

Article

Motivation for change and psychological distress in homeless substance abusers

Mary M. Velasquez^{a,*}, Cathy Crouch^b, Kirk von Sternberg^a, Irene Grosdanis^b

^aDepartment of Family Practice and Community Medicine, University of Texas-Houston Medical School, Suite 2.112, 6431 Fannin Street, Houston, TX 77030-1501, USA

^bSEARCH Homeless Project, 2505 Fannin Street, Houston, TX 77002, USA

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Abstract

This study explores the treatment needs of homeless individuals participating in a large urban day shelter program. Alcohol and drug use, psychological distress, and stage of change were assessed in 100 participants presenting for services. The associations among substance use, risk perception, and readiness to change were examined for alcohol and drugs separately. Participants had high levels of psychological distress compared to “non-patient” samples. Eighty percent had used alcohol in the past 6 months, with 65% of those drinking at higher-risk levels; 60% had used drugs, with 82% in the higher-risk levels. While the majority felt that they drank and/or used drugs “too much,” most were in precontemplation or contemplation stages of change. Intervention efforts for this population should focus on motivation, facilitation through the stages, and the associations between psychiatric symptoms and substance use. © 2001 Elsevier Science Inc. All rights reserved.

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1. Introduction

Homelessness is a significant social problem that continues to exist despite repeated attempts at local, state and national levels to respond to the many and varied needs of this population. The substance-abusing homeless represent a special subset of the population that may be underserved by public treatment programs (Dixon & Osher, 1995). Although substance abuse treatment for this group is a major need, few treatment programs exist specifically for the homeless and most programs lack the resources to adequately address addictive disorders (Burt et al., 1999; Cousineau, 1995). The National Coalition for the Homeless (NCH, 1998) includes long waiting lists, lack of transportation, and lack of supportive services among the barriers to treatment and recovery opportunities. While it is difficult to determine prevalence of substance abuse disorders among the homeless due to regional differences and methodological

issues, researchers and service providers agree that substance abuse among the homeless is a major public health concern (Fischer & Breakey, 1991).

While accurate estimates of mental disorders among the homeless are also hard to determine, recent studies indicate that as many as 50% of the total homeless population have some form of mental illness with 70–80% having a lifetime diagnoses (Scott, 1993). It is uncertain whether these disorders are a cause or a consequence of homelessness (or a combination of both), but it does seem clear that mental illness tends to worsen as one's homelessness continues (Lamb & Lamb, 1990). The dearth of substance abuse services for this group is further complicated by the fact that any program developed specifically for the homeless must also take into account clients' levels of psychological distress and the relation of this distress to their substance use.

This study explores the issues of alcohol, other drug use, motivation for change, and psychological distress among the homeless; presents data on these variables from a sample of homeless day shelter clients in a large urban city; and offers insight into the need for specialized treatment programs.

* Corresponding author. Tel.: +1-713-500-7549; fax: +1-713-500-7598.

E-mail address: mvelasquez@fpcm.med.uth.tmc.edu (M.M. Velasquez).

1.1. Substance abuse and the homeless

Many studies have identified alcoholism and other substance abuses as the most pervasive health problem for the homeless. Prevalence estimates of alcohol dependence and abuse among this population range from 59% to 68%. According to Fischer and Breakey (1991), the magnitude of alcohol problems among the homeless can best be appreciated through comparison with rates described for the general population, where 10% of men and 3% of women develop pervasive and persistent alcohol problems. That means that prevalence rates among homeless populations are six to seven times greater than what would be expected in the general population.

Alcoholism has a major impact on the physical health of the homeless. Studies indicate that among patients receiving health care in programs for the homeless, alcohol abusers tend to be much sicker than other patients. They are more likely to engage in high-risk life-endangering behaviors, experience serious trauma, and suffer from serious health problems such as liver disease, nutritional deficiencies, hypertension, chronic obstructive pulmonary disease, gastrointestinal disorders, and arterial disease (Harris, Mobray, & Solarz, 1994; Stine, Fischer, & Breakey, 1988).

Patterns of the homeless' abuse of drugs other than alcohol have been studied less intensively, yet it is clear that use of illicit drugs is also widespread. It is estimated that from 25% to 50% of homeless people use illicit drugs and that rates of use exceed those reported for the general population. Drug use increases the likelihood of arrests and incarcerations, and homeless individuals who use drugs are more likely to engage in prostitution, increasing their risk for contracting sexually transmitted diseases — particularly HIV (Fischer & Breakey, 1991).

