuse, with the acceptance policies recoded from five to two values. The values never, and rarely were combined to form one do not accept category, and the values sometimes, often, and does not influence our decision were combined to form one do accept category. There was a moderate relationship noted between referral acceptance policies and the presence of marijuana use in boarding homes (Phi = .44, Chi-Square = .07); none of the facilities that did not accept applicants with histories of substance abuse reported any cases of marijuana use. Thus, all
eleven facilities with at least one reported marijuana user accepted applicants with histories of substance abuse. There were no reported cases of substance abuse in facilities that did not accept applicants with histories of substance abuse, while four of the facilities that reportedly did accept applicants with histories of substance abuse had at least one resident who was currently abusing substances. Put differently, all of the facilities that reportedly had at least one substance abusing resident also indicated that they did accept applicants despite their histories of substance abuse.

Another aspect of boarding home substance use and/or abuse policies concerns the tendency to permit, or not to permit, the consumption of alcoholic beverages at parties or other special functions. Four directors (14%) indicated that they did allow alcohol consumption at special functions, seven (25%) said that they sometimes allowed alcohol consumption at special functions, and seventeen directors (61%) said that they did not allow alcohol consumption at special functions. With the above three values (yes, no and sometimes) recoded into two values (yes/no), it appears that alcohol consumption was permitted in eleven (39%) of the facilities, and was not permitted in seventeen (61%) of the facilities. Data was missing in one case. Figure 10 shows the number of facilities that do, do not, and sometimes allow alcohol consumption at special parties. The majority do not!

One director had this to say about serving alcohol at special functions:

The residents vote [at house meetings] on whether or not to serve alcohol at the monthly formal [candle-light] dinners we have, and it seems to me that it is about 50/50. They voted in
Figure 10.

ALCOHOL CONSUMPTION AT SPECIAL HOUSE FUNCTIONS

ALCOHOL USE AT SPECIAL FUNCTIONS
The Number of Homes That Allow Alcohol Consumption at Special Functions

- Yes: 4 / 14%
- Sometimes: 7 / 25%
- No: 17 / 61%

Data was missing in one case
N=28
favor of alcohol last month and against it this month. They don't abuse the privilege. Our residents don't really seem to want to drink alcohol very much. We had one woman who bought a lot of alcohol once, but she didn't drink it, she just bought a case [of hard liquor] and kept it [in her room].

Another director, who sometimes allowed alcohol consumption at special functions, and who expressed an interest in starting a "pub night," commented that: "[The] owners [of the boarding home] do not want any drinking in the facility, [but] I have worked in other homes where there was a pub night and it [was] quite successful. I don't think that it is harmful for someone to have a glass of wine once a month." An interesting contradiction became apparent here; on the one hand this director advocated a pub night and thought an occasional glass of wine was fine, while on the other hand he/she indicated that, for people with psychiatric problems, substance use and substance abuse were synonymous terms. Following the logic of a classical syllogism, advocating substance use in this case is tantamount to advocating substance abuse. One other director who indicated that alcohol consumption was allowed at special functions said: "We had a party here last week and I made an alcoholic punch, and about one half of the residents drank the alcoholic punch and the rest drank a nonalcoholic punch."

Surprisingly, the association between boarding homes that allow alcohol consumption at special parties, and reports of alcohol use, is very low (Phi=.24). This weak association is due, no doubt, to the practice in many homes of forbidding alcohol consumption within the facility, while permitting moderate consumption outside of the facility. There does not appear to be a relationship
between substance abuse and the practice of allowing or not allowing residents to drink alcohol at special functions.

We have established that, while substance (especially alcohol) use is not uncommon, in very few cases is this use considered abusive. This reveals an interesting paradox between the practices and professed beliefs of some respondents. Though many respondents make a clear distinction between the use and abuse of substances, many of them also believe that substance use and substance abuse are synonymous terms (in reference to people with psychiatric problems). Eight (47%) of the staff members and thirteen (46%) of the directors indicated that substance use and substance abuse were synonymous terms; six staff members (35%) and seven directors (25%) indicated that use and abuse were not synonymous terms; two staff members (12%) and seven directors (25%) indicated that the term substance use was sometimes synonymous with the term substance abuse; one director (4%) indicated that he/she did not know if substance use and abuse were synonymous terms; and one staff member (6%) provided a comment that could not be coded into the above categories.† Data were missing from one director (n=28) and three staff (n=17). Figure 11 shows the percentage of directors, staff, and residents who did, did not, and sometimes thought that substance use and substance abuse were synonymous terms. Additionally, the no and sometimes values are combined to form a fourth category, as it can be assumed that respondents who selected the "sometimes" category do not believe that substance use and substance abuse are synonymous terms, but rather, are only so under special circumstances.

†This respondent’s reaction to the specified statement was: "it needs help."
Figure 11: Percentage of Respondents

ABUSE SYNONYMOUS TERMS?
ARE SUBSTANCE USE AND SUBSTANCE ABUSE SYNONYMOUS TERMS?
The following comments are examples of those that were coded as disagreeing with the statement that substance use and abuse are synonymous terms:

1. "Usually the care team says to residence [sic] one or two beer is OK. I tend to support this view, although very few at our residence drink."

2. "Every case I've seen has been so individual. I do not believe there is always a worsening of psychiatric symptoms with substance use."

3. "In the majority of people they aren't any more affected than other 'well' people."

4. "I disagree. Many of our residents have had one beer when going out with friends and their behavior [has] not [taken] on any radical change."

5. "Use is different than abuse. I disagree with the above statement. If one has a psychiatric problem it does not necessarily mean [one] will be [an] alcohol abusers. Use of alcohol is an individualized experience and what one person can tolerate another person can not."

6. "I think it's nonsense. I do warn clients about possible dangers about medications and booze, and ask them to tell me if they've been drinking."

Similarly, the following comments are examples of those that were coded as agreeing with the statement that substance use and substance abuse are synonymous terms:

1. "I agree that even small amounts of substances can worsen psychiatric symptoms. One of our clients became extremely difficult to handle after having a few drinks."

2. "Given the seriousness of symptoms of schizophrenia and affective disorders, any added chemical substance makes them worse. In my twelve years of
experience I would say that well over one half of those [residents] under thirty had a history of substance abuse prior to diagnosis."

And, the following comments are examples of those that were coded as conferring that substance use is *sometimes* abusive and sometimes is not.

1. "If a person is an alcoholic, yes, but if not a small amount may only make them happier, but I believe it must be different in some cases according to what medications they take."

2. "Moderation is OK, but most people with psychiatric problems seem to include compulsive behavior patterns and therefore over do it."

3. "Sometimes yes - sometimes no - if the consumption/use of alcohol/drugs causes a "worsening" of the psychiatric symptoms, and if the person continues to consume/use, *then* it becomes abuse."

4. "Usually true, but not necessarily - in the case of marijuana. Probably true for other substances."

5. In my experience, most people use substances to get relief from their symptoms (i.e. voices, anxiety). However, some [people] seem to be using them (as well as prescribed drugs) for self abuse. Some seem to be able to tolerate small amounts of alcohol as well. Some seem psychotic on marijuana. I believe that the responses are highly individual."

Regarding the inherently abusive nature of substance use by people with psychiatric problems, there appear to be two polarized groups, one at each end of the agreement/disagreement continuum, with an additional group characterized by ambivalence. Of course, as some of the respondents' comments suggest, this "ambivalence" seems to be the result of careful attention to the complexities of
individual circumstances (which render "black and white" generalizations ineffectual), rather than the result of "wishy-washy" indecision.

In order to test the relationship between the estimated prevalence/incidence of substance use and/or abuse, and respondents' opinions regarding the inherently abusive nature of substance use, the latter variable was recoded from five to three categories. The *I disagree* and *I sometimes agree* values were combined into one category, as were the *I don't know* and *can not code* categories. Thus, the data were coded into the three categories of: *I don't agree*, *I do agree*, and *I don't know*. Only the first two values (*I don't agree that substance use and abuse are synonymous terms, and I do agree that they are synonymous terms*) were included in tests of association.

Some statistically significant relationships were found between director's attitudes concerning the inherently abusive nature of substance use, and the reported presence or absence of substance using residents in the various facilities (Phi=.55, Chi-Square<.05). While all fourteen of the boarding homes whose directors *did not* believe that use and abuse were synonymous terms had at least one resident who consumed alcohol, the same was only true for six of the thirteen facilities whose directors *did* believe use and abuse were synonymous terms. Thus, it appears that residents are more likely to consume alcohol in facilities whose directors do not believe substance use and abuse are synonymous terms. A similar relationship was noted between the presence of at least one marijuana user and the opinion that, for persons with psychiatric problems, any level of substance use is abusive because it causes a worsening of psychiatric
conditions (Phi=.59, Chi-Square<.01). While only one (8%) of the thirteen facilities whose directors indicated that use and abuse were synonymous did not have any marijuana using residents, nine (64%) of the fourteen facilities whose directors indicated use and abuse were not synonymous had at least one resident who used marijuana. However, there did not seem to be a relationship between directors’ attitudes concerning the inherently abusive nature of substance use, and the incidence of substance abuse in boarding homes.

Respondents were also asked if going out for a drink could be a positive accomplishment for people with psychiatric problems, because at least they were doing something. Only one director (4%) and two staff members (11%) indicated that going out for a drink of alcohol was a positive accomplishment. Six directors (21%) and two staff members (11%) indicated that it was sometimes a positive accomplishment to go out for a drink of alcohol; eighteen directors (64%) and fourteen staff members (74%) indicated that drinking was not a positive accomplishment; and three directors (11%) and one staff member (5%) provided comments that could not be coded into the above categories. Data were missing in two cases (one director and one staff member). Figure 12 shows how many respondents did, did not, and sometimes thought that going out for a drink could be a positive accomplishment for people with psychiatric problems, because at least they were doing something. Additionally, the yes and sometimes values were combined to form a fourth category. Even with these two values combined into a yes/sometimes category, considerably more people indicated that going out for a drink could not be a positive accomplishment, than thought that it could be a positive accomplishment.
CAN GOING OUT FOR A DRINK OF ALCOHOL BE A POSITIVE ACCOMPLISHMENT?

Percentage of Directors, Staff, and Residents

Responses

Percentages do not equal 100. "I don't know" category was not included, and some responses could not be coded. Dr (n=25), Staff (n=18), Res (n=10)
The following comments are from respondents who indicated that going out for a drink could be a positive accomplishment:

1. "I think it can be positive that some people with psychiatric problems choose to go out for a drink; since it is a popular social tradition going out for a drink may help strengthen a person's feeling of membership in his culture."

2. "Having found that most residents do enjoy the occasional bit of pubbing, I see it as a positive step in normal social activity. I stress occasional because I've noticed some residents use alcohol 'to get away from the voices.' Abuse as such seems to lead to a false sense of independence and drifting away from structured programs."

3. "For some residents, this is applicable because they are going out into the community; resocialization. As long as it is not abused I feel residents have the right to go have a drink. They are adults and have the right to make their own decisions as long as it does not create violent/abusive behavior towards themselves or others."

4. "I have no problem with people social drinking, or going out for a drink like anyone else, as long as it doesn't create other problems."

5. "It depends on the individual's behavior when he or she drinks. I have known psychiatric patients to be quite sociable and relaxed and without any problems - as a matter of fact 'Pub Night' is usually held once a week (Saturday) in most psychiatric units - and it appears to be beneficial."

As previously mentioned, the majority of respondents indicated that they did not think that going out for a drink of alcohol was a positive accomplishment for
people with psychiatric problems. The following comments are examples of this point of view:

1. "Going out is a positive accomplishment for many - but consuming alcohol is unnecessary and potentially very dangerous in combination with many other drugs. Just as I would refrain from drinking if on prescription drugs (when drinking alcohol has been advised against), I would (and do) encourage these people I work with to refrain from drinking."

2. "Do not agree. Alcohol is just another form of a drug, and in no way do I regard it as a positive influence, especially with regard to a person who already has psychiatric problems. Alcoholism is just another disease."

3. "This is not true because in the majority they do not know when to stop. Medication for their psychiatric problems cannot be given when alcohol is consumed. Therefore, their problems become worse. Medication and alcohol cannot be mixed!!"

4. "Absolute rubbish. 'Doing Something' should be self-enhancing, not destructive, by alcohol use. The last toxic drug that psychiatric (the majority) patients require, is indeed alcohol."

5. "Nonsense."

6. "Usually the consumption of alcohol and its effects on [a] person who takes psychotropic medication is highly intensified and therefore not advisable."

7. "I'd say that it could be dangerous for a psychiatric patient to drink as it may cause a problem with a bad reaction to the medication. Also some psychiatric patients also have an alcohol problem and need to abstain."

8. "It is a statement born out of frustration or uncaring. Certainly, going out for 'a drink' may be perceived as 'normal' behavior - but we strive for
healthy, normal behavior."

9. "Not much ... actually, I am opposed to it and somewhat angry. Alcohol interferes with medication and physiologically is detrimental to mental health as most residents who drink do so to excess.†

In addition to those respondents who clearly agreed or did not agree with the statement that going out for a drink of alcohol could be a positive accomplishment, there were several people who indicated that it sometimes was, and sometimes was not true. The following comments are examples of responses that were somewhat ambivalent and were coded into this sometimes category:

1. "Alcohol in moderation can be helpful to feel comfortable in social situations although it is 'crutch'."

2. "Depending on the individual this statement can be correct, as it is with any sector of our society. The one difference is with people whose beneficial results from medications, is altered dramatically by alcohol."

Respondents' reactions to the statement that going out for a drink of alcohol could be a positive accomplishment, were recoded to simplify the tests of association carried out between this variable, and the estimated prevalence of substance use and substance abuse. Those respondents who clearly agreed with the specified statement and those that thought it was sometimes true were combined into one category, and the cannot code and I don't know values were similarly combined.

