

## Substance Use and Mental Disorder Diagnostic Profiles in a Sample of Long-Term Self-Help Agency Users

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This study examined the prevalence of substance use and mental disorder profiles in a sample of mental health self-help attendees. Findings demonstrate that the rates of these disorders are equivalent to or exceed those found in clinical and community samples. Implications for the role that self-help agencies play in the lives of vulnerable individuals, as well as the justification for increased funding from drug and alcohol treatment sources, are discussed.

A considerable body of literature now exists documenting the prevalence of co-occurring substance use and mental health disorders across a variety of settings (Bebout, Drake, Xie, McHugo, & Harris, 1997; Havassy, Shopshire, & Quigley, 2000; Herman, Galanter, & Lifshutz, 1991; Kingree, Stephens, Braithwaite, & Griffin, 1999; Laudet, Magura, Vogel, & Knight, 2000; Leal, Galanter, Dermatis, & Westreich, 1999). One of the first examples of this descriptive trend was the Epidemiological Catchment Area Study (ECA). Initiated to assess the rates of psychiatric disorders in community and institutionalized samples, the ECA found that 22.3% of those with a lifetime mental disorder diagnosis had a lifetime history of alcohol abuse-dependence, whereas 15.0% reported a lifetime comorbid drug abuse-dependence disorder. The rates of co-occurrence/comorbidity or dual diagnosis rise considerably when viewed from the base rates of substance use. Thirty-seven percent of those with a lifetime diagnosis of alcohol abuse-dependence have a co-occurring mental disorder, whereas 53.1% of individuals with a lifetime drug disorder report a comorbid mental disorder. The rates are even higher among the institutionalized ECA sample, similar to the prevalence of substance use and dual

disorders that is found in samples of homeless and unstably housed adults (Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Regier et al., 1990).

Those studies that have followed in the wake of the ECA have examined the prevalence of substance use and dual disorders in such diverse sites as homeless shelters, inpatient psychiatric units, residential and outpatient substance abuse treatment programs, and outpatient mental health settings. One setting, however, in which the incidence of substance use and dual disorders has not been mapped is the mental health self-help agency (SHA). To some extent, the reason for the lack of mapping of the prevalence of these conditions in the SHA is bound up with the antipsychiatry/strengths ideology of the organizations. SHAs attempt to avoid labeling people and creating self-fulfilling prophecies regarding potential outcomes. The downside of this phenomenon is that SHAs, in competing for resources, often have difficulty demonstrating that they are serving equivalently disabled populations.

Typically, when researchers or clinicians discuss self-help in the context of recovery from a chemical addiction, they are referring to 12-step groups such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). However, the paradigm of self-help, although it does not yet have the longevity that it has in the field of addiction and addiction treatment, has been firmly established in the mental health community as well. SHAs are the direct legacy of the self-help movement, which developed out of the ferment of the civil rights movements, the forces of deinstitutionalization, and the challenges that were being mounted, both from within and from without, against the authority of the psychiatric establishment. Self-help activists characterized traditional mental health treatment as, at its most benign, an undermining of individuals' sense of agency and, at its

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most pernicious, an insidious means of social control (Segal, Silverman, & Temkin, 1990). Thus, SHAs are based on the premise that individuals are most helped by mutual support from others who are coping with a mental illness rather than through the hierarchical relationships found in mainstream treatment settings.

SHAs characteristically provide free access to such services as food, shelter, and clothing referrals; assistance in locating housing; access to benefits and other sources of income and job training; peer counseling and support; independent living skills training; and a place to socialize and meet people. SHAs are administered and staffed by members—individuals who themselves are living with a mental illness and thus have shared many of the life experiences of the users of SHA services. Although professionals may participate in these organizations, they do so at the discretion of the SHA member group. SHA members set their treatment plan by prioritizing which services of the SHA they elect to use.

An important element of the SHA is its role as a drop-in facility, a place where individuals may come to meet others, have a cup of coffee, and relax. For individuals who are marginally housed, such a facility may play a critical part in helping them maintain a sense of coherence and purpose in their daily life.