1.2. The “dually diagnosed” homeless

A particular source of increasing public health concern is the homeless mentally ill. Although estimates vary, evidence indicates that substantial numbers of the homeless suffer from severe and chronic mental illness (Belcher, 1989). It has also been estimated that a quarter to a third or more have multiple diagnoses of mental illness or disability and substance abuse (Lomas, 1992). These individuals have often become homeless due to their inability to hold jobs, poor social skills, and inability to cope with everyday events. Most often, they have no social support systems, high rates of contact with the criminal justice system, and no established relationship with service systems. The dually diagnosed often fall between the cracks of the public health care system. When these individuals present for care, they are often shuttled back and forth between services. Substance abuse care providers frequently exclude the mentally ill because they are difficult to deal with, and mental health professionals often refuse to treat dually diagnosed clients until they achieve sobriety (Farriello & Scheidt, 1989;

Velasquez, Carbonari, & DiClemente, 1999). While there have been some recent attempts to develop “hybrid” programs in which mental health and substance abuse treatments are integrated, how to accomplish this integration most effectively is still a matter of debate (Kofoed, Kania, Walsh, & Atkinson, 1986; Minkoff, 1989; Ridgley, Goldman, & Willenbring, 1990; Velasquez et al., 1999). Add the problem of homelessness to this already complex situation and it is easy to understand why the homeless dually diagnosed are often left untreated.

1.3. Treatment programs for substance-abusing homeless

Due to the complexity of their problems and needs, homeless substance abusers pose special challenges for treatment providers. They have multiple needs in addition to treatment, and they are generally not well served by traditional treatment programs. This is evidenced by extremely high dropout rates, lower compliance, and lower success rates (Caton et al., 1994; O'Brien, Alterman, Walter, Childress, & McClellan, 1989). It is likely that homeless individuals' immediate needs for security, food and shelter often prevail over their need for treatment of substance abuse problems. A degree of bias may also exist within some traditional treatment programs with treatment providers seeing the homeless as being less deserving of services (Goldberg, & Simpson, 1995; Stahler & Cohen, 1995).

A few agencies that serve the homeless have attempted to implement substance abuse programs. While these programs are well intended, and while there is obviously a high degree of need for this type of service, their effectiveness may be limited by the fact that service providers most often do not know the type or extent of the clients' substance use, or their degree of motivation for change. When substance abuse treatment service is incorporated into the services offered by homeless shelters and resource centers, participation rates in these types of programs tend to be low unless they are a requirement for obtaining services. Twelve-Step groups, which are often effective for domiciled individuals, are typically not well attended by the homeless (Schutt & Garrett, 1992). Another problem is one that is common to many substance abuse treatment programs — they are “action-oriented”; i.e., most substance abuse programs are geared toward individuals who are ready to change, with the focus being on relapse prevention rather than on increasing and sustaining motivation for change.

1.4. Study goals

The impetus for the present study was to learn about the substance abuse treatment needs of homeless clients participating in a large urban day shelter program. We explored the prevalence of alcohol and other drug use among the shelter participants, and assessed their stage

of readiness to change these behaviors. We also examined the associations among participants' alcohol and drug use, mental illness, and readiness to address the various problems.

2. Materials and methods

2.1. Setting

The setting for this study was the drop-in day shelter of SEARCH Homeless Project. SEARCH was established in 1989 to identify and meet the needs of homeless persons in Houston and Harris County, TX, a service area of 1800 square miles.

The SEARCH Resource Center (RC) is designed to provide a single portal of entry from which individuals can access a variety of services. The RC houses representatives from SEARCH programs such as an employment center, case management services, and medical and dental services. The RC also provides meals, access to showers and laundry facilities, and a library. When needed, clients are referred to a SEARCH agency or to one of its collaborating service agencies, many of which have staff on site. The RC served 3772 unduplicated individuals in 1997–1998 with a total of 64,972 visits (Emergency Shelter Grant Program, 1998).