†This comment was made by a director who indicated that there were nine residents in the facility who drank alcohol. And yet, despite his/her belief that most residents who drink "do so to excess," no cases of substance abuse were reported (perhaps due to the specified two week time span for reports of abuse).
Only a weak relationship was noted between directors’ professed agreement with
the statement that going out for a drink could be a positive accomplishment, and
their reports of marijuana use in a given facility (Cramer’s $V = .36$); though not
significant at the 95% level, a stronger relationship was noted when alcohol use
was substituted for marijuana use (Cramer’s $V = .43$, Chi-Square = .07). In the
latter case, all seven (100%) of the directors who reported that drinking could be
positive, also indicated that at least one resident in their respective facilities
consumed alcohol, compared to thirteen (72%) of those who believed that going
out for a drink was not a positive accomplishment. Thus, it appears that
residents are more likely to drink alcohol in facilities whose directors’ believe
drinking alcohol can be a positive accomplishment.

An even stronger relationship was noted between reports of alcohol use and the
belief that substance use was inherently abusive, controlling for those respondents
who believed that going out for a drink of alcohol could not be positive
(Cramer’s $V = .66$, Chi-Square < .05). Six of the respondents (43%) who thought
substance use was inherently abusive, and who did not believe going out for a
drink of alcohol could be positive, reported that none of the residents in their
facilities drank alcohol. On the other hand, only one of the respondents (7%) who
indicated that substance use was not necessarily abusive reported that none of
the residents in their facilities drank alcohol. There does not appear to be a
significant relationship between directors’ attitudes in relation to residents going
out for a drink of alcohol, and the estimated incidence of substance abuse.

One might expect there to be a strong relationship between respondents’ attitudes
concerning the positive or negative nature of going out for a drink, and their attitudes concerning the inherently abusive or nonabusive nature of substance use. However, there was a considerable amount of variation between individuals' answers to these two questions. The following excerpts are examples of this variation, with respondents' answers to both questions juxtaposed:

1. Example number one:
   a. "An occasional drink is not harmful unless contraindicated by medications - frequent use of alcohol or over indulgence is a problem."
   b. "[I] agree [that substance use is the same as substance abuse]."

2. Example number two:
   a. "I strongly disagree with the above statement [that going out for a drink can be a positive accomplishment]. My experience tells me that there are more motivators than just alcohol."
   b. "Use is different than abuse. I disagree with the above statement [that substance use is the same as substance abuse]. If one has a psychiatric problem it does not necessarily mean they will be alcohol abusers. Use of alcohol is an individualized experience and what one person can tolerate another can not."

3. Example number three:
   a. "[I] wouldn't really agree with this statement [that going out for a drink can be a positive accomplishment] as they could have a coke rather than alcohol and still be doing something."
   b. "Usually the care team says to residence [sic] one or two beer is OK. I tend to support this view although very few of our residence [sic] drink."
4. Example number four:
   a. "I believe that people with psychiatric problems combined with the desire to drink usually have an awareness of their psychiatric problem and drink in hopes of masking the problem or attempt to have some temporary relief. I believe it to be a definitely negative experience."
   b. "Every case I've seen has been so individual. I do not believe there is always a worsening of psychiatric problems with substance use."

Another way of determining what is done in individual facilities, about substance use and/or abuse by residents is to establish what, if any, programs are offered. Are there any substance abuse programs operating in Vancouver area mental health boarding homes? Only three directors (10%) and one staff member (5%) indicated that there were substance abuse programs operating in their respective homes. All four respondents were from different facilities. While there were additional respondents from all four of these facilities, none of these other respondents corroborated the reports that there were substance abuse programs. Only one of the facilities that reportedly had an in-home substance abuse program had any reported cases of substance abuse.

The following in-home programs were identified:
1. "Lectures - during current events."
2. "Mainly education of the dangers of alcohol in conjunction with medication."
3. "Drug awareness life skills; drug education regarding illicit and medicinal drugs and applications to daily living."

The fourth facility with an in-home substance abuse program really had none at
all! Although the director indicated that there was an Alcoholics Anonymous group operating in the facility, from conversations with the director and the resident who attended the program, it was clear that the Alcoholic’s Anonymous program was held in a community hall, sometimes, and a church, other times, and the boarding home ... never.

a. Resident Responses

Resident responses to questions concerning boarding home policies are outlined below. Residents were also asked to indicate what they thought staff and/or directors would do about alcohol consumption by residents. Three of the residents indicated that they would be asked to stop drinking alcohol; seven residents' indicated that the staff or director would not do anything; one indicated that they would be referred to either a mental health or a substance abuse counsellor; one indicated that they would be referred to Alcoholics Anonymous; two reported that they would be evicted; one indicated that their money would be controlled; and two residents thought that the staff and/or director would have some other response to residents' alcohol consumption. One of the residents who indicated that he/she did not think the staff or director would do anything about his/her alcohol consumption commented that: "if it was affecting things or people around me, I'm sure that it would be stopped. We are adults after all."

A strong relationship was noted between residents' reported belief that nothing would be done about their drinking and their own alcohol consumption (Cramer's V = .87, Chi-Square < .05). Six of the seven residents who thought nothing would
be done about their drinking consumed alcohol *monthly*, and the other resident consumed alcohol *yearly*. On the other hand, while one of the three residents who thought the staff or directors *would* do "something" drank alcohol *yearly*, two *never* consumed alcohol.

Thus, while causality can not be established, there does seem to be a noteworthy relationship between the prevalence of alcohol use among this small resident sample, and their perceptions concerning the likely response of staff and/or directors to alcohol consumption by residents.

Residents were also asked if they thought *substance use and abuse were synonymous terms*. Five of the residents stated that *use* and *abuse* were synonymous terms, one indicated that they *were not* synonymous terms, two said that they *were sometimes* synonymous terms, and two stated that they *did not know* if they were synonymous terms. Residents’ attitudes concerning the inherently abusive nature of substance use did not appear to be related to their self reports of alcohol use.

As with the directors and staff members, the majority of residents (six) indicated that *going out for a drink of alcohol* was *not* a positive accomplishment for people with psychiatric problems. The remaining four residents indicated that going out for a drink could *sometimes* be a positive accomplishment. While only four residents reported that going out for a drink could be positive, eight of them indicated that they consumed alcohol themselves. Of course, it does not necessarily follow that persons who consume alcohol (in certain unspecified
situations) would agree that going out for a drink of alcohol, *just to be doing something*, was a positive accomplishment.

One resident who reported that going out for a drink of alcohol was not a positive accomplishment, said: "that is such a negative and destructive attitude. There are other things one can do." This person reportedly drank alcohol once or twice a month. Similarly, another resident who stated that "alcohol [was] never positive," indicated that he/she consumed alcohol, albeit only once or twice a year. A somewhat more consistent\textsuperscript{1} response was obtained from another resident who reportedly drank alcohol once or twice a month, and who commented that "going out to drink [was] not [positive] all the time, but maybe [was] once a month." Similarly, another resident said: "I think any social activity is good as long as the participant conducts him or herself with moderation and acts in a responsible manner."

For this small sample of residents, relationships were noted between attitudes concerning the positive nature of going out for a drink of alcohol and the estimated prevalence of alcohol use (Cramer's $V = .67$), and between attitudes concerning the inherently abusive nature of substance abuse and the prevalence of alcohol use, controlling for those who do not think that going out for a drink of alcohol can be a positive accomplishment (Cramer's $V = .58$). Residents who drank alcohol reportedly believed that going out for a drink of alcohol could be a positive accomplishment, and did not believe that substance use and substance

\textsuperscript{1}References to "consistent" and "inconsistent" responses are not intended to imply that statements of one sort are "better" than statements of the other sort. Festinger's (1957) study of "cognitive dissonance" provides evidence of our frequent attempts to justify, or rationalize the inconsistencies in our own lives.
abuse were synonymous terms. The relationship between residents' attitudes about going out for a drink, and reports by residents that at least one of their house-mates abused substances, did not appear to be statistically significant. Thus, it does not appear that residents who indicated that a house-mate abused substances, were unduly influenced by their general attitudes regarding alcohol consumption.

G. PROGRAM OPTIONS: WHAT, IF ANYTHING, SHOULD BE DONE?

The fifth and final research question addressed in this study tried to determine whether or not special services should be offered in response to substance abuse in Vancouver area mental health boarding homes. Accordingly, respondents were asked if they thought any of a specified list of programs might help reduce substance abuse in boarding homes. Table 3 shows the number of directors, staff, and residents† who reportedly thought the specified services would be useful in response to dual diagnosis substance abuse in mental health boarding homes. A number of points deserve mentioning here. For instance, the relationship between respondents' reports that self help groups would be useful, and their actual use of self help groups as referral sources, was very low. On the other hand, there appeared to be a note-worthy relationship between respondents' professed support for individual counselling and reports that they would refer substance using residents to mental health counsellors (Chi-Square = .06). One staff member had this to say about individual counselling:

†Although resident responses have been reviewed seperately at the end of each section, they have been included here (in Table 3 and Figure 13) so that the three respondent groups can be juxtaposed.
### Table 3.

**SUPPORT EVIDENCED FOR SPECIAL SERVICES**

Reports Concerning the Probable Usefulness of Specified Services in Response to Dual Diagnosis Substance Abuse in Mental Health Boarding Homes

<table>
<thead>
<tr>
<th>Specified Programs</th>
<th>Director</th>
<th>Staff</th>
<th>Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Help Group</td>
<td>19 (68%)</td>
<td>16 (84%)</td>
<td>9 (90%)</td>
</tr>
<tr>
<td>Drug Education</td>
<td>22 (79%)</td>
<td>15 (79%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td>Life Skills</td>
<td>22 (79%)</td>
<td>15 (79%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td>Individual Counselling</td>
<td>23 (82%)</td>
<td>15 (79%)</td>
<td>7 (70%)</td>
</tr>
<tr>
<td>Group Counselling</td>
<td>12 (43%)</td>
<td>9 (47%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Family Counselling</td>
<td>12 (43%)</td>
<td>8 (42%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Job Training</td>
<td>14 (50%)</td>
<td>10 (53%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Housing Search</td>
<td>12 (43%)</td>
<td>8 (42%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Substance Free Recreation</td>
<td>19 (68%)</td>
<td>14 (74%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (11%)</td>
<td>2 (11%)</td>
<td>1 (10%)</td>
</tr>
</tbody>
</table>

Categories are not mutually exclusive.

Director n = 28, Staff n = 19, Resident n = 10
There are increasing numbers of people (professionals, para-professionals, 'lay persons') and facilities and programs for people in the Mental Health system. What seems to be lacking is extensive one-on-one by professional psychiatrists/counsellors. The Community Care Teams have such huge case-loads that each psychiatrist doesn't have time to do much more than save a client's life (important) and control medications. There are many clients (depressive, sexually abused, from alcoholic or dysfunctional families) whose quality of life could be greatly improved with individual counselling.

There was a significant relationship between respondents' professed support for group counselling and their tendency to refer substance using residents to substance abuse counsellors (Chi-Square<.05). Reports that family counselling would be useful were significantly related to reports that residents would be referred to substance abuse counsellors (Chi-Square<.05), and mental health counsellors (Chi-Square<.05). Data were missing in two cases (one director and one staff member).

**Figure 13** graphically depicts the support evidenced by directors, staff, and residents for the specified services. The greatest amount of support was generated for self help groups, drug education programs, life skills programs, and individual counselling. Some differences, and similarities can be noted between the services favoured by the different respondent groups. Both residents and staff evidenced the greatest amount of support for self help groups, while directors preferred individual counselling. All three respondent groups showed a high level of support for drug education, life skills, and individual counselling. It is interesting to note that the same percentage of staff and residents favoured family counselling and
RESPONDENT SUPPORT FOR SPECIFIED SERVICES
DIRECTOR, STAFF, AND RESIDENT REPORTS IN PERCENTAGES

These categories are not mutually exclusive
DIRECTOR (N=28), STAFF (N=19), RESIDENT (N=10)
housing search programs. One of the directors who selected the other category specified that "a lot of people abuse substances as a way of coping with their present and past - real counselling might be of great benefit." Apparently this respondent did not think that individual, group, or family counselling qualified as real counselling. Perhaps he/she was referring specifically to psychotherapy.

Directors and staff members were also asked if they wanted any of the previously specified programs offered within their facilities. Table 4 shows the number of directors and staff who reportedly thought the specified in-home services would be useful in response to dual diagnosis substance abuse in mental health boarding homes. Directors seemed to favour drug education, life skills, individual counselling, and substance free recreation programs, while staff seemed to favour life skills, substance free recreation, and drug education programs. Although substance abuse was only reported in four facilities, the directors of seventeen different facilities (59%) indicated that they would like a drug education program in their home. Thus, it does appear that dual diagnosis substance abuse is recognized as being a potentially relevant problem in over one-half of the surveyed mental health boarding homes.

As would be expected, the number of respondents who indicated that the specified services would be useful, generally exceeded the number who indicated that they would like those same services to be offered within their facility. There was, however, one exception. While only 79% of the staff members reportedly thought a life skills program would be useful, 84% wanted to have a life skills program in their respective facilities. And yet, despite this paradox, there was a
Table 4.

SUPPORT EVIDENCED FOR IN-HOME SERVICES

Reports Concerning the Probable Usefulness of Specified In-Home Services in Response to Dual Diagnosis Substance Abuse in Mental Health Boarding Homes

<table>
<thead>
<tr>
<th>Specified Programs</th>
<th>Director</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Help Group</td>
<td>4 (14%)</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>Drug Education</td>
<td>17 (59%)</td>
<td>11 (58%)</td>
</tr>
<tr>
<td>Life Skills</td>
<td>17 (59%)</td>
<td>16 (84%)</td>
</tr>
<tr>
<td>Individual Counselling</td>
<td>17 (59%)</td>
<td>9 (47%)</td>
</tr>
<tr>
<td>Group Counselling</td>
<td>6 (21%)</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>Family Counselling</td>
<td>3 (10%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Job Training</td>
<td>5 (17%)</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Housing Search</td>
<td>10 (34%)</td>
<td>8 (42%)</td>
</tr>
<tr>
<td>Substance Free Recreation</td>
<td>16 (55%)</td>
<td>12 (63%)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>

Categories are not mutually exclusive.

Director n=29, Staff n=19 (with the exception of the "self help" category, where n=18)
statistically significant relationship between these two variables (Phi = .64, Chi-Square < .01, after the Yates correction). Similarly, significant relationships were evidenced between the variables drug education and drug education in the home (Phi = .47, Chi-Square < .05 after the Yates correction), individual counselling and individual counselling in the home (Phi = .54, Chi-Square < .05 after the Yates correction), housing search and housing search in the home (Phi = .49, Chi-Square < .05 after the Yates correction), and recreation and recreation in the home (Phi = .64, Chi-Square < .01 after the Yates correction). Thus, there is a fairly high level of consistency between respondents' reported opinions regarding the general usefulness of various programs, and their desire to have these same programs offered within their respective facilities. This consistency suggests that there is a reasonably high level of internal validity associated with these two variables.