SHAs attract a population whose demographics resemble those of individuals found in community mental health and substance abuse treatment settings (Segal, Gomory, & Silverman, 1998; Segal, Silverman, & Temkin, 1990, 1997). Yet SHAs remain unacknowledged by the public mental health sector as a legitimate community resource for adults disabled by mental illness or substance use disorders as well as a host of additional economic and social liabilities. A closer look at the prevalence of such diagnostic profiles among a sample of SHA users provides an opportunity to examine the valuable role that such a site may play in the lives of similarly challenged and vulnerable adults. In this article, we seek to achieve cross-context comparisons between SHAs and other clinical and community settings, without the assumption of underlying psychological disorders. Thus, we report our results, consistent with SHA ideology, as behavioral diagnostic profiles of the members of these organizations.

## Method

This study is part of an overall investigation of the characteristics of mental health SHA users. Previous research has focused on patterns of SHA utilization, health status,

psychological disability, and level of social support (Segal et al., 1990, 1997, 1998).

## Participants

Participants were long-term adult users of four client-run mental health SHAs in the San Francisco Bay Area. SHA users were eligible for participation if they had attended the SHA at least 12 times over a period of 3 months or more. A cross-section of staff and volunteers who also utilized SHA services were included in the study sample. Informed consent was obtained from all study participants. Overall, 96.0% ( $N = 310$ ) of the individuals approached agreed to participate in the study.

## Study Sites

Each of the four SHAs is a multiservice agency offering a variety of resources along the lines of the SHA model articulated above. Each study site includes a drop-in component as part of its programs. Several of the sites also host 12-step meetings on their premises.

The demographics of the individuals attending each site reflect the population characteristics of the area of the participating site. Three of the SHAs are in densely populated, low-income, ethnically diverse areas where the housing stock includes a larger than average proportion of single residence occupied hotel rooms. The fourth is located in a gentrifying residential area of single-family homes and duplexes. Many of the SHA users in the study currently live or have lived in the areas where the agencies they frequent are located.

## Data Collection

Interviewers trained by the Center for Self-Help Research collected data. Interviewers included both mental health consumers and formally trained professionals knowledgeable about SHA culture and practice. Baseline data were obtained from 310 SHA users, 81.0% of whom completed a follow-up interview 6 months later.

## Measures

Lifetime substance use disorder and mental illness profiles were measured at baseline using the Diagnostic Interview Schedule (DIS), which is based on the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*: American Psychiatric Association, 1987) criteria (Robins, Helzer, Cottler, & Goldring, 1988). This standardized clinical instrument has been used to diagnostically assess other samples of homeless and marginally housed adults (North & Smith, 1994). Participants were determined to have a lifetime alcohol and/or drug diagnosis of abuse or dependence if they reported a sufficient number of symptoms throughout their life. Drug use was assessed

across eight classes of drugs, including cannabis, stimulants, cocaine, sedatives, opiates, phencyclidine (i.e., PCP), hallucinogens, and inhalants. Heroin-related symptoms were measured separately from other opiates; however, crack-related symptoms were not differentiated from cocaine-use symptoms.

A current substance use disorder profile was considered to be present if participants had a lifetime disorder and also reported a symptom of abuse or dependence in the past year. In addition to data on alcohol use disorder profiles, we report lifetime and current disorder data across four classes of drugs—cannabis, stimulants, heroin, and cocaine. Data on the remaining classes of drugs composed less than 15.0% of the entire sample and therefore are not reported.

Participants with a substance use disorder profile were classified in the following way. Those with a lifetime comorbid *DSM-III-R* psychiatric diagnosis profile were placed in the dual diagnosis group, whereas those with an alcohol and/or drug use disorder only profile were placed in the substance use disorder group. Because we were particularly interested in comparing participants with a dual disorder profile with all other participants, we created a third contrast group of participants with a psychiatric diagnosis only. Finally, a small proportion of individuals did not meet *DSM-III-R* criteria for a diagnosis. Although this group was too small to make comparisons with the other groups, these participants experienced some clinical symptoms as well as other disabilities associated with poverty and homelessness.

