U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas

Technical Assistance Publication Series

17

United Behavioral Systems

Michael G. Bricker, M.S., C.A.D.C. III, I. C.A.D.C.

250 W. Coventry Court
Suite 111
Glendale, WI 53217

414-228-5300 1-800-242-9070
FAX 414-935-3333

A member of the United HealthCare Corporation family of services

The STEMSS Supported Self-Help Model for Dual Diagnosis Recovery: Applications for Rural Settings

Michael G. Bricker, M.S., C.A.D.C. III
Executive Director
STEMSS Institute and Bricker Clinic
Saukville, Wisconsin

The 1980s witnessed the growth of a burgeoning literature that describes and bemoans the complexities of defining and treating the "dual diagnosis" of chemical dependency and major mental illness. This population has been described by various authors as:

- Rapidly growing
- Highly mobile
- Vastly underserved
- "Revolving door" patients who are chronic overusers of inappropriate and expensive emergency services because they are "drinking, drugging, and disturbed"
- Extraordinarily treatment-resistant to traditional modalities.

Abstract

Support Together for Emotional/Mental Serenity and Sobriety (STEMSS), a supported self-help model for "dual diagnosis" recovery developed in 1984, is currently being used with success in numerous communities across the United States and in Canada. This paper discusses the theoretical constructs of this recovery model, its defining characteristics, and its applicability to rural areas. The STEMSS model has proven its adaptability in treatment centers around the country, as well as in community support programs in Wisconsin and West Virginia, in homeless shelters in Las Vegas and Milwaukee, and by means of "circuit riders" who go from village to village in Alaska. The model is being used extensively in rural areas throughout Illinois, North Dakota, and upstate New York and has been translated into Spanish at the request of a program in Texas.

STEMSS is a psychoeducational group intervention designed to enhance recovery from the combination of addiction and mental illness. It is designed to complement and amplify the gains available through participation in 12-Step and mental health support groups by addressing the areas of confusion where the two diseases overlap and interact. The STEMSS concept is predicated on an Interactive Disease/Synergistic Recovery Model for conjoint addictive and mental disorders, which emphasizes the empowerment of consumers in their own recovery. To this end, the STEMSS model utilizes graduated professional assistance toward the goal of peer leadership and consumer governance of individual group meetings.

The numerous difficulties inherent in the case management of dually diagnosed consumers are further complicated in rural areas by such factors as geographical dispersal of the clientele. The flexibility of the STEMSS model makes it uniquely adaptable to the challenge of cost-effective rural service delivery. This model has proven to be an innovative program for bringing quality recovery services to an underserved segment of an underserved population: the rural dually diagnosed consumer.[1]

[1]For complete start-up materials for setting up a STEMSS supported self-help group at no cost, please contact the author: Michael G. Bricker, Executive Director, The STEMSS Institute: Consultation in Recovery from Addictive and Mental Disease, 275 East Green Bay Avenue, Saukville, Wisconsin 53080, phone (414) 268-0899.

Turf issues among service providers and paradigm clashes between the theoretical constructs of the addiction and mental health treatment fields have made for a confusing map to follow in attempting to bring needed services to this population. This challenge is complicated even further by the difficulties inherent in providing services to clients in exurban and rural areas, such as geographical dispersal of the clientele, a diffuse infrastructure for service delivery, underfunding relative to urban catchment areas, lack of specialized training opportunities for staff, continuity of care with other health providers, stigmatization, and community prejudice (Larson et al. 1993).

Rationale for the STEMSS Model in Rural Areas

The STEMSS supported self-help model can provide a fertile field for "dual recovery" to flourish in rural areas. It is community-based, participant-driven, requires little—if any—institutional funding, and is self-sufficient with minimal support from local resources. STEMSS is a model of "sustainable mental health care delivery" in the tradition of the Alliance for the Mentally Ill (AMI) and 12-Step fellowships. As such, it is an innovative program of proven value, which can function as a linkage point across systems in serving a special population of rural clients experiencing chemical abuse and mental illness.

The STEMSS model grows out of the author's 18 years of experience in the mental health and addiction treatment field, as well as the collective wisdom and experience of the consumers who have shared this journey. The model attempts to focus state-of-the-art methodology from both disciplines in ways that will allow consumers to empower themselves in moving along the path from "dual diagnosis" to "dual recovery."