2.2. Participants

Participants were 100 clients who presented for services over a 45-day period at the RC. They ranged in age from 19 to 64 years old (mean = 39) and were predominately male (87%). The majority (65%) were African-American; 29% were whites; 3% were of Hispanic origin; and another 3% endorsed a category labeled "other." The educational level ranged from 8 to 17 years with the mean educational level being 12 years. Forty-three percent of the participants reported having had at least one prior substance abuse treatment episode. The median number of treatment episodes was two, and the range was 0–30.

2.3. Procedure

All clients in the RC were approached and asked to complete an interview that consisted of seven questionnaires. Participants were told that the interview was confidential and that the purpose was to help SEARCH determine the need for expanded substance abuse treatment services. Clients were assured that participation was completely voluntary and informed that no incentives would be provided for participation. Only a few ($N = 7$) declined to participate, citing the lack of incentives. Data collected by the agency (Emergency Shelter Grant Program, 1998) indicate that our sample was demographically very similar to the overall annual population of the RC.

2.4. Measures

2.4.1. Demographic checklist

A demographic questionnaire was used to capture basic individual characteristics. These included age, gender, educational level, race/ethnicity, and number of previous psychiatric and/or substance abuse treatments.

2.4.2. Screening instruments

The *Simple Screening Instrument for Alcohol and Drug Abuse*, a brief 16-item questionnaire, was designed by the Center for Substance Abuse Treatment (CSAT) to assess a broad spectrum of signs and symptoms of alcohol and/or drug abuse [U.S. Department of Health and Human Services (USDHHS), 1994]. The primary domains are *preoccupation and loss of control*, *adverse consequences*, *problem recognition*, and *tolerance and withdrawal*. The markers or conditions of abuse that are addressed include negative social, physical, and emotional consequences of abusive consumption. The items used by CSAT in developing the questionnaire are from alcohol and/or drug scales such as the Michigan Alcohol Screening Test (MAST), CAGE, Alcohol Use Disorders Identification Test (AUDIT), DSM-III-R, and the Addiction Severity Index (ASI). A scoring schematic groups respondents into degrees of risk: none to low (0–1); minimal (2–3); and moderate to high (4 and above). It is expected that individuals with an alcohol or drug problem will score above 4 (USDHHS, 1994). In keeping with the intent of our study to demonstrate and explicate differences between alcohol and drug abuse in this population and assess their motivation to change in these respective areas, separate screening instruments were adapted for alcohol and for drug use.

2.4.3. Substance abuse checklist

A substance abuse checklist was adapted from the *Drug History Chart* designed by researchers at the Institute for Behavioral Research at Texas Christian University for the National Institute of Drug Abuse (NIDA)-funded DATAR Project [National Institute on Drug Abuse (NIDA), 1993]. The instrument was designed to capture "any" use of 16 different drug categories during three time spans: last 30 days, last 6 months, and lifetime.

2.4.4. Brief symptom inventory (BSI)

The 53-item BSI was used to measure participants' levels of psychological distress (Derogatis, 1993). The BSI is a self-report short form of the 90-item Hopkins Symptom Checklist Revised (SCL-90-R). It is appropriate in clinical situations where debilitation results in reduced attention and endurance, and where testing procedures demand brevity. The BSI measures nine primary psychological symptom patterns and provides

global indices of psychological distress. The nine subscales and the Global Severity Index (GSI) were used in this study. The GSI communicates in a single score the level or depth of symptomatic distress currently experienced by the patient. To calculate the GSI, the sums for the nine symptom dimensions are added together and then divided by the total number of responses. Comparisons are then made with adult non-patients using gender-specific norms.

2.4.5. Alcohol and drug algorithm

Stage of change was assessed by separate stage classification algorithms for drinking alcohol and for using drugs. Stage-of-change algorithms have been used with several problem behaviors, including smoking and (DiClemente et al., 1991) substance use (Belding, Iguchi, & Lamb, 1996; Rothfleisch, 1997). The following stage classification scheme was employed for each behavior:

- Precontemplation — individuals who currently drink alcohol and/or use drugs and have no intention “to quit and stay off forever” in the next 6 months;
- Contemplation — individuals who currently drink alcohol and/or use drugs and intend “to quit in the next 6 months and stay off forever”;
- Action — individuals who have used alcohol and/or drugs in the last 6 months but not in the last 30 days and who intend “to stay off forever”; and
- Maintenance — individuals who have quit using alcohol or drugs and have been in abstinence for 6 months or more.