A self-help protocol was developed for the larger study that assessed demographic variables such as gender, ethnicity, education, and housing status. Other measures included in the protocol were those designed to assess more abstract constructs, such as different types of empowerment, quality of life, and satisfaction with the various domains of one's life, including housing, income, social support, and SHA services received. Several scales measuring a variety of psychological syndromes were also included. Scales relevant to this article include the Center for Epidemiological Studies Depression (CES-D) Scale (Radloff, 1977), the Rosenberg Self-Esteem Scale (Rosenberg, 1962), the Novaco Anger Scale (Jones, Thomas-Peter, & Trout, 1999), and the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962). The CES-D assesses for cognitive, emotional, and vegetative symptoms of depression, whereas the BPRS measures the acuity of current psychiatric symptoms. The subscale of the Novaco Anger Scale measuring impulsive reaction was used for this study. Finally, the Rosenberg Self-Esteem Scale, which measures self-concept, competency, and satisfaction with self, was included in the study protocol. The self-help instrument was administered at baseline and follow-up.

## Analyses

Chi-square tests were performed in analyses comparing categorical variables. One-way analyses of variance were

used to examine the difference in means on continuous variables.

## Results

### *Demographics, Housing Characteristics, and Diagnostic Profiles*

Table 1 reports the demographic characteristics of the overall study sample. The modal participant in this sample was a single, African American man between the ages of 30 and 39 who had obtained a high school education, currently received some type of government supported income, and was likely to have had an intimate partner at some point in his life. Gender was the only demographic variable that differed significantly across our three major diagnostic groupings, with women ( $n = 88$ , 28.0%) more likely to be in the psychiatric diagnosis only group,  $\chi^2(1, N = 310) = 6.13, p = .013$ . Additionally, women were more likely to present with no lifetime or current *DSM-III-R* diagnosis,  $\chi^2(3, N = 277) = 10.31, p = .016$ .

Although the groups did not differ in the numbers of homeless among them (45.8% of the study sample), dually diagnosed participants displayed the most current housing stability. Of those participants who reported being able to remain for 2 months or less in their current housing arrangement, dually diagnosed participants were significantly more likely to know where they were going to live at the end of that 2-month period,  $\chi^2(2, N = 63) = 7.48, p = .024$ .

### *Using the SHA and Diagnostic Profiles*

The various pathways by which participants came to the SHA provide another perspective on the level of functioning of this study sample. More than two thirds (67.7%) of respondents stated that they had first heard about the agency either by word of mouth, from a friend or relative, or by walking by the agency itself. Only 16.5% identified having received a formal referral from a social services or mental health provider. The mean number of days per week that participants reported attending the agency was 4.10 ( $\pm 1.47$ ).

Overall, respondents endorsed coming to the agency to help fulfill very concrete needs. Sixty percent of the study sample identified the agency's resources, such as housing and counseling, as the most important reason for coming to the SHA. Out of this proportion, only 3.5% prioritized obtaining help in addressing their substance use issues, whereas 9.8% came to the SHA seeking mental health coun-

Table 1  
*Demographic Characteristics of Long-Term Users of Four Self-Help Agencies in the San Francisco Bay Area (N = 310)*

Characteristic	n	%	M	SD
Gender				
Women	88	28.0		
Men	222	72.0		
Ethnicity				
African American	216	69.7		
White	55	17.7		
Hispanic	22	7.1		
Native American	7	2.3		
Asian	5	1.6		
Other	5	1.6		
Marital status				
Never married	152	49.0		
Ever married	158	51.0		
On probation or parole	69	22.0		
Age			38.4	±3.7
Education			12.4	±2.3
Less than high school	85	27.0		
High school	94	30.0		
Some college	102	33.0		
Bachelor's degree or higher	25	8.0		
Housing status				
Homeless <sup>a</sup>	132	45.8		
Hotel	60	18.9		
Apartment or house	85	29.6		
Other <sup>b</sup>	34	3.8		
Without address at least once in past 5 years	226	73.0		
Income (\$)			680.57	±487.59
Source of income				
SSI or SSD	138	45.0		
General assistance	112	36.0		
AFDC	15	5.0		
Employment	76	25.0		
Food stamps	101	33.0		
Money from family or friends	48	16.0		

Note. SSI = Supplemental Security Income; SSD = Social Security Disability; AFDC = Aid to Families With Dependent Children.

