A Comprehensive Guide

*for*

# Integrated Treatment

of People with
Co-Occurring Disorders

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## Foreword

In the mid 1970s I was asked by Fordham University to speak to a group of social work students. At that time I was President of the Federation of Parents Organizations for the New York State Mental Institutions. The textbook used at that time at Fordham University had nothing in it about the holistic special issues surrounding people with dual diagnosis of mental illnesses and substance abuse, or as it has come to be called, co-occurring disorders. The times are changing, and how fortunate we now are to have this textbook. It is must reading for anyone studying or working in the fields of severe mental illnesses or substance abuse.

I have been involved in the field of severe mental illnesses and substance abuse in a variety of capacities, and rarely have I seen a book of this importance. Approximately 25 years ago I founded three major psychosocial rehabilitation programs. I have served on the SAMHSA (Substance Abuse and Mental Health Services Administration) National Advisory Council for two terms, during which time I chaired the Subcommittee on Services Integration. In that capacity I convened a panel of more than 100 experts in the field of co-occurring disorders; the recommendations of that distinguished group included strong support for the concept of integrated treatment. Based on research and accumulated knowledge in the field, these experts concluded that both disorders should be treated simultaneously; in one setting, using cross-trained staff that would provide medical or service treatment by a single clinician or teams of clinicians, supervised by a psychiatrist. Cost effective integrated services with integrated treatment was bringing about the clinical, functional, and quality of life outcomes desired by all people, including people with co-occurring disorders. *A Comprehensive Guide for Integrated Treatment of People with Co-Occurring Disorders* is the critical resource for training professionals in the field.

Using the 2001 Census and recent studies as the basis for their estimates, experts have conservatively estimated that 14 to 16 million Americans experience a co-occurring disorder. People with co-occurring disorders are more apt to seek treatment than those individuals who

have only one of these disorders. As a result, a clear majority of people in treatment for substance abuse problems also have a mental disorder; community-based mental health treatment settings often estimate the rate of co-occurrence at 70 to 80 percent. A book such as this that examines the range of issues in co-occurring disorders is obviously needed.

The field of such co-occurring disorders must also be understood in the political and legislative context. While the National Institute of Mental Health has understood and supported the importance of cost-effective, integrated treatment based on their research, Congress has not been able to enact legislation that would facilitate and encourage integrated treatment. Rather, current legislation authorizing SAMHSA, the federal agency charged with administering service programs for people with mental illnesses and people with addictive disorders, does not attempt to co-finance cost-effective integrated treatment programs. Such "blended funding" for the treatment of people with dual disorders is contrary to the existing administrative structure, in which funding for mental illnesses and substance abuse are the responsibility and under the supervision of SAMHSA's administrator, Charles B. Currie, D.S.W.

Let us be clear about what is preventing the use of SAMHSA funds for cost-effective, integrated treatment or services. It is not lack of knowledge, which this book clearly shows not to be true. Instead, it is professional rivalries and jealousies, and a desire to keep one's power base at the expense of the people who need holistic integrated services. As a result, professionals have not been sufficiently and properly cross-trained; for the most part, most of them prefer to do what most have learned, i.e., work only with persons with the one disorder for which they are trained.

In 1992 Congress mandated that the National Institutes of Health (NIH) and its three institutes for mental health, alcoholism, and drug abuse conduct services research, with the results to be turned over to SAMHSA for national dissemination. There can be no question that Congress's intent was for SAMHSA to formulate service policies for mental health, alcoholism, and drug abuse, as well as co-occurring disorders that were based on the services research of the three institutes, i. e., NIMH, NIDA and NIAAA. In correspondence with me, NIH has stated that, based on available research, an integrated treatment model is the best approach in treating co-occurring disorders. *A Comprehensive Guide for Integrated Treatment of People with Co-Occurring Disorders*

impressively organizes this material for students, professional, advocates, and administrators. These individuals have to familiarize themselves with this up-to-date material and educate others about the facts of co-occurring disorders. It is extremely difficult for me to envision how Congress can continue with the dual status quo of parallel and sequential treatment, which has not been proven through research. In fact, research supported by the federal government shows that, in most cases, parallel and sequential treatment of both disorders has failed. The NIH and the officials of two of its Institutes have reported that existing dual diagnosis treatment has failed. Research personnel from both of these Institutes have found that the treatment of co-occurring disorders does not meet acceptable standards for treating the medical as well as the mental disorders.