Not only were respondents asked if they thought any of the specified programs would be useful in response to substance abuse; they were also encouraged to identify and comment freely about any additional services they thought should be offered to help reduce drug and/or alcohol related problems of mental health boarding home residents. Although very few people actually identified substance abuse as a current problem in their facility, many suggested ways that the problem could be reduced. There was a wide range of comments, and rather than code them into discrete categories (not an easy task), I have ordered them according to general themes, and have included a number here, "as is." One such theme concerns respondents professed support for drug education programs. One director stated that:
Mandatory attendance at an evening substance abuse information group geared towards psychiatric clients [would be useful]. Attendance at this group would be necessary to continue residing within the facility. At present there are no such classes offered. Evening classes are necessary as most clients attend day programs ... there is a total lack of any groups dealing with this [dual diagnosis substance abuse] problem. And any group that does have some input runs during the hours of nine to five, when most clients are in structured programs, workshops, or employed. There is a need for evening and weekend drug education and support programs.

Four additional directors, four staff members, and three residents also professed their support for drug education programs. Of course, one way of increasing the level of participation in a program is by taking the program to the consumer, thereby maximizing the ease of use and accessibility of the service. Such an approach was espoused by one of the boarding home directors, who stated that "there should be in-house counselling on drug use and psychotropic medication ... there is a real need for service in this [dual diagnosis substance abuse] area."

Another director commented that it would be useful to have:

Speakers coming into homes to talk about alcohol and drugs mixing with prescribed antipsychotic medications ... there was a marked difference in people here after we had a psychologist come in [to provide Cognitive Therapy] for about one week, but the effects died down because the program was not continued ... there should be more psychologists working in this area.

Self help groups constituted another general theme. While three staff members advocated an Alcoholics Anonymous program, one of the directors stated that:
"We don't like sending people to Alcoholics Anonymous because of its religious foundation. A lot of people with psychiatric problems are obsessed with religion anyway, and we have found that Alcoholics Anonymous has confused them even more because it encourages them to continue their religious delusions. Then we have to try and sort it all out here." Additionally, one of the staff members who did think Alcoholics Anonymous was a useful service, had this to say about that program: "I think a program like Alcoholics Anonymous without the religion might be useful because some people get turned off by the religion. It is a very good support group though, and maybe it is because of the religion that it is so successful. I mean, what do you replace the religion with? It's hard to replace God!"

A more comprehensive bevy of services was recommended by the director of another facility, who commented that:

[There should be] more opportunities for involvement and self-fulfillment; improved workshop facilities and opportunities; drug education and awareness programs; more accommodation for drug free residents to live and work together; job programs to provide improved earning capacity; and Ministry involvement to ensure drug free boarding homes increase. Over the years we have accommodated many individuals that represented previous drug affliction (alcohol included here as the drug that it is). And the majority of those debilitated by drugs, as well as some form of psychiatric diagnosis, favorably responded to a drug free living environment, while accommodated [here].

The need for more community mental health services was also espoused by one of the staff members, who said that "there should be group homes where
alcoholics can live and be supervised, as they probably need medication but would over do it on their own [and so] should be strictly supervised."

The need for government support was also espoused by two additional respondents: one stated that there should be "more subsidized or paid alcohol and drug free activities," and the other indicated that there should be "more money for community based recreation and social activities." Without specifically referring to persons with psychiatric problems, the director of another facility addressed the need for government, and thus, societal, preventative interventions to curb the flood of drug abuse that pervades all segments of Canadian society:

If the 'profit' were taken out of drugs (made 'legal'), and much stiffer penalties for 'trafficking' [were enacted], there probably might be less drugs sold. Although 'alcohol' is 'legal,' it is a great source of revenue for the government, therefore, it is the responsibility of the government to care for the treatment programs and [the] education of 'alcoholics.' If there was no profit to be made in both cases - probably there would not be any 'supply' - or at least much less.

One respondent expressed the following belief that substance abuse services for people with psychiatric problems should be located on the street, rather than in residential boarding homes:

I'd like to see a more active street level outreach program, for early diagnosis and more conducive towards group activity ... a support system (street level) for discharged psychiatric residents who do not chose to follow the 'system'. 
A number of respondents indicated that there should be *more interaction between mental health and drug and alcohol services*. The following comments are indicative of this viewpoint:

1. "Mental health service and drug and alcohol should work closer together. Special facilities for dual diagnosis people [are needed] because a person with acute substance abuse symptoms does not fit into the standard programs in boarding homes."

2. "It would be extremely helpful if a counsellor would be available through Mental Health who would be knowledgable about mental illness as well as substance abuse and the correlation there of. This person should be available for individual counselling of mental patients."

3. "I think drug and alcohol counsellors should have more training about sike [sic] patients."

4. "[They should] increase the interaction between Drug and Alcohol programs and the homes - increase the flow of educational information between Drug and Alcohol and the homes and Community Care Teams and the residents (clients)."

5. "The dual diagnosis project at Greater Vancouver Mental Health services will be very helpful."

Three respondents indicated that there was *not much point in offering substance abuse services to people with psychiatric problems*. One such person, a staff member, commented that "you can't stop people from drinking if they want to [drink]. No one can ever do that and people have been trying to for centuries."

A second staff member said: "education for residents [should be offered to reduce
the drug and alcohol problems in mental health boarding homes], although for most adult psychiatric patients I don't see much of a solution unless someone with a problem is willing to deal with it much the same as Alcoholics Anonymous believes." And lastly, the third respondent, a director, made the following comment:

I don't think there is a way [to reduce residents' substance abuse problems]. If someone wants help - there are already places who are willing to help. I think most people who have problems with drinking or drugs are on welfare, so they should be given food vouchers instead of money so they can not spend it on drugs or alcohol ... I don't think you can do anything about people drinking. You can try to talk to them but they don't usually listen to you. You can offer people services but they probably won't accept them.

So, what services should be offered to help reduce the drug or alcohol related problems of Vancouver area mental health boarding home residents? One final comment, by a staff member of one of the facilities, summed up his/her own thoughts about this question quite nicely, when he/she adroitly replied: "Hmmm..."

The services we have considered thus far have been geared towards the residents of mental health boarding homes, but what of the directors and staff members?† Programs for directors and staff members could, after all, actually be construed as programs for residents; the residents would ultimately benefit from the increased skill and expertise of the caregivers. With this in mind, the

†While the services/programs considered in this study are largely focused on individuals, it is also imperative that we focus on the broader political and economic issues that contribute to problems at a societal level.
directors and staff members were asked if they would like to be offered a workshop on dual diagnosis substance abuse, and if so, what they would like it to include. Seventeen directors (61%) and nine staff members (47%) indicated that they would like to be offered a workshop, seven directors (25%) and four staff members (21%) indicated that they might like to be offered a workshop, and four directors (14%) and six staff members (32%) indicated that they would not like to be offered a workshop. Thus, we can ascertain that twenty-four directors (86%) and thirteen staff members (68%) expressed some interest in the possibility of being offered a workshop. Data was missing in two cases (one director and one staff member). Figure 14 shows the number of directors and staff who do, do not, and might want to be offered a workshop, with the addition of a combined category which includes both the "yes" and "maybe" values. The data are displayed in percentages so that direct comparisons can be made between directors and staff. Most of the respondents were interested in a workshop; and comparatively few were not.

One staff member who indicated that he/she might like to be offered a workshop, clarified his/her position by stating that, while he/she did not think they had enough problems with substance abuse to warrant a workshop, he/she was still "interested in it." Considerably more directors (86%) than staff members (68%) expressed interest in a workshop. Perhaps this imbalance was due to the unequal distribution of staff participants across all facilities; while there was one, and only one director from each of the participating facilities, there was more than one staff respondent from some homes, and none from others. Or perhaps staff members were not as committed to the facilities as the directors were, or were
SUPPORT FOR A DUAL DIAGNOSIS SUBSTANCE ABUSE WORKSHOP

Percentage of Directors and Staff Who Want a Workshop

Responses

Data was missing from one staff member (n=19) and one director (n=28)
less concerned about providing "favorable" responses.

Specified workshop topics have not been coded into discrete categories, but rather, have been grouped according to common themes. Drug education services was the most frequently selected workshop topic. Of course, "drug education" meant different things to different people, and included a wide range of topics. Several people indicated that they thought drug education should include information concerning problem identification, or as one respondent put it, "how to spot the problem when you don't smell or see drugs." How indeed? Of course, the complexity of this task would depend largely on one's definition of abuse. If the consumption of even small amounts of substances, used in moderation, is considered abusive, then detection can be very difficult; if consumption is only considered abusive if it results in observable problems then detection can be a simple matter. The detection of substance use and/or abuse becomes even more difficult when unusual or suspect behaviors are automatically attributed to peoples' "mental illness." One staff member indicated that he/she not only wanted to know how to detect substance abuse, but also wanted to know how to respond to it. This person wanted a workshop to include "drug education, appropriate [ways to] approach individuals who are addicted, [and] the types of behavior to expect from these individuals."

Another popular workshop topic involved identifying community resources where substance abusing residents could be referred. One director stated that a workshop "would have to be practical, including information about how to deal with individuals who abuse substances, and what resources were available." Many
facilities are not equipped to handle substance abuse problems, either because the care givers are unwilling or unable to do so. It is not surprising that client referrals are so popular. Indeed, with the ever increasing specialization of services and service providers, and the near extinction of the "urban generalist" practitioner, referrals have become the norm rather than the exception.

Many respondents requested that information concerning the interaction of prescription and nonprescription substances be included. It would be helpful to focus on the effects of specific combinations of drugs, rather than simply stating that drugs and drugs do not mix. Several respondents thought a workshop should provide opportunities to develop their counselling skills. Both the personal skills to intervene directly, and the ability to access other resources would benefit boarding home service providers. This sentiment is summed up nicely by the following comment:

Although alcohol abuse is not a major problem here, it has been in the past. More information on this subject would increase staff's ability to relate empathically to someone with a drug or alcohol problem. It would also alert us to potential problems and enable [us] to informally counsel clients or direct them [to a professional counsellor] ... this study has [already] led us to reevaluate just what we would do if someone did come home drunk.

Another director specified that he/she wanted information about "how [treatment programs] could be integrated into the boarding home, [and] what happens when people continue to use or abuse substances ... they are currently dumped out and probably end up in hospital." A nicely itemized workshop agenda was
provided by one of the staff members, and it included:

1. An explanation of terms.
2. Case studies introduced as examples.
3. A talk on history/predictors etc.
4. Role playing working with these people.
5. Specific items/indicators to look for in clients.

A number of respondents looked beyond the isolated, personal problems of identifying and responding to individual problems after they arise, to the larger contextual, societal problems of identifying and responding to common problems before they arise. The comment by one director that workshops should focus on "pro-active interventions" is indicative of this "macro" perspective. Of course, both proactive and reactive interventions are needed. In addition to requesting information concerning the indicators and health effects of substance abuse, prognoses after treatment, and the pros and cons of treatment options, one staff member requested information concerning the possible social, psychological, physical, and/or other causes for the abuse. While not addressing this particular issue, one director had this to say about the possible causes of psychoses: "I wonder how many peoples' psychotic episodes are really triggered by drug use. I lived in Africa before I moved here and we did not have any schizophrenia there, and there was no drug use. But here, marijuana use is very widespread, as are psychiatric problems."

Of course, it does not logically follow that because many Canadians both smoke marijuana and are schizophrenic, and no Africans allegedly either smoke
marijuana or are schizophrenic, that marijuana use causes schizophrenia. Nonetheless it is clear that the symptoms of certain forms of psychoses are often extremely difficult to differentiate from certain drug induced states, and the chemical structures of certain naturally occurring neurotransmitters are startlingly similar to those of certain drugs.† Perhaps the relationship between substance use and psychoses is stronger than we think.

Three respondents provided rather unique comments in response to the what would you like a workshop to include question. First, one director indicated that what he/she really wanted to see included in a workshop, which he/she did not want to be offered anyway, was "a good lunch." A bit of humor is refreshing, it is true, but we must not underestimate the importance of a nutritionally balanced diet. A good lunch, indeed! The second respondent, another director, took a more serious approach and indicated that he/she thought a workshop should contain information regarding the history, and pros and cons of the dual diagnosis substance abuse diagnostic category. This interest in the new dual diagnosis diagnoses was shared by the third respondent (director), who said: "I have heard of this dual diagnosis label and I sometimes wonder if it isn't just another attempt to create another service provider." Indeed, is the creation of the dual diagnosis label legitimately in the client's best interests?

†Refer to Chapter III for a more detailed discussion of these chemical similarities, and the similarities between certain drug induced states and "naturally" occurring psychoses.
Resident responses to questions exploring what, if anything should be done about substance use and/or abuse in mental health boarding homes are summarized below.† Self help groups (specified as "Alcoholics Anonymous" on resident questionnaires) generated the most support, followed by drug education, life skills, and individual counselling. One resident stated that he/she thought Cognitive Therapy would be helpful (the director from the same facility favoured the same form of therapy). Another resident stated that there should be "compulsory education about what happens when drugs and alcohol are mixed with medication." It is interesting that a resident advocated a compulsory program, as that approach is more often advocated by professionals or other service providers (especially when the offered service fails to otherwise "draw them in") rather than by service consumers. An "exercise" program was advocated by one of the residents, and an additional resident stated that "programs specifically dealing with prescription drug abuse [would be useful, such as] education [about] alternative ways to deal with problems." However, as a third resident succinctly pointed out, before substance abuse services can be effective, people have to admit they have substance abuse problems.