<sup>a</sup>Living on streets, in cars, or in shelters.

<sup>b</sup>Living in board and care, transitional housing, or a similar situation.

selling. The remaining participants endorsed coming to the SHA either "to be with people" or for "a place to hang out" (25.0%), to "find out what's available" (9.9%), or to avail themselves of the empowering ideology of self-help (4.3%). Further, participants with a dual diagnosis were more likely to come seeking help with housing,  $\chi^2(2, N = 277) = 6.06, p = .048$ .

### *Prevalence of Substance Use and Psychiatric Diagnostic Profiles*

*Diagnostic profiles.* The majority of study participants, 89.5% ( $n = 277$ ), had diagnostic profiles matching lifetime *DSM-III-R* diagnoses (see Table 2).

Over three quarters of participants (75.5%) had a lifetime substance abuse or dependence disorder profile.

Among participants with a lifetime dual diagnosis profile (55.8% of the sample), 95.0% were assessed as having a substance use disorder profile of moderate to severe dependency. Similarly, 88.5% of those with a substance use disorder profile met the criteria for moderate to severe substance dependency.

Table 3 shows the prevalence rates for lifetime and current substance use disorder profiles. Alcohol was the most frequently misused substance. Over half the sample had a lifetime alcohol use disorder profile (60.0%), with over half of this group (61.3%) meeting the criteria for a current alcohol disorder profile.

Table 2

*Lifetime DSM-III-R Diagnostic Profiles Among a Sample of Participants Attending Self-Help Agencies*

Diagnostic profile	Proportion matching profile	
	Frequency	%
Psychiatric diagnosis only	43	13.9
Alcohol disorder only	25	8.1
Drug disorder only	20	6.5
Alcohol and drug disorder only	16	5.2
Dual diagnosis	173	55.8
No DSM-III-R diagnosis	33	10.6

Note.  $N = 310$ . DSM-III-R = *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev).

Men were significantly more likely to have lifetime,  $\chi^2(1, N = 310) = 12.59, p = .000$ , and current  $\chi^2(1, N = 310) = 4.77, p = .029$ , alcohol disorder profiles than were women in this sample. Rates of lifetime and current alcohol disorder profiles were equivalent across ethnic groups.

Over half the sample (55.2%) met the diagnostic profile criteria for a lifetime drug disorder, with over half of this group displaying current drug disorder symptoms (60.8%). African American participants demonstrated a significantly higher rate of lifetime drug disorder profiles than all other participants,  $\chi^2(1, N = 277) = 3.88, p = .049$ . Cocaine was the most frequently used drug, with 60.0% meeting diagnostic profile criteria for lifetime and current disorder. Participants between the ages of 30 and 39 were significantly more likely to have a cocaine disorder profile than were either their younger or their older cohorts,  $\chi^2(3, N = 277) = 10.34, p = .016$ , in the sample. Similarly, African American participants were significantly more likely to have both a lifetime,  $\chi^2(1, N = 277) = 28.08, p = .000$ , and a current,  $\chi^2(1, N = 277) = 14.18, p = .000$ , cocaine disorder profile but were significantly less likely to have either a lifetime,  $\chi^2(1, N = 277) = 27.00, p = .000$ , or a current,  $\chi^2(1, N = 277) = 20.64, p = .000$ , stimulant disorder profile. The rates of lifetime stimulant,  $\chi^2(1, N = 277) = 4.94, p = .026$ , and cannabis,  $\chi^2(1, N = 277) = 7.21, p = .007$ , disorder profiles were significantly higher for men than for women. Moreover, in bivariate analyses of current disorder, the rate of cannabis disorder profiles was significantly higher for men,  $\chi^2(1, N = 277) = 4.09, p = .043$ ; however, men and women reported corresponding rates of current disorder profiles for cocaine, heroin, and stimulant dependence.