Since its inception in 1984, the STEMSS model has been adopted by no fewer than 80 sites across the United States and Canada. It has demonstrated its effectiveness across the entire continuum of care, from inpatient hospital units to residential treatment programs, outpatient clinics, aftercare groups, community drop-in centers, homeless shelters, and autonomous community support groups.

Attributes of the STEMSS Model

The STEMSS model is psychoeducational in format. It uses a set of six steps as a springboard for peer exploration of dual recovery from both addiction and mental illness (see figure 1). The centerpiece of the model is the STEMSS group, which provides a caring and *supportive* environment in which consumers can meet and interact with others who are on the same "dual recovery" path. Under the guidance of a facilitator, the group works *together* toward mutually selected goals of education, low-stress group process, and the opportunity to interact with trained professionals as an adjunct to their own recovery program.

Members are encouraged to pursue their own ongoing therapy and support group regimen—particularly Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and mental health groups. The emphasis is on accepting responsibility for one's own recovery and coming to grips with the *emotional* growth necessary to break the cycle of dependency, disease, and despair. The medical aspects of *mental* health are emphasized, and members are encouraged to discuss their symptoms, medications, and side effects as full partners in the treatment partnership. The goal is to help members stay psychiatrically stable and chemically free, so that they can achieve *serenity* and *sobriety* as functional participants in society.

The STEMSS model does not attempt to supplant the many exist-

Figure 1. STEMSS Six Steps

1. I admit and accept that my mental illness is separate from my chemical dependency, and that I must work a "double-recovery" program.
2. As a result of this acceptance, I am willing to accept responsibility for my life and help for my recovery.
3. As a result of this acceptance I came to believe that, with help and understanding, recovery is possible.
4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery process. This may include prescribed medications taken as directed.
5. As part of this recovery process, I accept the fact that I must maintain a lifestyle free from all "recreational" chemicals...including alcohol and drugs.
6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.

NOTE: These Steps are designed to complement (not replace!) those of Alcoholics Anonymous and Narcotics Anonymous.

ing resources for recovery from addictive and mental disease. It celebrates and welcomes the contributions of the 12-Step fellowships, the Depressive and Manic-Depressive Association (DMDA), MIRA (Mentally Ill Recovering Alcoholics), GROW, Inc., Schizophrenics Understood, MICA (Mentally Ill Chemical Abusers), Recovery, Inc., and mental health advocacy groups. Figure 2 shows a comparison between STEMSS and other 12-Step recovery programs.

Members are actively encouraged to pursue their "dual recovery" using all the richness these varied fellowships bring to the process. The model recognizes the role of pharmacology in mental health treatment and acknowledges the ease of confusion between a "med" and a "drug." STEMSS honors the contributions from differing perspectives of psychotherapy. It provides a "level field" upon which the consumer can examine alternatives and, with the guidance of professionals

Figure 2. STEMSS and 12-Step Recovery Programs: A Comparison[2]

Core Concept	STEMSS	General 12-Step Recovery Program
	Support Together for Emotional and Mental Serenity and Sobriety	*Alcoholics/Narcotics Anonymous (AA/NA) and others*
Acceptance	1. I admit and accept that my mental illness is separate from my chemical dependency, and that I have a dual illness.	1. We admitted we were powerless over our addiction—that our lives had become unmanageable.
Surrender	2. As a result of this acceptance, I am willing to accept help for my illnesses.	3. We made a decision to turn our will and our lives over to the care of God as we understood him.
Hope	3. As a result of this willingness, I came to believe that, with help and understanding, recovery is possible.	2. We came to believe that a Power greater than ourselves could restore us to sanity.
Need for BOTH medication and therapy	4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery program.	4–11. Includes all the remaining recovery steps as worked through in therapy and AA/NA program participation.
Abstinence	5. As part of this recovery program, I accept the fact that I must maintain an alcohol- and drug-free[3] lifestyle.	1. We admitted we were powerless over our addiction—that our lives had become unmanageable.
Recovery as the key to the FUTURE	6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.	12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Note that the STEMSS and 12-Step recovery models are complementary and designed to be used together. By "working" both programs simultaneously, they offer the promise of recovery from both chemical dependency and chronic mental illness. Working together, they offer experience, strength, and hope for the "doubly-troubled."

---

[2]From Bricker 1987, 1989.

[3]"Drug" in this context refers to recreational chemicals, not prescribed medications.

and the support of peers, explore the commonalities of apparently different points of view.