It is not enough to determine what programs might be useful in response to substance abuse in mental health boarding homes; it is also important to determine what programs might be accepted and used. Thus, it is important to

†Refer to Table 3 for a complete itemization of residents' reported opinions regarding the relative usefulness of the specified programs, in relation to dual diagnosis substance abuse.
try and establish which programs the residents themselves would be willing to use. Accordingly, residents were asked to indicate if they currently attended any of the specified programs, or if they would attend them if they were made available. Five residents indicated that they attended at least one of the specified programs. The programs that residents reportedly used were: a self help group, Alcoholics Anonymous, individual counselling (specified by two people), job training, assistance obtaining independent housing, life skills, and "a very good relationship with [a] doctor." One person indicated that he/she would attend Alcoholics Anonymous (this same person was currently attending Alcoholics Anonymous). Another resident indicated that he/she would attend both a drug education and a substance free recreation program; although this respondent reportedly did not have a substance abuse problem, he/she indicated that that had not always been the case. Although one additional resident indicated that he/she would attend one of the specified programs, this person specified that he/she would only do so "if [he/she] needed them." This person did not apparently feel that he/she needed them at present.

The last resident who indicated that he/she would attend one of the specified programs reported that he/she would, in fact, attend all of them, and had this to say:

I drink in moderation. Alcohol does not affect my life. I am always a phone call away from Alcoholics Anonymous if I need it. I really believe its helped a lot of people. It's there when I need it. My work history hasn't been the best but I know beyond a reasonable doubt it hasn't been alcohol. Maybe cigarettes, but they help my stress levels and I am attempting to quit.
While this resident had apparently been told that he/she had a drinking problem, he/she did not concur with that assessment, because he/she was able to "moderate" him/herself. Clearly, this was a person who did not believe that abuse and use were synonymous terms, and in response to that question had replied: "Moderation is the key."

Although one additional resident indicated that he/she would not attend any of the specified programs he/she also said: "I feel my drug problems are a thing in my past (twelve years ago). But for sure, if I ever slipped only once, I would seek help immediately." The following account tells of this resident's struggle with both psychiatric and substance abuse problems:

I had been a prescription junkie for eighteen years - since a back injury started me on pain killers. It wasn't long before I was on tranquilizers and sleeping pills. When I was diagnosed as manic depressive at twenty-nine years of age I'd had enough and tried to kill myself. It wasn't until I found a caring and dedicated counsellor through my doctor that I gained the knowledge and confidence to get off pills and realize my potential as a productive and alive individual. I've just moved into three-quarter way housing after spending two years in a group home and will be going back to school and work soon, hopefully in the mental health field.

The following chapter summarizes the data, explores the findings, puts forth a program proposal, discusses the limitations of the study, and makes suggestions for future research.
VII. CONCLUDING REMARKS

A. SUMMARY OF FINDINGS

The primary purpose of this study has been to estimate the prevalence/incidence of substance abuse in Vancouver area mental health boarding homes. The data suggest that substance abuse is not a large problem in these facilities. Of 358 residents, from twenty-nine different facilities, only six had reportedly abused alcohol, and two had abused illicit drugs. Thus, there was a combined total of eight (2%) substance abusers. The term "substance abuse" was clearly operationalized according to World Health Organization (1986) specifications, so it is assumed that respondents' understanding of what behaviors constituted abuse were fairly constant. However, the following factors suggest that the prevalence of substance abuse may have been underreported:

1. The specified two week period may have been too short, and consequently narrowed the scope of the data considerably.

2. "Political" pressure to present a "clean" image of substance free facilities may have influenced some respondents' reports, and influenced others' decisions not to participate at all.

3. Alcohol was consumed by 115 residents (32%), and 57 (16%) had consumed alcohol during the past two weeks.

4. Director and staff respondents from fifteen facilities (52%) indicated that they had tried to get help for a resident with a substance abuse problem.

5. And similarly, cases of substance abuse were reported in eleven different facilities.

†See the introductory section on "definitions" for a complete World Health Organization definition of substance abuse.
facilities (38%), without reference to the specified two week period.

While it cannot be assumed that those residents who consumed alcohol also abused alcohol, the combined data do indicate that the prevalence of substance abuse may be higher than is indicated by reports of substance abuse during the specified two week period. Nonetheless, in relation to the total number of residents in the surveyed boarding homes, it appears that very few residents have substance abuse problems. Thus, while there may be considerable numbers of dual diagnosis substance abusing patients in acute care hospitals, and boarding home residents referrals consist primarily of persons discharged from these hospitals, very few persons with substance abuse problems seem to be entering, or residing in, Vancouver area mental health boarding homes.

In addition to estimating the prevalence/incidence of substance abuse, this study has explored different factors, such as demographic characteristics, to map out the significant associations between these factors and the prevalence of substance use and/or abuse. The following associations were found to be significant:

1. There are significant relationships between the number of men in boarding homes and the frequency of alcohol consumption (p<.05), and the number of women in boarding homes and the number of alcohol consumers (p<.01). However, while this appears to imply that more women drink alcohol than men, and men drink more often than women, the data obtained from directors and staff members refer to totals and averages and can not be extrapolated to individual residents, but rather, provide evidence of general

†Refer to Chapter III for a review of studies that estimate the prevalence of dual diagnosis substance abuse in psychiatric acute care hospital settings.
trends.

2. Significant relationships were noted between residents' average age and the prevalence of marijuana use (p<.01) and monthly alcohol use (p<.05). The data do not support findings in the literature that age is significantly related to substance abuse. In any case, a higher prevalence of substance abuse among younger age groups may be more the result of experimentation, and "rites of passage," than it is to the presence or absence of psychiatric problems.

3. The data show significant relationships between tranquillizer use and the yearly consumption of alcohol (p<.01), antidepressant use and the yearly consumption of alcohol (p<.05), and antiparksonian use and the yearly consumption of alcohol (p<.01).

4. Additionally, significant associations were noted between the prevalence of alcohol use and the following psychiatric diagnoses: schizophrenia (p<.01), manic depression (sig<.01), and personality disorder (sig<.05). There was also a significant relationship between the prevalence of alcohol abuse and the diagnosis of depression (sig<.01). The data support findings in the literature† regarding the relationships between substance use/abuse and diagnoses.

As was expected, the policies of boarding homes were associated with the estimated prevalence of substance use. Ninety-four percent of the homes that do not do anything about residents' alcohol consumption had at least one resident who consumed alcohol (Chi-square<.05). There was also an inverse relationship

†Refer to Chapter III for a summary of studies showing relationships between dual diagnosis substance abuse and specific psychiatric diagnoses.
between reports by directors that they would refer substance using residents to mental health counsellors, and the estimated prevalence of alcohol use (Chi-square<.05). Not surprisingly, significant relationships were noted between directors' beliefs that substance use and substance abuse are synonymous terms, and the presence of at least one resident who consumed alcohol (Chi-Square<.05), or marijuana (Chi-Square<.05). All of the facilities whose directors did not believe that substance use was inherently abusive had at least one resident who consumed alcohol, and 64% of these same facilities had at least one resident who consumed marijuana (compared to only 6% of those facilities whose directors did believe the two terms were synonymous).

No significant relationships were noted between directors' opinions regarding residents going out for a drink of alcohol, and the prevalence of either substance use or substance abuse. However, a significant relationship was noted between their reports of alcohol consumption and their belief that substance use and substance abuse were synonymous terms, controlling for those who did not believe that going out for a drink of alcohol could be a positive accomplishment (Chi-Square<.05). Thus, it appears that more residents drink alcohol in facilities whose directors believe that going out to drink alcohol can be a positive accomplishment, and do not believe that substance use and substance abuse are synonymous terms.

In addition to estimating what the prevalence of substance abuse was, and testing different associations, this study also attempted to determine what, if any, services should be offered in response to dual diagnosis substance abuse in
Vancouver area mental health boarding homes. Not very many people working in Vancouver area mental health boarding homes appear to have received training in either substance abuse or dual diagnosis substance abuse, and most of those people who did have training in one area also had training in the other. Further, directors who did have training in these two areas were from facilities that reportedly had substance using (though not abusing) residents.

Respondents evidenced support for a number of different services. Drug education, life skills, individual counselling, and self help programs generated the most support. With a few exceptions, comments by respondents supported findings in the literature that suggest existing community mental health services do not adequately meet the needs of dual diagnosis substance abusing persons. As was expected, fewer of the respondents wanted the specified programs to be offered within their facilities than were in favor of them being offered somewhere, in a more general sense. It is one thing to believe that a service might be useful, and another thing to have that service in your own parlor.

Nonetheless, there was a fairly high level of consistency between respondents' expressed support for programs, in general, and support for programs offered in the home. The in-home programs that received the highest levels of support were drug education, life skills, recreation, and individual counselling. The highest level of support for any given program, according to the comments of respondents, was for drug education. Similarly, drug education was the most frequently selected workshop topic (83% of the directors and 65% of the staff members indicated that the programs they were interested in were drug education). A summary of studies that suggest existing services are inadequate is contained in the discussion of homelessness and deinstitutionalization in Chapter III.
that they would be interested in attending a workshop on dual diagnosis substance abuse). These findings are congruent with those in the literature that indicate that drug education forms a component of almost all substance abuse treatment strategies.†

B. DISCUSSION

We have already established that, while many facilities reportedly had problems related to dual diagnosis substance abuse, few individual residents reportedly had dual diagnosis substance abuse problems. However, as previously noted,‡ three of the resident participants had received treatment for substance abuse, three had been told they had a substance abuse problem, and three had tried to get help for a substance abuse problem. Thus, while resident reports (in this study) can not be reliably used to make statistical inferences, it is worth noting that a whopping "30%" of the residents seem to have had substance related problems at some time.

On the other hand, it does not necessarily follow that people who have received treatment, or been told they have a problem, or tried to get help for substance abuse, actually have substance abuse problems at all. The one resident who had neither tried to get help, nor been told that he/she had a problem, but who received "treatment" nonetheless is a case in point. This resident seems to have attended Alcoholics Anonymous (AA) meetings for social, and more specifically,

†Refer to Chapter III for a review of different treatment approaches.
‡Chapter VI, section C, summarises findings of this study regarding prevalence estimates.
spiritual reasons. Drawn to the religious framework, this resident reportedly relied on AA meetings as an adjunct to Sunday church services (this statement was corroborated by the director of the same home). Thus it would seem that while this person attended an alcohol treatment program, he/she had never tried to get treatment for an alcohol problem, had never been told that he/she had an alcohol problem, and, it would seem, did not have an alcohol problem. Similarly, although it may be ascertained that someone has been told they have a substance abuse problem, it is difficult to determine how objective, and thus, how reliable the report is; put simply, just because someone says it is true does not mean it necessarily is.

Additionally, as for residents having received treatment, the data do not indicate when the treatment occurred. In like fashion, it is not clear how long ago the residents were told they had a problem, or tried to get help. Each of these events could have happened in the distant past. Strong advocates of the biomedical view on substance abuse and addiction (that it is an incurable, progressive disease state), may suggest that the issue of time is purely "academic." However, while some individuals may have a genetic predisposition to abuse substances, whether or not the individual consumes substances, and whether or not there are problems associated with that consumption, is largely the result of environmental conditions (whether they be social, political, physical, economic, or cultural environments). Behaviors must be viewed in their context!

We commonly focus on the identified "client," "patient," or "resident," when examining the prevalence of problem behaviors in a given population, without
recognizing or acknowledging that emotions, cognitions, and behaviors are only defined as problematic in relation to the "normal" emotions, cognitions, and behaviors of others. Thus, psychiatric or substance abuse "problems" only become such, within a given cultural context, when they contravene societal, and thus individual, expectations.† The socio-cultural characteristics of specific populations must be taken into account, and we must always ask ourselves: normal for what? And normal for whom? And does normal refer to the average characteristics of a population, or an ideal standard?

Our perceptions effect our interpretations, which are in turn effected by our experiences. Thus, it was assumed that the demographic characteristics of directors and staff members might influence their tendencies to "see" substance use as abusive in a given context. Although no significant relationships were found between the specific (identified) characteristics of staff and directors and their reports of substance abuse, considerable variations were noted between their respective perceptions regarding dual diagnosis substance abuse.

While the term "substance abuse" was clearly operationalized according to World Health Organization guidelines, it is clear that the "personal meanings," or "affective connotations"‡ associated with this term varied greatly among individual respondents. For example, a staff member in one facility stated that: "no one lets people drink in mental health facilities anywhere, and there is only one way to deal with [drinking]. If [they] drink, then [I say] there's the door." This

†Refer to Waxler's (1979) study, for a discussion of the influence of sociocultural contexts on the diagnosis and prognosis of schizophrenia.
‡Refer to Hayakawa (1973) for an insightful "expose" on the connotations of language.
individual was passionately opposed to any level of alcohol consumption, and consequently believed that the only way to respond to residents who drank was to evict them immediately. Obversly, the director of another home stated that he/she had "no problem with people social drinking [sic], or going out for a drink like anyone else, as long as it [didn't] create other problems." This individual believed that moderate levels of alcohol consumption were entirely acceptable. Clearly, if the former of these two individuals stated that a resident had a substance abuse problem, it would have a very different meaning than would the same statement made by the latter individual.

While not surprising that there was a positive relationship between the prevalence of alcohol use and a facility's tendency to do nothing about alcohol use, it is somewhat more surprising that "referrals to mental health counsellors" was the only specified response variable with an inverse relationship to alcohol consumption. Perhaps facilities that refer residents to mental health counsellors have closer ties to Greater Vancouver Mental Health Services (GVMHS) than facilities that do not. It is conceivable that such a relationship could influence boarding home policy makers to neither accept applicants who consume alcohol, nor tolerate alcohol consumption by existing residents. However, just as mental health boarding homes rely on GVMHS for funding, so too does GVMHS rely on mental health boarding homes as resources for client referrals. It is, therefore, unlikely that GVMHS would encourage boarding homes to reject its own referrals.

Another unexpected finding was that there did not appear to be a relationship between the estimated prevalence of alcohol use and directors' tendencies to evict
residents who use alcohol. One would think that residents would be less likely to drink alcohol if it was likely to result in their eviction. Problems of interpretation may have influenced this non relationship between eviction policies and alcohol consumption. No doubt, virtually every facility evicts residents for drinking alcohol, under certain conditions.