To allow for reading difficulties, the questionnaires were read aloud to the participant by a graduate student, a psychiatric nurse, or a student in a chemical dependency training program. Explanations of the items were given when necessary. None of the participants appeared to have serious difficulty with comprehension and they all indicated that they understood the questions.

3. Results

3.1. Psychological distress

Participants reported high levels of current psychological distress on the BSI. Table 1 provides their *t*-scores and percentile ranks on each of the BSI subscales, relative to a non-patient sample. On the Global Severity Index (GSI) subscale, the mean for male participants was in the 93rd percentile, and the mean for female participants was in the 97th percentile. The highest levels of distress for the males were found on the individual symptom subscales *paranoid ideation* ($t = 63.9$), *psychoticism* ($t = 60.0$), and *depression* ($t = 56.4$). The highest levels of distress for the females were found to be on the *paranoid ideation* ($t = 66.5$), *phobic anxiety* ($t = 60.0$), and *hostility* ($t = 59.8$) symptom subscales. (It should be noted that since the BSI norms are gender-specific, we stratified by gender. The small number of females ($N=13$) should be taken into account when considering these results.)

3.2. Substance use

Eighty percent ($n = 80$) of the participants assessed endorsed some alcohol use in the previous 6 months. An additional 15% reported some “lifetime” alcohol use, and 5% reported that they “never used.” Sixty percent ($n = 60$) of the participants endorsed having used drugs in the last 6 months; an additional 27% reported having used drugs in their lifetime; and 13% reported having never used drugs. The drug clients reported using most frequently was crack cocaine, with 69% of the drug users reporting crack use in the last 6 months. Crack was followed closely by marijuana, with 64% reporting use. Powder cocaine use was reported by 18% of the drug users and heroin use by 7%.

Polydrug use was also common. Fifty-nine percent of participants who endorsed drug use in the last 6 months also reported using more than one drug during that time. By far, the most common combination of drugs reported by the partici-

Table 1
Brief symptom inventory subscale scores using non-patient norms

BSI subscale	Males ($N = 86$)			Females ($N = 13$)		
	<i>t</i> -score	Percentile	SD	<i>t</i> -score	Percentile	SD
Somatization	44.7	38	30.89	51.3	54	25.11
Obsessive–compulsive	50.5	50	28.69	50.6	52	25.25
Interpersonal sensitivity	49.8	50	30.24	54.8	70	26.32
Depression	56.4	74	28.22	51.7	58	26.60
Anxiety	51.1	54	30.47	55.8	73	19.39
Hostility	47.0	38	30.40	59.8	84	22.30
Phobic anxiety	45.2	30	35.23	60.0	84	20.03
Paranoid ideation	63.9	92	23.14	66.5	95	7.45
Psychoticism	60.0	84	28.40	53.2	62	32.47
GSI	64.7	93	19.33	69.0	97	15.61

pants was crack and marijuana, with 43% of the drug users reporting having used both drugs. We also found a significant overlap in use of alcohol and other drugs. Of those who endorsed alcohol use, 71.4% also endorsed drug use during the same 6-month period, and 95.0% of those who endorsed drug use also endorsed drinking during that time.

3.3. Alcohol risk and readiness to change

Based on a composite score ranging from 0 to 14, the CSAT screening instrument classifies participants by their level of risk for alcohol abuse into one of three categories: none to low risk (0–1); minimal risk (2–3); or moderate to high risk (4 and above). Of the 80% of the participants who endorsed some drinking in the past 6 months, 65% fell into the highest-risk category (mean = 9.1). Thirteen percent was classified into the middle-risk category (mean = 2.6), and 22% into the low-risk category (mean = 0.28). Over half of those endorsing alcohol use (53%) responded “yes” to a problem recognition item that asked “In the past 6 months, have you felt that you use too much alcohol?” The screening instrument also assessed adverse consequences related to drinking. The consequences endorsed most frequently by those with alcohol use were family problems (53%), work problems (43%) and legal problems (41%).

The stage-of-change algorithm for alcohol classified 54% of those who had drunk alcohol in the past 6 months into the precontemplation stage (no intention of quitting in the next 6 months). Forty percent was in the contemplation stage (currently using but intend to quit within the next 6 months). Only 4% of the drinkers was found to be in the action stage for quitting their drinking (have not consumed alcohol for 30 days and intend to “stay off forever”).