The STEMSS group is perhaps best described as "closer to an AA meeting than group therapy, and closer to group therapy than an AA meeting." While most groups begin with a trained facilitator, and many maintain a central role for this facilitator, the STEMSS model encourages peer facilitation to the greatest extent possible. The "support" in Supported Self-Help refers to the minimal amount of facilitator and professional involvement used to maintain the stability of each group, allowing the group to pursue mutually agreed upon goals. The stated objective of the model is for professionals to be resources rather than the "driving force." Their role is to provide accurate information and guidance to assist the group toward self-empowerment, peer leadership, and self-governance to the greatest extent practical. Thus, the author views the STEMSS model as solidly in the mainstream of the consumer empowerment movement as promulgated by the Alliance for the Mentally Ill.

Core Concepts of the STEMSS Model

The author has posited elsewhere (Bricker 1985, 1987) an Interactive Diseases Model for the dual diagnosis of chemical dependency and major mental illness. The underlying assumption of this model is that there are separate disease processes which coincide within an individual, but which interact in complex and synergistic ways. When carried to its logical conclusion, this absurdly common-sensical approach embraces the three core concepts of the STEMSS model. Figure 3 lists the 12 parallels between chemical dependency and mental illness, as reflected in the STEMSS model.

Concept 1. The STEMSS model suggests that these disease processes are conjoint, co-occurring primary disorders with distinct genotypes, etiologies, courses, and outcomes. This is a key assumption, since consumers—and occasionally clinicians!—become mired in "chicken-and-egg" arguments about which problem "caused" the other. The confusion arises because the primary symptoms of each disease tend to exacerbate symptoms of the other; each disorder predisposes to relapse in the other disease.

Concept 2. This gives rise to the second premise of the model: That the diseases must be "treated separately together." There are clearly defined interventions of choice for each disorder. The "revolving door" syndrome results from the temptation to treat the so-called "primary" disease first, in the hope that this will stabilize the "secondary" problem...which then becomes the *primary* disorder, which...etc., etc., etc. The only hope for lasting recovery is to treat both diseases aggressively at the same time and to provide stabilizing supports to maintain treatment gains in each disease. Treatment and support for each disease will in turn help forestall relapse in the other disorder.

Concept 3. The third theoretical underpinning of the model is that

Figure 3. The 12 Parallels Between Chemical Dependency and Mental Illness

1. Both are physiological diseases with a strong genetic/hereditary component.
2. Both are physical/mental/spiritual diseases which result in global affliction of the person.
3. If left untreated, the course of both illnesses is progressive, chronic, incurable, and potentially fatal.
4. Denial of the disease process(es) and noncompliance with attempts to treat are cardinal symptoms of the disorder.
5. Both diseases manifest loss of control in behavior, thought, and emotions. Both are often seen by self or others as a "moral issue."
6. Both diseases afflict the whole family as well as all relational systems.
7. Growing powerlessness and unmanageability lead to feelings of guilt, shame, depression, and despair.
8. Both are diseases of vulnerability and isolation; the victim is exquisitely sensitive to psychosocial stressors.
9. Both the primary symptoms of each disease AND loss of control in behavior/thought/emotion are reversible with treatment.
10. Recovery consists of:
    - Stabilization of the acute disease
    - Rehabilitation of body, mind, and spirit
    - Launching upon an ongoing program of recovery
11. The risk of relapse in either disease is always high, and relapse in one disease will inevitably trigger a relapse in the other.
12. The only hope for life-long recovery lies in working our program(s) ONE DAY AT A TIME.

From Bricker 1989

both diseases result in developmental deficits; these become the primary destabilizing factors in the relapse process for either or both disorders (Bricker 1990, 1991). In other words, the consumer's normal psychosocial development is arrested by the onset of the disease process(es). This suggests that the central task of recovery is to develop more nearly age-appropriate coping skills for the inevitable stressors in the growth process (Bricker 1991).

The logical corollary of the Interactive Diseases Model is that the recovery processes are synergistic as well. The developmental gains made in response to the challenges of each disorder will also strengthen the recovery program for the other disorder. The aim of the model is to reduce the recovery from each disease to a maintenance issue, so that normal personality development can resume (see figure 4).