The admittance policies of boarding homes were not significantly related to either substance use or substance abuse. This finding was not expected, as it was assumed that a primary determinant of the prevalence of substance abuse in facilities would be their tendencies to admit, or refuse admittance to, persons with histories of substance abuse. The data do not support findings in the literature that indicate that most boarding homes refuse to take persons with substance abuse problems. Perhaps, as the literature also suggests, the low prevalence of substance abuse is largely due to the refusal of dual diagnosis substance abusers to sacrifice their autonomy by staying in boarding homes. The failure of the data to reveal a relationship between admitting policies and the prevalence of substance use and/or abuse, may have been influenced by incongruent interpretations of the relevant question by different respondents. There appeared to be some confusion over the temporal parameters of the phrase a history of substance abuse.

The statements that going out for a drink can be a positive accomplishment, and substance use and substance abuse are synonymous terms, were intended to be

†Refer to Chapter III for a summary of studies that examine boarding home admittance policies in relation to substance abuse, and persons' refusals to live in these facilities.
somewhat provocative, in an attempt to generate interest in the study and stimulate thought and discussion. As such, they were quite effective. However, it is possible that different individuals interpreted the statements in a variety of ways. The following comments by one director underscores the possible range of interpretations:

There are a variety of ways to go out for a drink (social to abusive), there are a variety of reasons for drinking (social to alcoholic), there are a variety of reasons for going to bars (normal socializing versus alcoholism), etc. etc. etc. It is individualized as to how a person behaves while drinking, what happens after drinking, and why they went out for a drink.

Just as the director who made the preceding comment intimated that the motivations for, and results of drinking vary greatly, so too does the potential range of interpretations of the questions vary greatly. The following comments by another director show evidence of two different interpretations within the same answer:

The process of planning a social event, going to it and being comfortable in public is important - [for example] developing leisure activities, social skills, friendships etc. When alcohol is involved, there is an added pressure of responsibility to use it appropriately, or not to use it at all because of medications. 'Mentally ill' or not, when alcohol is the activity it can't be viewed positively.

Thus, the statement going out for a drink of alcohol can mean going out for the sole purpose of consuming alcohol, or it can mean going out on a social excursion that will involve, among other things, drinking alcohol. On the one
hand, drinking alcohol is the activity, while on the other hand drinking alcohol is only part of the activity. Discrepant interpretations such as these may account for some of the apparent inconsistencies. Of course, the presence of inconsistencies does not negate the significance of respondents’ comments, though it does create the potential for problems of internal validity when the data are coded into quantitative, discrete categories. In fact, as respondents’ comments indicate, discrepancies between responses are in large part a reflection of the complexity of responses, and the thoughtfulness of respondents, rather than the unreliability of responses and the inefficiency of respondents.

While there were reportedly substance abuse programs operating in four different facilities, there seem to have been a variety of different ideas about what, exactly, constituted a substance abuse program. On the one hand, it could be supposed that refusing to admit anyone with a history of substance abuse into a facility, or evicting residents who use or abuse substances, are actually substance abuse "programs." Certainly, these programs might solve the boarding homes' substance abuse problems. On the other hand, it could be supposed that doing absolutely nothing about residents’ substance use or abuse problems is, in effect, a substance abuse "program." While true that these examples are extreme, the fact remains that respondents seem to have interpreted the phrase in the home substance abuse program in a variety of different ways. It is probably safe to assume that, if the word program were taken to mean a formal, regular planned service with an established agenda or structure, the number of programs was over reported; and if the word program were taken to mean an informal, irregular, spontaneous ‘response’ without an established agenda, the number of
programs was under reported. Nonetheless, at the very least it can be ascertained that in some facilities, there is an awareness of, and an attempt to respond to, the potentially damaging effects of substance abuse.

A number of respondents made comments that support findings in the literature which reflect the general inadequacy of community based mental health services (perhaps a problem of quantity rather than quality) to meet the needs and, increasingly, demands of de-institutionalized ex-mental patients. Several respondents indicated that there was a need for our government to extend its present commitment (to providing specialized dual diagnosis substance abuse services), to the development of more community living facilities for persons with psychiatric problems. However, on the one hand facilities that would in large part exclude persons with substance abuse problems were advocated, while on the other hand facilities that would house only persons with substance abuse problems were advocated. Perhaps a more integrated service would be best. A "tiered" boarding home system, where people can move to increasingly autonomous living environments might be a viable alternative to the existing structure.

Many people have expressed concern that the combination of prescription and nonprescription drugs will either negate the effects of prescription drugs, or result in an undesirable "interaction effect." Thus, the high prevalence of prescription drug use by persons with psychiatric problems (and the assumption that substance use causes a worsening of psychiatric symptomology) has led some people to conclude that any level of substance use is, in fact, abusive. While generalizations of this sort often do contain an element of truth, they nonetheless
do their targets a disservice. Persons with psychiatric problems are not only members of a group, but are also individuals. One respondent stated that people with psychiatric problems should follow his/her example, and not consume alcohol while taking prescription drugs. While this logic is basically sound, it does not acknowledge the difference between temporary and permanent prescription drug use. For the respondent who made the preceding comment, not drinking alcohol while taking medication means not drinking for a few days, weeks, or possibly months, while for many people with psychiatric problems it means a lifetime of abstinence. The inclusion of data in this study regarding medication use is in recognition of the potential, rather than inherent, problems caused by the interaction of prescription and nonprescription drugs.

One question that has been raised in this study concerns the legitimacy of creating the "dual diagnosis substance abuse" label. Is the creation of the dual diagnosis substance abuse label truly in the clients' best interests? Kutchins and Kirk (1987, 1988a & 1988b) provide interesting critiques of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III), and the diagnostic categories it contains. Why, for instance, was homosexuality, which was included in early editions of DSM, excluded from later editions? And why were the three new categories of Paraphilic Rapism, Premenstrual Dysphoric Disorder (PMS) and Masochistic Personality Disorder, which were proposed additions for DSM-III-R, either excluded, or revised and moved to an appendix? The answer, it seems, is "political pressure." Certainly, there were no sudden medical discoveries justifying these revisions. It was political pressure exerted by homosexuals and other interest groups that "cured" homosexuals of their "disease;" it was political
pressure exerted by the U.S. Justice Department, and feminist interest groups, that "cured" rapists of the "disease" that would have protected them from criminal prosecution, redefining their heinous acts of aggression as the uncontrollable symptoms of a disease, and thereby legitimizing their brutalization of women by transforming the perpetrator into the victim (or "patient"); it was political pressure exerted by feminists and other interest groups that "cured" women of their "disease," by normalizing PMS and ensuring that basic biological processes would not be stigmatized and labelled "abnormal;" and it was political pressure exerted by the Surgeon Generals Conference on Violence, and other interest groups, that "cured" women and other victims of domestic violence of their "disease," ensuring that they retain their rightful status as victims, rather than as mentally ill deviants who entreat others to beat and abuse them to satisfy their own masochistic tendencies.

Psychiatric diagnoses have been criticized and defended with equal alacrity by innumerable protagonists. Nonetheless, it is clear that mental disturbances are influenced by a wide variety of factors, and while the symptomology may be linked to microbiological aberrations, the causes of these aberrations are multifactorial, and the meaning that the symptomology has depends on the social, cultural, political, and economic contexts within which they occur. Schizophrenia, for example, has no objective reality: it is the symptoms of schizophrenia that objectively exist, while "schizophrenia" is the label we use to compartmentalize these symptoms and symptom sufferers into the explanatory model of 'choice' in the western world, the biomedical disease model. "Reality" is constructed through, and does not exist independently of, human experience.
Certainly, with the creation of a dual diagnosis service industry, there is a danger that the interests of the individual will be lost in a fog of generalizations. Blanket statements like: "for persons with psychiatric problems substance use is synonymous with substance abuse," are indicative of our all too common tendency to strengthen the distinction between us and them, between the in group and the out group, between the normal and the less than normal, by pointing to the failure of the deviant subgroup to conform to the mainstream parameters of normality. Ours is a society made up of a plethora of differentiated segments, and we struggle diligently to maintain the boundaries. The "mentally ill" have not fared well in this system of segmentation; crouched on the periphery, they have been steadfastly denied access to the exclusive world of the nondistinct normal. When even the well established psychiatric diagnostic labels are of questionable validity, should we be creating another unproven, untested, unsubstantiated, objectively indeterminate category?

And yet, on the other hand, for some people with psychiatric problems the combination of prescription and nonprescription substances is likely to cause some problems.† And substance use is likely to cause the thought patterns of persons whose thought patterns are already somewhat unusual to become even more so; and it is likely to cause some management problems for service providers; and it is bound to cause interpersonal, financial and legal problems for some. As long as we do not lose sight of the fact that it is not the act of substance use, but the consequences of that act, the occurrence of substance related problems, that constitutes substance abuse, then perhaps the label of dual diagnosis substance

†Refer to Chapter III for a discussion of the "additive," "synergistic," and "antagonistic" effects that can result from coingesting different substances.
abuse can be used responsibly. Nonetheless, the potential for "dual diagnosis label abuse" is great.

It was suggested by a few respondents that there was really no point in offering services to dual diagnosis substance abusers, as they will not change their behavior in any case. Certainly, it is true that the motivation to change must not only come from within, but must also exceed the motivation not to change if any meaningful change is to occur. When the costs of continuing a certain behavior consistently exceed the rewards, then the stage for change is set. Of course, the balance between rewards and costs must be measured in the mind of the individual concerned. While an external, "objective" analysis may suggest that the costs of a certain behavior far outweigh the rewards, it is the perceptions of the individual concerning the relative value of costs and rewards that is of paramount importance.† Further, a key step in the process of becoming motivated to change one's dysfunctional behaviors involves recognizing that the behaviors are, in fact, dysfunctional. One can do something about a person's substance abuse problem, even if that person does not acknowledge that his/her substance use is problematic. True, the individual will probably not be motivated to change, and the problem behaviors may continue, so it may appear that all efforts to stimulate change have been fruitless. It is less expedient, when working with "unmotivated clients," to refer them to this, or that service, or to demand immediate change, than it is to consistently and systematically expose the inconsistencies between behaviors and beliefs, between consequences.

†There is always a danger that we, as "professionals," will evaluate clients' from the comfort of our "armchairs," within our own frame of reference, without adequately considering how their standard of living and quality of life influences their behaviors, cognitions, and emotions.
and objectives, between external and internal realities, between objective and subjective truths, until the protective shield of rationalizations has been stripped away to reveal the problem within.

Of course, this does not suggest that problems always rest within the individual. Rather, we must redefine the term treatment, so that it transcends the narrow confines of conventional treatment modalities. Just as drug abuse problems are not unique to persons with psychiatric problems, neither can the causes of, nor the solutions to, dual diagnosis substance abuse be viewed in isolation. While not negating the need for individual or group oriented reactive measures, it is imperative that we develop preventative measures at a societal or cultural level if we are to effectively "cure" peoples' substance abuse problems.

C. RECOMMENDATIONS

The data do not reveal a sufficiently high prevalence of substance abuse in Vancouver area mental health boarding homes to justify the expenditures of time and money necessary to create a new service delivery system for residents who abuse drugs and/or alcohol. Perhaps the creation of "new" services should involve redefining the parameters of "normality," thereby opening up the doors of existing services to people with psychiatric problems. Estimations of prevalence do suggest that some level of service is warranted when viewed in relation to facilities rather than individuals. While not enough residents abuse substances to justify the creation of services for residents, enough boarding homes have had substance abusing residents to justify the creation of education services for
It is the recommendation of this author that a trial drug education program/workshop be offered to the directors and staff members of Vancouver area mental health boarding homes. Such a service can be offered within existing services, thereby minimizing both the monetary and temporal investments needed. The "dual diagnosis team" recently formed by Greater Vancouver Mental Health Services (GVMHS), in conjunction with Alcohol and Drug Programs (ADP), provides an excellent medium for such a drug program.

Following are some general operations that might prove useful in developing a drug education service for mental health boarding homes.

1. Select the appropriate program personnel (hereafter referred to as the "project coordinators"). The director and personnel of the Greater Vancouver Mental Health Services dual diagnosis team would seem to be a logical choice.

2. Contact potential service consumers to inform them of the pending program, elicit their support, and solicit their input. Consumer involvement increases participation. Involving consumers in the planning process not only increases the likelihood that "appropriate" services will be developed, but also increases the likelihood that, by instilling in them a sense of "ownership" in the program, consumers will be motivated to accept and participate in resultant services.

3. Develop a "mission statement." The mission of this project should be to

†Refer to Chapter III for a summary of studies delineating the effects of information sharing on subsequent group participation.
increase the quality of life for substance abusing mental health boarding home residents, by increasing the caregivers awareness of, and ability to respond effectively to, dual diagnosis substance abuse.

4. Define the program goals and objectives. The primary goal of this proposed project is to increase the awareness of directors and staff members regarding the many complexities of dual diagnosis substance abuse. It is assumed that by so doing, the caregivers will be able to provide better services to residents with substance abuse problems. Following, is a list of program objectives. The degree to which these objectives are attained should be systematically monitored.

a. Increase participants' knowledge of the potentially adverse effects of substance use on an individuals' psychiatric symptomology.

b. Increase participants' knowledge of the additive, synergistic, and antagonistic effects that may occur when substances are taken in combination, with a particular emphasis on the interaction of specific prescribed and nonprescribed substances.

c. Increase participants' knowledge about alternative coping strategies.

d. Increase participants' awareness of the pros and cons of creating a new (dual diagnosis substance abuse) service industry.

e. Increase participants' knowledge about the possible "causes" of dual diagnosis substance abuse (and substance abuse in general), including physiological, societal, cultural, economic, and political factors and their global ramifications.

5. Develop the program content/agenda. Suggestions for agenda items are detailed at a later point.
6. Select, develop or adapt measurement instruments designed to test the effectiveness of the project. There are a number of measurement tools available that have been designed for use in conjunction with drug education programs, though most of these have not been designed for populations with both psychiatric and substance abuse problems, and thus, would need to be modified to fit a dual diagnosis substance abuse program.

7. Locate a suitable facility to run the program in. One of the boarding homes may be able to host the program.

8. Develop and distribute information and registration packages.

9. Identify and contact possible guest speakers to address specific concerns. It would be preferential to have representatives from a variety of different disciplines and resources, providing a variety of different viewpoints. Thus, the "education" participants received would not solely reflect the relatively narrow interests of any one interest group.

10. Arrange for videotaping of the program. This would not only provide a useful assessment tool, but could also serve future educational goals, or provide guidelines for the development of future services.