Table 3  
*Lifetime and Current Prevalence Rates of Substance Use Disorders by Diagnostic Category (N = 310)*

Substance use disorders	Lifetime disorder profile						Current disorder profile					
	Total (N = 310)		Substance use diagnosis only (N = 61)		Dual diagnosis (N = 173)		Total (N = 310)		Substance use diagnosis only (N = 61)		Dual diagnosis (N = 173)	
	n	%	n	%	n	%	n	%	n	%	n	%
Alcohol use disorder	186	60.0	44	72.1	142	82.1	114	36.8	24	39.4	90	52.0
Alcohol and drug use disorder	123	39.7	19	31.1	104	60.1	55	17.7	7	11.4	48	27.7
Drug use disorder	171	55.2	36	59.0	135	78.3	104	33.5	15	24.6	89	51.4
Cocaine	128	41.6	27	44.3	101	58.4	77	24.8	13	21.3	64	37.0
Stimulants	38	12.3	4	6.6	34	19.7	21	6.8	1	1.6	20	11.6
Heroin	29	9.4	1	1.6	28	16.2	6	1.9	0	0.0	6	3.5
Cannabis	39	12.6	11	18.0	28	16.2	10	3.2	1	1.6	9	5.2

*Dual disorders.* Another way to look at the incidence of disorder profiles in a population is to examine rates of dual disorders across the various base rates of diagnostic categories. In terms of co-occurrence of disorder, 80.0% of participants with a lifetime psychiatric diagnosis had a comorbid lifetime substance use disorder profile, whereas 74.0% of those with a lifetime substance dependence diagnosis had a co-occurring lifetime psychiatric disorder profile. Among those with a lifetime alcohol disorder profile, 76.3% had a lifetime mental disorder profile, whereas 79.0% of those with a lifetime drug disorder profile had a co-occurring lifetime psychiatric disorder profile. Participants with current disorder profiles demonstrated a similarly elevated pattern of dual diagnosis.

*Polydependency.* The prevalence of polydependency among sample participants reveals another level of disability within this population. The rate of comorbidity between lifetime alcohol and drug disorders in the overall sample is 39.7%. Dually diagnosed participants with a lifetime comorbid alcohol and drug disorder account for just over 60.0% of this proportion. The most frequently reported combination was alcohol and cocaine. Out of the total sample, 31.0% reported a lifetime comorbid alcohol and cocaine disorder profile, whereas 14.5% met criteria for a current diagnosis of alcohol and cocaine disorder profile.

*Lifetime mental illness diagnostic profiles.* Table 4 compares the prevalence of lifetime mental illness diagnostic profiles between the two groups of psychiatric diagnosis only and dual diagnosis participants. Participants with schizophrenia, major depression, or dysthymia profiles were more likely to be in the psychiatric diagnosis only group, whereas

those with a diagnosis of either posttraumatic stress disorder, bipolar disorder, generalized anxiety disorder, or antisocial personality disorder profile were more likely to present a dual diagnosis profile. There were no differences between the groups in the rates of panic disorder profiles or schizoaffective disorder profiles.

### *Psychiatric Hospitalization and Psychological Disabilities*

Over half of those with a dual diagnosis reported a history of inpatient psychiatric care (59.5%). It is surprising that just over a third ( $n = 12$ ) of the participants who did not meet criteria for a lifetime *DSM-III-R* substance use or psychiatric diagnosis ( $n = 33$ ) also reported a history of psychiatric hospitalization.