3.4. Drug risk and readiness to change

Of the 60% of the participants who endorsed some drug use on the screening instrument, 82% fell into the higher-risk category (mean = 9.6), 13% into the middle-risk category (mean = 2.8), and 5% into the low-risk category (mean = 0.33). A high percentage (71%) of those endorsing drug use responded “yes” to the item “Have you felt that you use street drugs too much?” As with the alcohol users, many endorsed items associated with adverse consequences. The consequences endorsed most frequently by those reporting drug use were family problems (72%), work problems (57%) and legal problems (36%).

On the stage-of-change algorithm for drug use, 30% of the participants who had used drugs in the past 6 months were in the precontemplation stage, 60% were in the contemplation stage, and 10% were in the action stage.

3.5. Concurrent drug and alcohol use and readiness to change

Although a large segment of the sample endorsed both alcohol and drug use, one third of those individuals were in

different stages of change for quitting drinking than they were for quitting their drug use. Overall, individuals who were using both alcohol and drugs were more motivated to quit their drug use than they were to quit their drinking: 47.4% of those endorsing both substances were in precontemplation for quitting their drinking while only 29.8% were in precontemplation for quitting their drug use.

4. Discussion

This study found a high prevalence of both alcohol and drug use among the day shelter program participants. This finding is consistent with the literature and confirms the need for substance abuse treatment programs for shelter clients. Not all shelters are equipped to address their clients' substance abuse problems. Program philosophy may deny shelter services to those who are actively using. In order to access additional services, beyond the basic services to the homeless, a homeless individual must typically be free of drugs and alcohol and submit to periodic or random screens to assure maintenance of their substance-free status. This means that the training programs, employment placement, housing, and other opportunities designed for the homeless are often only available to the minority of the population who do not use alcohol or drugs.

Many homeless shelter programs do not offer substance abuse treatment programs. When they are available, they are typically action-oriented, requiring abstinence, or geared toward relapse prevention. In a recent study, DeLeon, Sacks, Staines, & McKendrick (1999) looked at circumstance, motivation, readiness, and suitability for treatment among homeless substance abusers and they concluded that there was a need for specific treatment programs tailored to the motivation and the circumstances of this population (NCH, 1998). Lack of participation and difficulty with engagement and retention in services for the homeless indicate the need for substance abuse counseling programs specifically geared to address issues related to homelessness, psychological distress, and increasing motivation to change.

This study found that while a large number of participants acknowledged that they drank or used drugs too much, most of the sample fell into the precontemplation and contemplation stages for changing their substance use. While this may appear at first look to be discrepant, it makes sense in light of the multiple problems and limited resources faced by this population. The “precontemplators” are likely to be demoralized and of the type that DiClemente and Hughes (1990) call “discouraged”, as opposed to those who deny that a problem exists.

Participants also had high levels of psychological distress as measured by the BSI. While it must be kept in mind that measures of psychological distress among the homeless can be inflated due to the nature of the items, it is also important to recognize that many homeless individuals suffer from mental illness and high levels of distress. It is likely that substance use

serves to help homeless clients “manage” their distress and provides a temporary escape from their problems.

Substance abuse programs for the homeless should include components that address mental health issues, particularly those that are most related to temptation to use alcohol and drugs. Efforts must also be made to develop interventions that do not restrict treatment only to those who are “in action” for their substance use; they should also include treatment components that serve those who are not yet ready, or in the earlier stages of change. For the homeless, who typically struggle with motivation issues in many areas of their lives, the use of counseling techniques such as motivational interviewing, which is designed to increase client motivation for change (Miller & Rollnick, 1991), would be a useful intervention strategy. Programs such as those based on Prochaska and DiClemente’s transtheoretical model also seem promising for this population. These types of interventions focus first on building clients’ motivation and then on preparing them for action. Specific change processes which facilitate movement through the stages of change can be emphasized, depending on the clients’ readiness for change. In this model, slips and relapses are seen as a normal part of the process of change and clients are encouraged to learn from each episode.

It is likely that counseling approaches such as those recommended here would be more effective with, and appealing to, the homeless, many of whom have cycled through multiple change attempts. In any case, the challenge faced by those who provide services to the homeless is to develop comprehensive substance abuse services that are more tailored to the needs of this complex population.

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