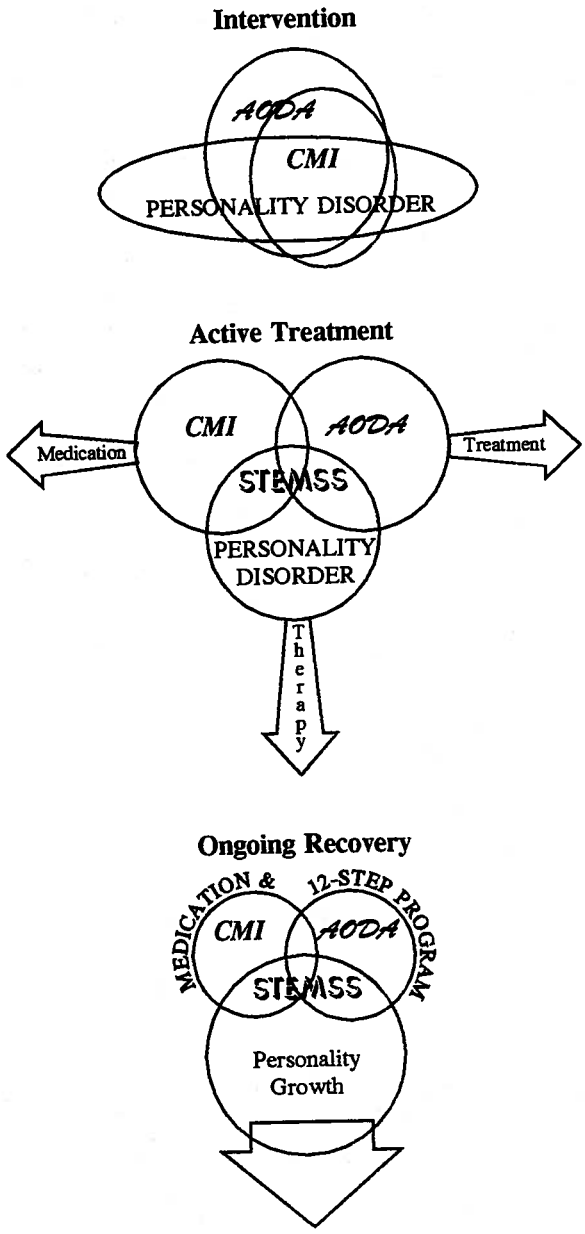
The STEMSS Supported Self-Help Meeting

When we began to apply these theories to a "self-help" meeting for those dually diagnosed, some problems were immediately apparent. Consumers had little to offer other than complaints, "drunkalogues," and euphoric recall of fun times. The need for professional guidance became clear early in the development process.

In keeping with the ideal of consumer empowerment and personal responsibility, it was decided to limit the role of support to facilitation rather than "leadership" by a therapist. While most institutions sponsoring the supported self-help model provide a staff member as facilitator, this staff member's role is to begin developing peer leadership as quickly as possible. The staff member then becomes a resource person and source of accurate educational information on such subjects as medication, side effects, and recovery concepts.

Many staff facilitators are trained clinicians: therapists, nurses, and/or addiction counselors. However, a number of STEMSS groups have discovered that a paraprofessional with a "gift" for working with this population can be extremely effective. One meeting was facilitated for years by the facility's Maintenance Director! Other meetings are led by nursing assistants, social workers, and community support program

Figure 4. Interactive Diseases Model for Dual Diagnosis



personnel. This can be helpful in getting around the trust issues consumers may have with clinicians and it weakens the "us/them" dichotomy. A progression the author has used successfully is to begin with a clinician, who trains a paraprofessional; this paraprofessional then develops peer leadership and becomes a stabilizing participant until the group becomes self-sustaining.

This progression allows each individual group to seek its own level along the continuum between a staff-led therapy group and an autonomous self-help group. This continuum is illustrated in figure 5.

Many groups across the country have moved quite naturally along this continuum by starting out as an inpatient therapy group, which later becomes part of the aftercare support for consumers who are discharged. As more alumni become stable, a formal aftercare group is split off with a paraprofessional facilitator. As peer leadership is cultivated, this level of staff support can be gradually reduced until the membership is stable enough to become a mutual help meeting (see Osterstrom 1994).