11. Run the program/workshop, administer selected assessment tools using an A/B (pretest/posttest) design. It would be useful to structure such "research" so that it is conducive to longitudinal data collection.

12. Analyze collected data.

13. Based on the subjective insights of the project coordinators and service consumers, and the "objective" insights derived from measurement scales, videotapes, and a cost analysis, determine if the project has met its specified goals and objectives.
14. Present a summary of findings and recommendations to the executive directors of GVMHS and ADP, and the service consumers.

The program/workshop agenda would have to be developed by the project coordinators, in conjunction with the service consumers, although this study has provided many suggestions regarding potential agenda items:

1. How to detect substance abuse.
2. When does use become abuse?
3. What behaviors might one expect?
4. How to respond to residents who abuse substances. Direct intervention techniques could be strengthened by role playing or small group formats.
5. The effects of specific combinations of drugs.
6. The similarities between the molecular structures of specific psychoactive drugs and neurotransmitters.
7. The effects of prolonged abuse of specific substances.
8. What community support services are available? Only two respondents in this study made any reference to the newly formed GVMHS dual diagnosis team! Increased access to existing services is needed.
9. Identify the pros and cons of available treatment options.
10. Discuss the pros and cons of the "dual diagnosis" label.
11. Explore the motivating factors that influence people's choice to use or abuse substances.
12. Suggest alternative, substance free, stress management and problem solving skills.
While there is a growing awareness among health care professionals that dual diagnosis substance abuse is a significant problem, and that most existing treatment services are not sensitive to the needs of this population, there is less certainty about what, exactly, should be done. It is hoped, of course, that a drug education project would help boarding home staff and directors better understand the many complexities of dual diagnosis substance abuse, and would increase the quality of services available to boarding home residents. But in addition, this project would be extremely valuable as a guide for health care professionals, boarding home personnel, and policy planners (and thus, dual diagnosis substance abusers), to help develop increasingly "consumer friendly" services for this troubled and much maligned population.

D. LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH

One (unjustified) criticism of this study might be that it does not survey the population with the highest prevalence of dual diagnosis substance abuse, and that findings, therefore, can not be generalized to the majority of persons with such problems. While it is true that mental health boarding home residents with substance abuse problems are not representative of all dual diagnosis substance abusers, a similar point can be made of the homeless, jailed, or hospitalized people that have been the focus of previous research in this area. This study was designed to look specifically at boarding home populations, to estimate the prevalence of dual diagnosis substance abuse therein. Attempts have not been made to generalize findings specific to this study, to other populations.
Several comments are in order concerning the method of data collection used in this study. First, while survey questionnaires are generally assumed to be a quicker means of data collection than personal interviews, this assumption rests on the premise that respondents will complete and return the questionnaires promptly ... which they seldom do. Furthermore, the expense of compiling, copying and mailing questionnaires can be considerable. Certainly, mailing questionnaires would be less expensive than hiring interviewers, however, in a study of this size the researcher, author, and interviewer are one and the same. Thus, the researcher would have only him/herself to pay. Additionally, not only is the breadth of information gained through personal interviews greater, but specific clarifications can be obtained when answers are ambiguous.

And finally, it is extremely difficult to ensure that the interpretations of questions remain constant among different respondents. For instance, directors and staff members were asked if they had received any "training" in substance use or dual diagnosis substance abuse. However, the word "training" was not specifically operationalized, and individual respondents may have interpreted this word in a variety of different ways. Although advantageous in that it increases the breadth of the information that can be collected, omitting specific operationalizing parameters makes it difficult to make comparisons between different respondents. One staff member commented that he/she had not had any training in either substance abuse or dual diagnosis substance abuse, but had "read up on it" and had "some introduction [to these areas] at university as well." Another respondent who indicated that he/she had received training stated that it was "on the job" training. It is probable that individual respondents'
definitions of "training" were quite varied, and that what one respondent might have included as an example of substance abuse or dual diagnosis substance abuse training, the next respondent may have dismissed as inconsequential. Additionally, the term "boarding home" was used as a "generic" term referring to all residential mental health living facilities used by the Residential Services Division of Greater Vancouver Mental Health Services for client referrals. However, many respondents insisted that clear distinctions existed between "boarding homes," "group homes," and "independent" or "semi-independent" living facilities (although the exact nature of these distinctions varied from one person to the next). It is extremely difficult to obtain a uniform understanding of concepts among different respondents when using survey questionnaires. Thus, making direct comparisons between respondents can be problematic. A good rule of thumb when operationalizing terms, is to assume that if there is the slightest chance that interpretations will vary ... they will. A clear distinction must be made between questions that require a wide breadth of data and those that require the consistency conducive to comparisons between subjects.

A number of points deserve mention regarding the content of the questionnaires, rather than the process of data collection. First, the prevalence of substance abuse during a two week period may not accurately estimate the true extent of substance abuse. Perhaps it would have been more expedient to simply ask respondents if any residents had had substance abuse problems, without reference to any specific temporal parameters. Respondents who did identify cases of substance abuse could be further prompted to provide additional information concerning prevalence, frequency, and temporality. Another problem involved the
question designed to estimate residents' "average length of stay" in boarding homes. The specified categories of *weeks*, *months*, and *years* were not sensitive enough to pick up much variation between facilities; 88% of the facilities had an average length of stay that was measured in years, and none had a length of stay that was measured in weeks. More variation in the data could have been obtained by using categories such as "*months,*" "*one year,*" "*two to five years,*" "*six to ten years,*" and "*more than ten years.*"

Further research is needed to survey persons with psychiatric and substance abuse problems, whose needs are not being met by the mental health boarding home infrastructure. A common assumption is that many people with both psychiatric and substance abuse problems either do not want to live in mental health boarding homes, or are restricted from doing so by boarding home policies. This study suggests that the *latter* of these two assumptions may be true, when the abuse is *current.* Thus, it would logically follow that the *former* assumption may also be true. After all, would you want to live with others who were highly critical of your behavior?

The refusal of persons to use services or receive treatment is often attributed to the individual's "noncompliance," and very seldom is attention paid to the failure of the service provider to comply with the consumer's needs and/or demands. If the existing mental health boarding homes are not meeting the needs and/or demands of people with both psychiatric and substance abuse problems, then what needs to be done? Should we attempt to change the people to fit the service, or the service to fit the people? Are the authoritarian structures of
many of these facilities too restrictive for many people with both psychiatric and substance abuse problems? Is it better to provide housing that emphasizes people's autonomy and independence, even if it means allowing people to make their own mistakes? Should there be increased freedom for persons with psychiatric problems, with or without the addition of substance related problems; freedom of choice ... freedom to be crazy? Should some of the attention currently focused on dual diagnosis substance abuse be shifted to further examine the problems associated with prescription drug use and/or abuse? These and other questions are waiting to be explored. But for now, community mental health boarding homes provide a suitable forum for increasing the quality of service delivery, and the quality of life for substance abusers that do make it into the "system." Drug education programs are an essential step in the struggle to increase awareness of the many complexities of dual diagnosis substance abuse.


APPENDIX 2. INTRODUCTORY LETTER TO DIRECTORS

August, 1989

Mental Health Boarding Home
Dual Diagnosis Project

Dear Boarding Home Director,

I am a Master of Social Work candidate at the University of British Columbia, and as part of my degree requirements I am conducting some research to find out how common drug or alcohol (substance) use is among the residents of mental health boarding homes in Vancouver. A number of studies have shown that many "homeless" people have both psychiatric and substance abuse problems, and hospital admittance records show that many people who enter acute care psychiatric wards in hospitals also have histories of substance use or abuse. However, very little is known about the extent of drug or alcohol use by mental health boarding home residents.

Your knowledge and opinions are very important. Not only do I need your help to establish the extent of substance use or abuse in mental health boarding homes (is it a problem?), but also to determine what, if any thing, should be done about it.

Quite often, people in different positions within the same agency have different opinions about the same thing, and so it would be extremely valuable to me if not only you but also the staff and residents of your boarding home would each agree to complete a questionnaire. In the next week I will phone you to try
APPENDIX 3. INTRODUCTORY LETTER TO STAFF

June, 1989

Mental Health Boarding Home

Dual Diagnosis Project

Dear Staff Member,

I am a Master of Social Work candidate at the University of British Columbia, and as part of my degree requirements, I am conducting some research to find out how common drug or alcohol (substance) use is among the residents of mental health boarding homes in Vancouver. A number of studies have shown that many "homeless" people have both psychiatric and substance abuse problems, and hospital admittance records show that many people who enter acute care psychiatric wards in hospitals also have histories of substance use or abuse. However, very little is known about the extent of drug or alcohol use by mental health boarding home residents.

Your knowledge and opinions are very important. Not only do I need your help to establish the extent of substance use or abuse in mental health boarding homes (is it a problem?), but also to determine what, if any thing, should be done about it.

Participation in this study is entirely voluntary. If you complete the questionnaire I will assume that you have given your consent to participate in this study, and will send a copy of the results to this boarding home in the autumn. It should not take more than 45 minutes to complete this questionnaire, and you can
APPENDIX 5. DIRECTOR PRETEST QUESTIONNAIRE

[FOR DIRECTORS]

DUAL DIAGNOSIS SUBSTANCE ABUSE
IN VANCOUVER'S MENTAL HEALTH BOARDING HOMES:
A NEED ASSESSMENT SURVEY

This questionnaire is designed to find out what the extent of alcohol and drug use is by people who live in mental health boarding homes, and to find out if any difficulties arise from this use. There are no right or wrong answers. Your answers are very important. By answering these questions, you will not only help me fulfill part of my Master of Social Work degree requirements, but will also help me make some program planning recommendations to the Greater Vancouver Mental Health Services and the Vancouver Drug and Alcohol Program.

It will only take about forty-five minutes to fill out this questionnaire. Participation in this study is entirely voluntary, and if you complete this questionnaire I will assume that you have agreed to participate. These questionnaires are coded so that I can tell which boarding home they came from. Do not put your name on the questionnaire if you do not want to be identified. To ensure confidentiality, only I and my U.B.C. thesis advisors will have access to these questionnaires. Please feel free to contact me at 224-4786 if you have any questions.

Timothy J. Hayward, B.S.W., U.B.C. Master of Social Work Candidate

*Please mark an 'X' at the beginning of any questions that you find unclear or confusing. Thank you for your help.

1. What is the date today? ____________________________
   month               day               year

2. How many people are living in the boarding home at this time? ____

3. What is the average age of your residents? ____________________________

4. What number of the residents are:
   ____Male?  ____Female?  (These should equal the number given in question number 2)

5. What is the average length of stay for the residents? (Please fill in the appropriate blanks) ____Days  ____Weeks  ____Months  ____Years
6. Please indicate how many of your boarding home residents have been given the following diagnoses:

   ___ Schizophrenia
   ___ Unipolar Affective Disorder
   ___ Bipolar Affective Disorder
   ___ Personality Disorder
   ___ Organic Disorder
   ___ Other (please specify)

7. What number of the residents are currently taking the following medications?

   ___ None.
   ___ Major tranquilizers.
   ___ Minor tranquilizers.
   ___ Neuroleptics
   ___ Antidepressants.
   ___ Lithium.
   ___ Antiparkinsonians.
   ___ Other (Please specify)

8. As far as you know, how many of the residents living in the home take any of the following drugs the specified number of times?

   For example, if there were 10 residents in the home, and three of them used alcohol once or twice a week, one of them used alcohol once or twice a year, and the remaining 6 of them never used alcohol, it would look like this:

   every day  once or twice a week  once or twice a month  once or twice a year  never  I don't know
   a) Alcohol

   (Please fill in the appropriate numbers)

   every day  once or twice a week  once or twice a month  once or twice a year  never  I don't know
   a) Alcohol
   b) Marijuana
   c) Opiates
   d) PCP/Angel Dust
   e) LSD/Acid
   f) Amphetamines
   g) Barbiturates
   h) Inhalants/Glue
   i) Other

   (If you indicated use of drugs in the "other" category, please indicate what they are)
9. I have heard it said that for some people with psychiatric problems, going out for a drink is actually a positive accomplishment, because "at least they are doing something." What, based on your experience, is your reaction to that statement?


10. Does your boarding home have a policy concerning alcohol or drug use by residents?

   _No_
   _I Don't Know_
   _Yes (what is it?)_


11. What would you do if you discovered one of the residents was drinking alcohol? (Mark as many as apply)
   a) Outside of your boarding home?
      _Nothing, as long as they didn't over do it_
      _Ask them to stop_
      _Refer them to a mental health counsellor_
      _Refer them to a substance abuse counsellor_
      _Refer them to a self-help group like Alcoholics Anonymous_
      _Ask them to move out of the boarding home_
      _Control their money_
      _I don't know_
      _Other (Please specify)_

   b) In your boarding home?
      _Nothing, as long as they didn't over do it_
      _Ask them to stop_
      _Refer them to a mental health counsellor_
      _Refer them to a substance abuse counsellor_
      _Refer them to a self-help group like Alcoholics Anonymous_
      _Ask them to move out of the boarding home_
      _Control their money_
      _I don't know_
      _Other (Please specify)_


12. Have you ever tried to get help for a resident with an alcohol or drug problem?

   _No_
   _Yes a) With whom?_

   b) What was the outcome?
13. How often do you accept applicants with histories of substance abuse into your boarding home? (Check the category that fits best)

- _Never
- _Rarely
- _Sometimes
- _Often

A history of substance abuse does not influence our decision.

14. I have heard it said that for people with psychiatric problems, substance use is the same as substance abuse, because "even small amounts of these substances cause a worsening of psychiatric symptoms." What, based on your experience, is your reaction to that statement?

15. Think for a minute about the past two weeks. To the best of your knowledge, how many times have the individual residents in your boarding home taken illicit "street" drugs or used alcohol? (Please indicate the number of residents who fit in the following categories).

a) Amount of Drug Use During The Past Two Weeks:

- _0 times
- _1 thru 5 times
- _6 thru 10 times
- _don't know
- _11 thru 15 times
- _16 or more times

b) Amount of Alcohol Use During The Past Two Weeks:

- _0 times
- _1 thru 5 times
- _6 thru 10 times
- _don't know
- _11 thru 15 times
- _16 or more times

16. How many residents have had problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (if applicable, would you briefly describe one or two incidents for me?)

a) Number of Residents With Drug Related Problems.