All participants scored in the clinically depressed range on the CES-D, though the dually diagnosed and psychiatrically diagnosed participants were significantly more depressed in contrast to those participants with a substance disorder only (see Table 5). Participants with a dual diagnosis manifested a significantly lower level of self-esteem in comparison with the two other diagnostic groups. Dually diagnosed participants also demonstrated the least amount of impulse control and anger management skills in contrast to the rest of the study sample. Whereas participants without a lifetime *DSM-III-R* diagnosis scored in the clinical range on the aforementioned scales, their scores reflected less acute and obvious psychological disability than the scores of the three comparison groups of dually diagnosed, psychiatrically diagnosed only, and substance use disorder only participants.

Table 4  
*Prevalence Rates of Lifetime Mental Illness Diagnostic Profiles Among Self-Help Agency Users With Dual Diagnosis and Psychiatric Diagnosis Only Profiles (N = 216)*

Psychiatric diagnosis	Psychiatric diagnosis only (N = 43)		Dual diagnosis (N = 173)		$\chi^2(2, N = 216)$	p
	Frequency	%	Frequency	%		
Schizophrenia	9	20.9	28	16.2	12.73	.002
Schizoaffective	2	4.7	9	5.2	3.26	.196
Posttraumatic stress	17	39.5	97	56.1	58.60	.000
Bipolar I and II	1	2.3	20	11.6	10.61	.005
Major (unipolar) depression	14	32.6	33	19.1	20.43	.000
Generalized anxiety disorder	1	2.3	18	10.4	9.28	.010
Panic disorder	2	4.7	13	7.5	5.03	.081
Dysthymia	13	30.2	36	20.8	18.91	.000
Antisocial personality disorder	10	23.3	81	56.6	46.94	.000

Table 5  
*Current Psychological Functioning Among Study Participants (N = 277)*

Characteristic	Psychiatric diagnosis only (N = 43)		Substance disorder only (N = 61)		Dual diagnosis (N = 173)		F(2)	p
	M	SD	M	SD	M	SD		
CES-D	47.47	11.85	41.94	8.34	47.63	10.46	6.36	.002
Rosenberg Self-Esteem Scale	37.93	7.34	38.36	6.34	35.44	6.43	5.71	.004
Novaco Impulse Control Scale	18.71	5.26	19.21	4.24	21.31	4.96	7.39	.001
BPRS	44.28	12.65	39.85	12.08	42.79	11.43	2.05	.131

*Note.* CES-D = Center for Epidemiological Studies Depression Scale; BPRS = Brief Psychiatric Rating Scale.

## Discussion

We found rates of substance use disorder (75.5%) and dual diagnosis (55.8%) exceeding those found in urban clinical settings in both the community mental health and the substance use treatment domains (Burnam et al., 1995; Dixon, Haas, Weiden, Sweeney, Frances, & 1991; Hien, Zimberg, Weisman, First, Ackerman, 1997). Other studies examining rates of substance use and dual diagnosis among homeless adults, however, have found equivalent rates. For example, Koegel, Sullivan, Burnam, and Wenzel (1999) reported that just under three fourths of respondents in their Course of Homelessness study had a lifetime substance use disorder, whereas they obtained a 77.0% rate of comorbidity among individuals with a psychiatric disorder; the latter figure is virtually the same as the 80.0% rate we found in our study. In another study evaluating the prevalence of substance use disorders and treatment contact among a sample of homeless adults in Northern California, Robertson, Zlotnick, and Westerfelt (1997) found that 69.0% of their sample, recruited at shelters, meal programs, and drop-in centers serving the homeless, evidenced a substance use disorder.

Utilization of the SHA and, to some extent, the character of its client population seem to be determined by the SHA's location in those central city neighborhoods that are populated by the most needy and disabled poor, who are frequently homeless or unstably housed. Most people come to the SHA seeking basic resources, bringing with them the baggage of poverty and a multitude of social vulnerabilities (Devine & Wright, 1997). The demographic characteristics of SHA sample participants were similar to those found in other studies of multiply disabled homeless and unstably housed adults (Kingree et al., 1999; Koegel, Melamid, & Burnam, 1995; Leal et al., 1999; North & Smith, 1994; Wright & Devine, 1995). The