Methodology Used by STEMSS Groups

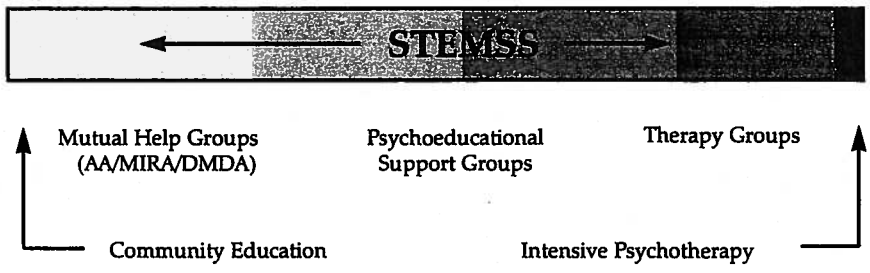
The common denominator of all STEMSS groups is the set of six steps (see figure 1). Most are designed as "open-entry, open-exit" groups; at any given meeting, there may be newcomers as well as seasoned members. A few STEMSS sites have developed some sort of "level system" to track progress toward recovery goals, starting with a group format that is heavy on education and then "graduating" members into a discussion group. The STEMSS model is adaptable to a number of formats and hybrid approaches. Some of the most commonly used—moving from least to most interactive—are discussed below.

1. The *Step Education Group* is closest to an educational format and is a non-threatening way to introduce the model and the steps. The facilitator may teach about the steps; later, members may volunteer to speak on a step. "Class discussion" can be used to begin modeling group skills. A variation on this is the Speaker Meeting, in which an invited guest gives a presentation on a topic of interest.
2. Some facilitators have developed *Step Exercise Groups* to help members look at recovery concepts; these groups use simple pen and paper worksheets to examine the steps. This format can be fun and helps consumers get to know each other, as well as the steps.
3. In the *Step Discussion Group*, one of the six steps is selected (in rotation) for discussion by each member in turn. This is similar to a 12-Step meeting, and consumers familiar with AA will feel comfortable with this format. Newer and less vocal members will be inclined to "pass" and may need to be drawn into the process. This is probably the most commonly utilized format for STEMSS groups around the country and occupies the middle range of the continuum described in figure 5.
4. The *Step Process Group* goes into both steps and group process in greater depth. It is a good model for advanced consumers to get feedback on personal issues and to work on relapse prevention skills. It is more interactive than the group formats described above and requires a certain level of skill in facilitation, if not a trained clinician.
5. The last portion of the continuum is occupied by the *Open Topic Process Group*, which is closest to a therapy group with rounds and agenda-setting by members. This group is often led by a therapist in treatment programs and used as a "feeder group" for other types of STEMSS meetings.

Numerous hybrid combinations are possible. For example, many sites will have a speaker meeting once a month, with step discussion the rest of the time. The setting in which meetings are held is also highly variable. Some are held in a church basement, while other groups prepare and eat a meal as a prelude to the meeting. Numerous sites have discovered that coffee and cookies have a salutary effect on attendance, especially when a group is getting started.

Figure 6 shows a list of suggested basic rules for STEMSS groups to follow. This figure also recommends guidelines for group norms, which will be variable and best decided by each group.

Figure 5. Continuum of Group Process



Recommendations for Using the Model in Rural Areas

The flexibility of the STEMSS model can be helpful in addressing some of the following complicating factors in rural mental health delivery:

- **Geographic dispersal of clients and diffuse infrastructure**: Since nothing is needed for a STEMSS group but the clients, copies of the STEMSS materials, and a facilitator, groups can be located wherever the need exists.
  STEMSS groups meet in church basements, community support program offices, 4-H clubs, and community centers.
- **Underfunding of rural programs relative to urban catchment areas**: Since STEMSS is not reliant on "tight" affiliations and subsidies with a treatment program, funding requirements are minimal. Often dedication of a portion of a staff member's salaried time to do startup and training of paraprofessional facilitators is sufficient. Some programs use a "circuit rider" concept, wherein a designated staff person may travel and be a resource to several peer-facilitated groups that are geographically dispersed.
- **Lack of specialized training for staff "generalists"**: Since the STEMSS model is not predicated on "expert therapeutic intervention" for maintenance of recovery gains, enthusiastic generalists who are willing to learn from their clients can be extremely effective. Moreover, comprehensive training materials are available at minimal cost, as well as focused consultation by the author.
- **A linkage point across service delivery systems**: Since the STEMSS groups are not dependent on institutions or "funding" in the

Figure 6. STEMSS Group Norms and Rules

To some extent, each STEMSS group will be shaped by the administrative character of the sponsoring organization. The writer's experience has been that the less restrictive the environment, the better.