Description.

b) Number of Residents With Alcohol Related Problems.

Description.
17. Are alcoholic beverages allowed at boarding home Christmas parties and/or other special functions? (Check the best answer)
   ___ Yes
   ___ No
   ___ Sometimes

18. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

19. Are there any substance abuse programs operating in your boarding home? (If there are, please specify what they are)
   ___ No I Don't Know ___ Yes (What?)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

20. Would you please answer the following questions about yourself, to help me understand more about the people who work in mental health boarding homes? (Of course, your answers will be kept confidential).
   a) What is your job title? ________________________________

____________________________________________________________________________________

b) What is your gender? ___ Male ___ Female

c) What is your date of birth? ___ Day ___ Month ___ Year

d) What level of education have you completed? ________________________________

____________________________________________________________________________________

e) Have you received any training in the area of substance abuse?
   ___ No ___ Yes (if yes, please specify what this was)

____________________________________________________________________________________

____________________________________________________________________________________

f) Have you received any training in the area of dual diagnosis substance abuse?
   ___ No ___ Yes (if yes, please specify what this was)

____________________________________________________________________________________
21. Various programs have been suggested as responses to dual diagnosis substance abuse. Which of the following services do you think would be useful? (Please rank those programs that you select in their order of importance, with "1" as the most important).

   a) Self-help group like Alcoholics Anonymous
   b) Drug education program
   c) Life skills training
   d) Individual Counselling
   e) Group Counselling
   f) Family Counselling
   g) Job training program
   h) Assistance obtaining independent housing
   i) Recreation programs that are alcohol and drug free
   j) Other (Please specify) _______________________________

22. Which of the above programs do you think should be offered within the boarding home? (check the appropriate categories)

   a) b) c) d) e) f) g) h) none

23. Would you like to be offered a workshop on dual diagnosis substance abuse? (Select only one answer)

   _____ Yes (Why?) _______________________________
   _____ No (Why?) _______________________________
   _____ Maybe (Why?) _______________________________

24. If a workshop or staff training session on dual diagnosis substance abuse were available, what would you like it to include?

   _______________________________
   _______________________________
   _______________________________
   _______________________________
25. Please use this space (and the other side of this page) to include any additional comments you would like to make. 

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
2. As far as you know, how many of the residents living in the home take any of the following drugs the specified number of times?

For example, if there were 10 residents in the home, and three of them used alcohol once or twice a week, one of them used alcohol once or twice a year, and the remaining 6 of them never used alcohol, it would look like this:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Every Day</th>
<th>Once or Twice a Week</th>
<th>Once or Twice a Month</th>
<th>Once or Twice a Year</th>
<th>Never</th>
<th>I Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Alcohol</td>
<td>___</td>
<td>3</td>
<td>___</td>
<td>___</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

(Please fill in the appropriate numbers)

a) Alcohol
b) Marijuana
c) Opiates
d) PCP/Angel Dust
e) LSD/Acid
f) Amphetamines
g) Barbiturates
h) Inhalants/Glue
i) Other

(If you indicated use of drugs in the "other" category, please indicate what they are):

________________________________________________________________________

________________________________________________________________________

3. I have heard it said that for some people with psychiatric problems, going out for a drink is actually a positive accomplishment, because "at least they are doing something." What, based on your experience, is your reaction to that statement?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. Does the boarding home have a policy concerning alcohol or drug use by residents?

___ No
___ I Don't Know
___ Yes (what is it?)

________________________________________________________________________
5. Are alcoholic beverages allowed at boarding home Christmas parties and/or other special functions? (Check the best answer)
   ___Yes
   ___No
   ___Sometimes

6. What would you do if you discovered one of the residents was drinking alcohol? (Mark as many as apply)
   a) Outside of your boarding home?
      ___Nothing, as long as they didn't over do it
      ___Ask them to stop
      ___Refer them to a mental health counsellor
      ___Refer them to a substance abuse counsellor
      ___Refer them to a self-help group like Alcoholics Anonymous
      ___Ask them to move out of the boarding home
      ___Control their money
      ___I don't know
      ___Other (Please specify) ________________________________

   b) In your boarding home?
      ___Nothing, as long as they didn't over do it
      ___Ask them to stop
      ___Refer them to a mental health counsellor
      ___Refer them to a substance abuse counsellor
      ___Refer them to a self-help group like Alcoholics Anonymous
      ___Ask them to move out of the boarding home
      ___Control their money
      ___I don't know
      ___Other (Please specify) ________________________________

7. Have you ever tried to get help for a resident with an alcohol or drug problem?
   ___No
   ___Yes  a) With whom? ______________________________________
           ______________________________________
           ______________________________________
           ______________________________________
   b) What was the outcome? ____________________________________

8. I have heard it said that for people with psychiatric problems, substance use is the same as substance abuse, because "even small amounts of these substances cause a worsening of psychiatric symptoms." What, based on your experience, is your reaction to that statement? ______________________________________
    ______________________________________
    ______________________________________
9. Think for a minute about the past two weeks. To the best of your knowledge, how many times have the individual residents in your boarding home taken illicit "street" drugs or used alcohol? (Please indicate the number of residents who fit in the following categories).

   a) Amount of Drug Use During The Past Two Weeks:
   ______0 times ______1 thru 5 times ______6 thru 10 times
   ______don't know ______11 thru 15 times ______16 or more times

   b) Amount of Alcohol Use During The Past Two Weeks:
   ______0 times ______1 thru 5 times ______6 thru 10 times
   ______don't know ______11 thru 15 times ______16 or more times

10. How many residents have had problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (If applicable, would you briefly describe one or two incidents for me?)

   a) Number With Drug Related Problems. ________
   Description. __________________________________________
   ______________________________________________________

   b) Number With Alcohol Related Problems. ________
   Description. __________________________________________
   ______________________________________________________

11. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

12. Are there any substance abuse programs operating in your boarding home? (If there are, please specify what they are)
   _______No _______I Don't Know _______Yes (What?) __________
   ______________________________________________________
   ______________________________________________________
13. Would you please answer the following questions about yourself, to help me understand more about the people who work in mental health boarding homes? (Of course, your answers will be kept confidential).
   a) What is your job title?
   
   ________________________________
   
   b) What is your gender?  ______Male  ______Female
   
   c) What is your date of birth?  ____Day  ____Month  ____Year
   
   d) What level of education have you completed?
   
   ________________________________
   
   e) Have you received any training in the area of substance abuse?  
   ____No  ____Yes (if yes, please specify what this was)
   
   ________________________________
   
   f) Have you received any training in the area of dual diagnosis substance abuse?  
   ____No  ____Yes (if yes, please specify what this was)
   
   ________________________________

14. Various programs have been suggested as responses to dual diagnosis substance abuse. Which of the following services do you think would be useful? (Please rank those programs that you select in their order of importance, with "1" as the most important).

   a)  _____Self-help group like Alcoholics Anonymous
   b)  _____Drug education program
   c)  _____Life skills training
   d)  _____Individual Counselling
   e)  _____Group Counselling
   f)  _____Family Counselling
   g)  _____Job training program
   h)  _____Assistance obtaining independent housing
   i)  _____Recreation programs that are alcohol and drug free
   j)  _____Other (Please specify)
   
   ________________________________

15. Which of the above programs do you think should be offered within the boarding home? (check the appropriate categories)

   a)  _____  b)  _____  c)  _____  d)  _____  e)  _____
   f)  _____  g)  _____  h)  _____  none_____
16. Would you like to be offered a workshop on dual diagnosis substance abuse? (Select only one answer)

Yes (Why?)

No (Why?)

Maybe (Why?)

17. If a workshop or staff training session on dual diagnosis substance abuse were available, what would you like it to include?

18. Please use this space to include any additional comments you would like to make.

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
2. How long have you lived in this boarding home? (Please fill in the appropriate numbers as close as you can remember)
   _____ Days
   _____ Weeks
   _____ Months
   _____ Years

3. How much longer do you plan to live in this boarding home?
   _____ Days
   _____ Weeks
   _____ Months
   _____ Years

4. I have heard it said that for people with psychiatric problems, substance use is the same as substance abuse, because "even small amounts of these substances cause a worsening of psychiatric symptoms." What, based on your experience, is your reaction to that statement?

5. Please indicate what psychiatric diagnosis you have been given. (Check the appropriate category below)
   _____ Schizophrenia
   _____ Unipolar Affective Disorder
   _____ Bipolar Affective Disorder
   _____ Personality Disorder
   _____ Organic Disorder
   _____ I Don't Know
   _____ Other (please specify what)

6. Do you agree with the above diagnosis?
   _____ Yes
   _____ No
   _____ I Don't Know

7. Are you currently taking any of the following medications?
   _____ None.
   _____ Major tranquilizers.
   _____ Minor tranquilizers.
   _____ Neuroleptics
   _____ Antidepressants.
   _____ Lithium.
   _____ Antiparkinsonians.
   _____ I Don't Know What Medication I Am Taking
   _____ Other(s) (Please specify)
8. How often do you take any of the following drugs: (Please check the appropriate categories)

<table>
<thead>
<tr>
<th></th>
<th>every day</th>
<th>once or twice a week</th>
<th>once or twice a month</th>
<th>once or twice a year</th>
<th>never</th>
<th>I don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Alcohol</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) Marijuana</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) Opiates</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) PCP/Angel Dust</td>
<td></td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>e) LSD/Acid</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>f) Amphetamines</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>g) Barbiturates</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>h) Inhalants/Glue</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>i) Other</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

(If you take drugs in the "other" category, please specify what they are)

9. How many of the people living in your boarding home have had problems with their health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (if applicable, would you briefly describe one or two examples for me?)

a) Number With Drug Related Problems.

Description of Problems.

b) Number With Alcohol Related Problems.

Description of Problems.

10. Have you had any problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (If you have, will you please give me one or two examples?)

a) drugs

___ No ___ Yes Example(s)

b) alcohol

___ No ___ Yes Example(s)

11. Have you ever received treatment for drinking or drug use?

___ No

___ Yes (Where?)
12. Have you ever tried to get help for an alcohol or drug problem?
   ____ No   ____ Yes

13. If you answered 'No' to the above question, then skip this question and go to question 14. If you answered 'Yes,' then who did you try to get help from?
   ____ A Friend
   ____ A Family Member
   ____ A Boarding Home Staff Member
   ____ A Counsellor
   ____ A Doctor
   ____ I Don't Remember
   ____ Other (Please specify what their relationship was to you)

14. Have you ever been told that you have an alcohol or drug problem?
   ____ No
   ____ Yes (By Who?)  ____ A Friend
                      ____ A Family Member
                      ____ A Counsellor
                      ____ A Doctor
                      ____ A Police Officer
                      ____ Other (What was their relationship to you?)

15. Are alcoholic beverages allowed at boarding home Christmas parties and/or other special functions?
   ____ Yes   ____ No   ____ Sometimes   ____ I don't know

16. Are there any substance abuse programs operating in your boarding home? (If there are, please specify what they are)
   ____ No   ____ I Don't Know   ____ Yes (What?)

17. Does the boarding home have a policy concerning alcohol or drug use by residents?
   ____ No
   ____ I Don't Know
   ____ Yes (What is it?)
18. What do you think the boarding home staff would do if they found out that you were drinking alcohol: (Mark as many categories as apply)
   a) Outside of the boarding home?
      ______ Nothing, as long as I didn't over do it
      ______ Ask me to stop
      ______ Refer me to a mental health counsellor
      ______ Refer me to a substance abuse counsellor
      ______ Refer me to a self-help group like Alcoholics Anonymous
      ______ Ask me to leave the boarding home
      ______ Control my money
      ______ I don't know
      ______ Other (Please specify) ____________________________

   b) In the boarding home?
      ______ Nothing, as long as I didn't over do it
      ______ Ask me to stop
      ______ Refer me to a mental health counsellor
      ______ Refer me to a substance abuse counsellor
      ______ Refer me to a self-help group like Alcoholics Anonymous
      ______ Ask me to leave your boarding home
      ______ Control my money
      ______ I don't know
      ______ Other (Please specify) ____________________________

19. Would you please answer the following questions about yourself, to help me understand more about the people who live in mental health boarding homes? (Of course, your answers will be kept confidential).
   a) Do you have a job at this time?
      ______ No  ______ Yes (Please indicate what it is) ______________

   b) Are you: ______ Male, or ______ Female

   c) What is your date of birth? ______Day ______Month ______Year

   d) What level of education have you completed? ________________________

   f) What is your ethnic background_____________________________
20. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

21. Various programs have been suggested as responses to dual diagnosis substance abuse. Which of the following services do you think would be useful? (Please rank those programs that you select in their order of importance, with "1" as the most important).

   a) Self-help group (like Alcoholics Anonymous)
   b) Drug education
   c) Life skills training
   d) Individual Counselling
   e) Group Counselling
   f) Family Counselling
   g) Job training
   h) Assistance obtaining independent housing
   i) Recreation programs that are alcohol and drug free
   j) Other (Please specify)

________________________________________________________________________

22. Do you attend any of the above listed programs? (If yes, please specify what)  
   ____No
   ____Yes (What?)

________________________________________________________________________

23. Would you attend any of the above mentioned programs if they were offered to you? (If yes, please specify what) 
   ____No
   ____Maybe
   ____Yes (What?)

________________________________________________________________________

24. Which of the above programs do you think should be offered within the boarding home? (check the appropriate categories)

   a) b) c) d) e)
   f) g) h) none
25. Please use this space to include any additional comments you would like to make.


THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
5. Please indicate how many of your boarding home residents have been given the following diagnoses:

- Schizophrenia
- Manic Depression
- Depression
- Personality Disorder
- Organic Disorder
- Diagnoses are not seen as relevant
- Other (please specify)

6. What number of the residents are currently taking the following medications?

- Tranquilizers
- Neuroleptics
- Antidepressants
- Lithium
- Antiparkinsonians
- None
- Other (Please specify:

7. Please indicate if any of the residents use any of the following drugs: (If they do, please indicate how many people fit into each of the specified categories:)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Everyday</th>
<th>Once or Twice a Week</th>
<th>Once or Twice a Month</th>
<th>Once or Twice a Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiates</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP/Angel Dust</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LSD/acid</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants/Glue</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

> (If you indicated use of drugs in the "other" category, please indicate what they are:

8. I have heard it said that for some people with psychiatric problems, going out for a drink of alcohol is actually a positive accomplishment, because "at least they are doing something." What, based on your experience, is your reaction to that statement?
9. Does your boarding home have a policy concerning alcohol or drug use by residents?
   - No
   - I Don't Know
   - Yes (what is it?)