homeless rate found in our study (45.8%) approaches the 50.0% homeless rate found in a study that examined risk factors for homelessness among a cohort of individuals participating in a residential substance abuse treatment program (Kingree et al., 1999). Furthermore, in a study that evaluated the rate of homelessness among a sample of dually diagnosed adults on an inpatient psychiatric unit, 44.0% of the sample reported a history of protracted homelessness (homeless continuously for more than 1 year), whereas 31.0% reported a history of being homeless for less than 1 year (Leal et al., 1999). Almost three fourths of our sample reported having been without a permanent address at least once in the past 5 years, which indicates that these participants bear a similar set of vulnerabilities for housing instability and homelessness as do those individuals found in both clinical and community settings.

The issue is not why so many individuals with a substance use or dual disorder are found among a sample of mental health self-help users but rather what the factors are that draw these individuals to this setting. We found that the SHAs in this study are indeed serving the nation's most disabled and marginalized groups—individuals with mental illness, substance use, and unstable housing profiles. Because these individuals possess a host of risk factors for the development of myriad vulnerabilities, their primary reason for coming to the SHA is to seek basic resources. SHAs may also be the recipients of individuals who are unable to access care in the public sector, a system that has become increasingly constrained by fiscal limitations and a managed care brief treatment/medical necessity model. These findings also reflect the willingness of policy makers to allow the continued abandonment of the seriously mentally ill to areas of high social disorganization and poverty and to risks of increasing substance abuse and other health problems (Segal et al., 1998).

This neglect on the part of policy makers and legislators points toward other reasons why participants may have chosen to affiliate with an SHA. For instance, participants may have chosen to attend an SHA because it was more culturally syntonic with their perceptions of the origins of their vulnerabilities and deficits as well as how those deficits might best be addressed. Given participants' level of socioeconomic deficits, the choice to attend an SHA may reflect a realistic assessment of the need to address these deficits before being able to engage fully in a program of treatment that addresses the participant's diagnosis. This point highlights a tremendous gap in the services available to unstably housed or homeless individuals with either a substance use or a dual disorder. Unfortunately, all too often, treatment continues to be offered without the availability of housing. Thus, participants' involvement with the SHA may represent their attempt to create a more integrated milieu for themselves.

Dually diagnosed individuals in particular may also prefer the low commitment, low disclosure norms that prevail in SHAs rather than undergo the scrutiny of the assessment process that typically occurs when one enters a traditional mental health or substance abuse treatment program. Several researchers have found that an initial approach that some have characterized as a low demand style seems to be more successful in retaining dually diagnosed individuals in treatment (Burnam et al., 1995; Noordsy, Schwab, Fox, Drake, 1996). It is certainly plausible that the dually diagnosed individuals in this study may have sought out the SHA not only because of its focus on linkage to survival resources but also because they could titrate their interpersonal involvement with other SHA members. Equally operative is the notion that study participants were using the SHAs as a harm reduction intervention, receiving assistance in meeting their survival needs while they continue to negotiate other aspects of their life.

### Conclusion

This study highlights the valuable role that mental health SHAs play in the lives of this group of participants. Not only do SHAs represent a kind of indigenous harm reduction response to community members who may be multiply impaired, they also function as a culturally appropriate venue for certain individuals who understand the origins of their life situation primarily from a structural point of view.

Mental health SHAs have traditionally been supported in part by state and local mental health funding streams. This fiscal support represents tacit acknowl-

edgment of the level of mental illness present in the individuals who utilize SHAs. However, given the overwhelming proportion of individuals with a substance use disorder among sample participants, SHAs would certainly be justified in pursuing funding from substance abuse treatment sources as well. Politically, the timing may be propitious in several states for such a request. Among the populations that SHAs serve are individuals involved in the criminal justice system. Given the passage of Proposition 36 in the state of California—treatment for first and second time non-violent drug offenders—SHAs could play an extremely significant role in helping to meet the needs of this vulnerable population.

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Received March 19, 2001

Revision received February 11, 2002

Accepted April 22, 2002 ■