Suggestions for Rules

1. Meetings start on time, end on time.
2. Anyone under the influence of mood-altering chemicals will be asked to leave and invited to return for another meeting.
3. Anyone in psychiatric crisis will be encouraged to seek appropriate care and welcomed back for a future meeting.
4. "Cross talk" is encouraged, but group members will treat each other respectfully...one conversation in the room at a time, please.
5. No physical acting-out or verbal aggression will be tolerated.
6. Anonymity and confidentiality foster trust. "What's said in the room, stays in the room!"
7. So that everyone may have a chance to work on their recovery, a "5-minute rule" may be suggested by group conscience.

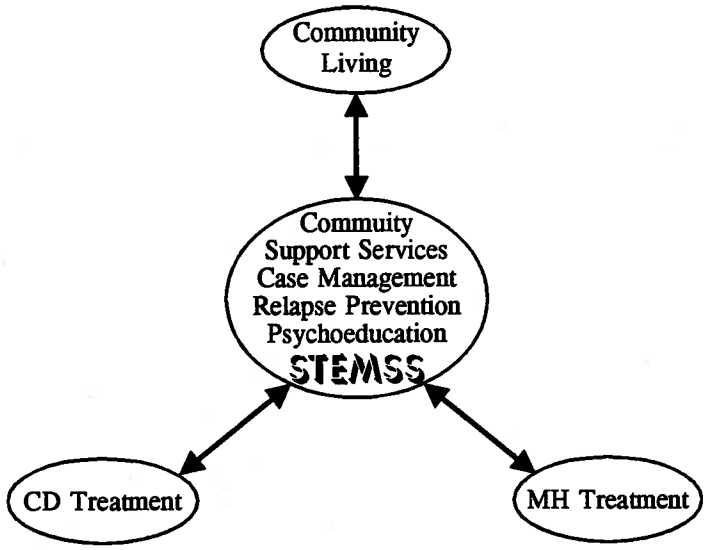
Guidelines for Group Norms

The group norms will be more variable and are best decided by the peers and facilitator as the group is forming. Some good guidelines include:

1. The group is open to all who are willing to work a "double recovery" program of sobriety and psychiatric stability.
2. Members will be encouraged, but not required, to participate.
3. The group members, with the help of the facilitator, will decide how the meeting is to run.
4. Members may feel the need to move quietly around the room, but are encouraged to stay with the group process until closure.

Different STEMSS groups adopt different traditions. For instance, the "Feelin' Good" group from Buffalo has written a ***Preamble*** *based on that of AA which they read to open the meeting. This consumer initiative is greatly encouraged. The greater the level of involvement, the greater the gains.*

Figure 7. STEMSS Case Management Model



usual sense, they tend to minimize the "turf issues" and function as common ground between agencies (see figure 7).

- **Community prejudice and client stigmatization**: Since the STEMSS model is designed to be community-based and consumer-empowering, it tends to minimize problems of prejudice and of stigmatizing clients.

Perhaps the greatest strength of the STEMSS model is that it encourages and empowers consumers, facilitators, and sponsoring institutions to adapt and create powerful solutions to their unique challenges. It offers a unique opportunity to offer experience, strength, and hope for the "doubly-troubled" in rural areas.

References

Bricker, M.G. "STEMSS: A Proposed Supported Self-Help Group for the Dual Diagnosis of AODA/CMI." Unpublished manuscript, University of Wisconsin-Milwaukee, 1985.

Bricker, M.G. STEMSS group offers hope and help for the "doubly-troubled." Milwaukee: DePaul Hospital Press, 1987.

Bricker, M.G. STEMSS treatment model offers experience, strength and hope for the "doubly-troubled." *TIE Lines: Journal of the Information Exchange* 6(1), 1989.

Bricker, M.G. The operation was a success, but the patient died: The phenomenon of relapse on Axis II. *TIE Lines: Journal of the Information Exchange* 7(1), 1990.

Bricker, M.G. Intervention for the NEXT crisis: Psychosocial stage theory applied to crisis resolution with the "chronically young." *TIE Lines: Journal of the Information Exchange* 8(1), 1991.

Larson, M.L.; Beeson, P.G.; and Mohatt, D. *Taking Rural Into Account: Report on the National Public Forum Co-sponsored by the Center for Mental Health Services* (June 24, 1993). Washington, DC: U.S. Dept. of Health and Human Services. Rockville, MD: Center for Mental Health Services, 1993.

Osterstrom, S. From psychoeducation to self-help: The STEMSS model in Buffalo. *TIE Lines: Journal of the Information Exchange* 11(2), 1994.