10. What would you do if you discovered one of the residents was drinking alcohol: (Mark as many as apply)
    a) Outside of your boarding home?
       - Nothing, as long as they didn't over do it
       - Ask them to stop
       - Refer them to a mental health counsellor
       - Refer them to a substance abuse counsellor
       - Refer them to a self-help group like Alcoholics Anonymous
       - Ask them to move out of the boarding home
       - Control their money
       - I don't know
       - Other (Please specify)

    b) In your boarding home?
       - Nothing, as long as they didn't over do it
       - Ask them to stop
       - Refer them to a mental health counsellor
       - Refer them to a substance abuse counsellor
       - Refer them to a self-help group like Alcoholics Anonymous
       - Ask them to move out of the boarding home
       - Control their money
       - I don't know
       - Other (Please specify)

11. Have you ever tried to get help for a resident with an alcohol or drug problem?
    - No
    - Yes -> a) With whom?

    b) What was the outcome?

12. How often do you accept applicants with histories of substance abuse into your boarding home? (Check the category that fits best)
    - Never
    - Rarely
    - Sometimes
    - Often
    - A history of substance abuse does not influence our decision
13. I have heard it said that for people with psychiatric problems, substance use is the same as substance abuse, because "even small amounts of these substances cause a worsening of psychiatric symptoms." What, based on your experience, is your reaction to that statement?

14. Think for a minute about the past two weeks. During that time, how many residents have taken illicit "street" drugs or used alcohol the following number of times? (Please indicate the number of residents who fit in the following categories:)

<table>
<thead>
<tr>
<th>USED ALCOHOL</th>
<th>USED &quot;STREET&quot; DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 times</td>
<td></td>
</tr>
<tr>
<td>1 thru 5 times</td>
<td></td>
</tr>
<tr>
<td>6 thru 10 times</td>
<td></td>
</tr>
<tr>
<td>11 thru 15 times</td>
<td></td>
</tr>
<tr>
<td>16 or more times</td>
<td></td>
</tr>
<tr>
<td>I don't know</td>
<td></td>
</tr>
</tbody>
</table>

15. Have any of the residents had problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (If they have, please indicate how many people, and give a brief description of the problems:)

a) Alcohol Related Problems:
   No
   Yes—> (How many people?____) 
   —> (Description:________________________)  

b) Drug Related Problems:
   No
   Yes—> (How many people?____) 
   —> (Description:________________________) 

16. Are alcoholic beverages allowed at boarding home Christmas parties and/or other special functions? (Check the best answer)
   Yes
   No
   Sometimes
17. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

18. Are there any substance abuse programs operating in your boarding home? (If there are, please specify what they are)
No__
I Don't Know__
Yes__ -> (What? __________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

19. Would you please answer the following questions about yourself, to help me understand more about the people who work in mental health boarding homes? (Of course, your answers will be kept confidential).

a) What is your sex? Male ___ Female ___

b) What is your age? (Please mark the appropriate category)
   30 or less___ 31-49___ 50-64___ 65 or more___

c) Do you have a college diploma or university degree, or several years of work experience relevant to your present job?
No__
Yes__ -> (If you do, please specify what:)_college ______university ______work

d) Have you received any training in the area of substance abuse?
No__ -> (if you have, please specify what this was:________
____________________________________)
Yes__

e) Have you received any training in the area of dual diagnosis substance abuse?
No__
Yes__ -> (if you have, please specify what this was:________
____________________________________)
20. Various programs have been suggested as responses to dual diagnosis substance abuse. Which of the following services do you think would be useful?

a) _____ Self-help group like Alcoholics Anonymous
b) _____ Drug education program
c) _____ Life skills training
d) _____ Individual Counselling
e) _____ Group Counselling
f) _____ Family Counselling
g) _____ Job training program
h) _____ Assistance obtaining independent housing
i) _____ Recreation programs that are alcohol and drug free
j) _____ Other (Please specify)

21. Which of the above programs do you think should be offered within the boarding home? (check the appropriate categories)

a) _____ b) _____ c) _____ d) _____ e) _____
f) _____ g) _____ h) _____ i) _____ j) _____

22. Would you like to be offered a workshop on dual diagnosis substance abuse? (Select only one answer)

_____ Yes (Please feel free to comment here: _____)
_____ No
_____ Maybe (Please feel free to comment here: _____)

23. If a workshop or staff training session on dual diagnosis substance abuse were available, what would you like it to include?

24. Please use this space to include any additional comments you would like to make.

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
2. Please indicate if any of the residents use any of the following drugs: (If they do, please indicate how many people fit into each of the specified categories:)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>No</td>
<td>2 times a week</td>
</tr>
<tr>
<td>Marijuana</td>
<td>No</td>
<td>2 times a month</td>
</tr>
<tr>
<td>Opiates</td>
<td>No</td>
<td>2 times a year</td>
</tr>
<tr>
<td>PCP/Angel Dust</td>
<td>No</td>
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</tr>
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<td>LSD/Acid</td>
<td>No</td>
<td>2 times a year</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>No</td>
<td>2 times a year</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>No</td>
<td>2 times a year</td>
</tr>
<tr>
<td>Inhalants/Glue</td>
<td>No</td>
<td>2 times a year</td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td>2 times a year</td>
</tr>
</tbody>
</table>

(If you indicated use of drugs in the "other" category, please indicate what they are: ________________________________)

3. Does the boarding home have a policy concerning alcohol or drug use by residents?
   - No
   - I Don't Know
   - Yes -> (What is it? ________________________________)

4. What would you do if you discovered one of the residents was drinking alcohol: (Mark as many as apply)

   a) Outside of your boarding home?
      - Nothing, as long as they didn't over do it
      - Ask them to stop
      - Refer them to a mental health counsellor
      - Refer them to a substance abuse counsellor
      - Refer them to a self-help group like Alcoholics Anonymous
      - Ask them to move out of the boarding home
      - Control their money
      - I don't know
      - Other (Please specify) ________________________________

   b) In your boarding home?
      - Nothing, as long as they didn't over do it
      - Ask them to stop
      - Refer them to a mental health counsellor
      - Refer them to a substance abuse counsellor
      - Refer them to a self-help group like Alcoholics Anonymous
      - Ask them to move out of the boarding home
      - Control their money
      - I don't know
      - Other (Please specify) ________________________________
5. Are alcoholic beverages allowed at boarding home Christmas parties and/or other special functions? (Check the best answer)
   ___ Yes
   ___ No
   ___ Sometimes

6. Have you ever tried to get help for a resident with an alcohol or drug problem?
   ___ No
   ___ Yes -> a) With whom?

   ____________________________________________________________

   ___ b) What was the outcome?

   ____________________________________________________________

7. I have heard it said that for people with psychiatric problems, substance use is the same as substance abuse, because "even small amounts of these substances cause a worsening of psychiatric symptoms." What, based on your experience, is your reaction to that statement?

   ____________________________________________________________

8. Think for a minute about the past two weeks. During that time, how many residents have taken illicit "street" drugs or used alcohol the following number of times? (Please indicate the number of residents who fit in the following categories).

<table>
<thead>
<tr>
<th>USED ALCOHOL, USED &quot;STREET&quot; DRUGS</th>
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<tr>
<td>16 or more times</td>
</tr>
<tr>
<td>I don't know</td>
</tr>
</tbody>
</table>

9. Have any of the residents had problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (If they have, please indicate how many people, and give a brief description of the problems:)

   a) Alcohol Related Problems:
      No ___
      Yes ___ -> (How many people? ____)

      ___ -> (Description: ____________________________)

   b) Drug Related Problems:
      No ___
      Yes ___ -> (How many people? ____)

      ___ -> (Description: ____________________________)
10. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

11. Are there any substance abuse programs operating in your boarding home? (If there are, please specify what they are)

   No
   I Don't Know
   Yes -> (What?

________________________________________________________________________

________________________________________________________________________

12. Would you please answer the following questions about yourself, to help me understand more about the people who work in mental health boarding homes? (Of course, your answers will be kept confidential).

   a) What is your sex?    Male    Female

   b) What is your age? (Please mark the appropriate category)

       30 or less  31-49  50-64  65 or more

   c) Do you have a college diploma or university degree, or several years of work experience relevant to your present job?

       No
       Yes -> (If you do, please specify what:)

       college
       university
       work

   d) Have you received any training in the area of substance abuse?

       No
       Yes -> (if you have, please specify what this was:)

________________________________________________________________________

   e) Have you received any training in the area of dual diagnosis substance abuse?

       No
       Yes -> (if you have, please specify what this was:)

________________________________________________________________________
13. Various programs have been suggested as responses to dual diagnosis substance abuse. Which of the following services do you think would be useful?

   a)____ Self-help group like Alcoholics Anonymous
   b)____ Drug education program
   c)____ Life skills training
   d)____ Individual Counselling
   e)____ Group Counselling
   f)____ Family Counselling
   g)____ Job training program
   h)____ Assistance obtaining independent housing
   i)____ Recreation programs that are alcohol and drug free
   j)____ Other (Please specify: ____________________________)

14. Which of the above programs do you think should be offered within the boarding home? (check the appropriate categories)

   a)____ b)____ c)____ d)____ e)____
   f)____ g)____ h)____ i)____ j)____

15. Would you like to be offered a workshop on dual diagnosis substance abuse? (Select only one answer)

   ____ Yes (Please feel free to comment here: ______)
   ____ No
   ____ Maybe (______________________________)

16. If a workshop or staff training session on dual diagnosis substance abuse were available, what would you like it to include?

   ____________________________
   ____________________________
   ____________________________
   ____________________________

17. Please use this space to include any additional comments you would like to make.

   ____________________________
   ____________________________
   ____________________________
   ____________________________

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
2. How long have you lived in this boarding home? (Please check the appropriate category)  
   Weeks____
   Months____
   Years____
   I Don't Know____

3. Do you think that even small amounts of alcohol or "street" drugs cause problems for people with psychiatric problems, because it makes their psychiatric problems get worse?

   Yes____  (Please feel free to comment here:_______)
   No____
   Sometimes____
   I Don't Know____

4. Do you take any medications? (please check the appropriate category)

   No____
   I Don't Know____
   Yes____ —> (If you know what medications you take, please indicate what they are:________________________)

5. Do you take any of the following drugs? (If you do, please indicate how often)

   a) Alcohol  No____ Yes____ —> (every day  once or twice a week  once or twice a month  once or twice a year)
   b) Marijuana  No____ Yes____ —> (________________________)
   c) Opiates  No____ Yes____ —> (________________________)
   d) PCP/Angel Dust  No____ Yes____ —> (________________________)
   e) LSD/acid  No____ Yes____ —> (________________________)
   f) Amphetamines  No____ Yes____ —> (________________________)
   g) Barbiturates  No____ Yes____ —> (________________________)
   h) Inhalants/Glue  No____ Yes____ —> (________________________)
   i) Other  No____ Yes____ —> (________________________)

   —> (If you take drugs in the "other" category, please indicate what they are:________________________)

6. Do you know of anybody in your boarding home who has had problems with their health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks?

   No____ —> (How many people?________________________)
   Yes____ —> (____________________)
7. Have you had any problems related to health, behavior, family, work, or the law due to drug or alcohol use during the past two weeks? (If you have, will you please give me one or two examples?)
   No
   Yes  --> (What kind of problems?)

8. Have you ever received treatment for drinking or drug use?
   No
   Yes  --> (Where?)

9. Have you ever tried to get help for an alcohol or drug problem?
   No
   Yes  --> (If you have tried to get help, please indicate who it was from:)
   ___ A Friend
   ___ A Family Member
   ___ A Boarding Home Staff Member
   ___ A Counsellor
   ___ A Doctor
   ___ I Don't Remember
   ___ Other  --> (What was their relationship to you?)

10. Have you ever been told that you have an alcohol or drug problem?
    No
    Yes  --> (If you have been told you have a problem, please indicate who said so:)
    ___ A Friend
    ___ A Family Member
    ___ A Boarding Home Staff Member
    ___ A Counsellor
    ___ A Doctor
    ___ A Police Officer
    ___ Other  --> (What was their relationship to you?)

11. What do you think the boarding home staff would do if they found out that you were drinking alcohol? (Mark as many categories as apply:)
    ___ Nothing, as long as I didn't over do it
    ___ Ask me to stop
    ___ Ask me to see a counsellor
    ___ Refer me to Alcoholics Anonymous
    ___ Ask me to leave the boarding home
    ___ Control my money
    ___ I don't know
    ___ Other (Please specify)
12. Would you please answer the following questions about yourself, to help me understand more about the people who live in mental health boarding homes? (Of course, your answers will be kept confidential).

a) Do you have a job at this time? No___ Yes___
b) Are you: Male___, or Female___
c) What is your age? (Please mark the appropriate category)
   30 or less___ 31-49___ 50-64___ 65 or more___
d) How many years of school have you completed?
   ___None
   ___Some Elementary School
   ___Graduated from Elementary School
   ___Some Secondary School
   ___Graduated from Secondary School
   ___Some College, Trade School, or University
   ___Graduated from College, Trade School, or University

13. Do you think that any of the programs listed below would be useful to help people who have both psychiatric and drug or alcohol problems? (Please put a check mark in front of any programs that you think would be useful:)

a) ___ Self-help group (like Alcoholics Anonymous)
b) ___ Drug education
c) ___ Life skills training
d) ___ Individual Counselling
e) ___ Group Counselling
f) ___ Family Counselling
g) ___ Job training
h) ___ Assistance obtaining independent housing
i) ___ Recreation programs that are alcohol and drug free
j) ___ Other -> (Please specify:

14. Do you attend any of the programs listed above? (If you do, please specify what) No___
   Yes___ -> (What?

15. Would you attend any of the programs mentioned above if they were offered to you? (If you would, please specify what:)
   No___
   Maybe___ -> (What?
   Yes___ ->
16. What, if any, services do you think should be offered to help reduce the drug or alcohol related problems of mental health boarding home residents?


17. Please use this space to include any additional comments you would like to make.


THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.