Those who fail to act on this knowledge will have to bear on their collective consciences the fact that they extended the aforementioned status quo, thus preventing over 16 million Americans with co-occurring disorders from receiving holistic medical treatment and services that would help them recover.

Let us not succumb to the pressures of some of the alcohol and substance abuse national organizations. Let us persevere, armed with the knowledge that will change our existing, out-of-date efforts. The researchers and scholars in this book have written eloquently about the medical and service issues in the co-occurring disorders field. Now is the time to get this holistic information into the mainstream of academia, practice, administration, and legislation. Let us make wise use of the knowledge that is so well presented in *A Comprehensive Guide for Integrated Treatment of People with Co-Occurring Disorders.*

MAX SCHNEIER, J.D.

## Preface

The concept of dual disorders has been around for over 20 years and is currently recognized as one of the most significant problems facing mental health systems. About 30 percent of people with a substance use disorder (SUD) also have a mental health disorder, and about 50 percent of people with severe mental illnesses (SMI) have a substance use disorder. Clearly there is a need for an effective response to this problem. There is less of a consensus on what is the most effective and efficient way to provide the person with a dual disorder with dual treatment. In many states, treatment programs are combining mental health and substance abuse interventions in what are called integrated treatment programs. Research on these integrated treatments is very promising.

Kenneth Minkoff, M.D., often cited as the nation's leading expert on dual disorders, has developed an integrated treatment model, the Comprehensive, Continuous, Integrated Systems of Care (CCISC). In helping states to implement this model, Minkoff argues that integrated treatment doesn't require all treatment dollars to be merged into one funding stream, however, it does necessitate an integrated approach to system planning. Programs do not have to change dramatically in order for them to serve people with dual disorders. Clinicians trained in either mental health or substance abuse treatment don't have to become experts in both specialties in order to serve the person with a dual disorder. They do need to acquire a basic level of competency in the field in which they were not originally trained.

Substance abuse is common and the consequences severe. Everyone touched by the problem—from program administrators and clinicians in mental health, substance abuse, and rehabilitation programs to those who struggle with recovery from dual disorders and their family members—need to be educated in the latest developments. The purpose of this book is to provide that information in a manageable format. This book was developed during an experience of the authors as co-teachers of a course on dual disorders—with Dr. Doyle Pita approaching dual disorders primarily as a substance dependence expert and Dr. Spaniol as an expert in severe mental illnesses. The intended use of this

book is as a text in an academic course or for in-service training, with the instructors or trainers offering context through their own experience working in the field. The articles reprinted here were selected for inclusion from a broad review of articles. Articles dealing with the most salient concepts and critical issues were selected.

The articles are grouped into eight chapters (parameters and course of disorders, assessment, treatment, cognitive-behavioral approaches, clinical issues, role recovery, family and self-help support, and legal system involvement). The parameters and course of disorders chapter includes five articles. The first four define and describe the course of dual disorders. Setting forth the parameters of dual disorders is essential. The literature at times defines a dual disorder as including only a severe mental illness, and at other times, as any mental illness. Including all mental illnesses increases the difficulty of providing valid prevalence estimates, assessment tools, and effective treatment plans because so many more variables are introduced. This book defines dual disorders as a co-occurring severe mental illness (SMI) and a substance use disorder (SUD)—not all mental illnesses and not all substance uses. Understanding the variable course of dual disorders is essential given the patterns of relapse and recovery throughout the lifetime of an individual. A person abstinent at intake may have relapsed at the second interview—the sobriety status impacts all aspect of functioning. An additional aspect of dual disorders introduced in this section is the relationship between substance use and psychosis. Our ability to determine how the two disorders are related affects treatment. For instance, if a psychosis preceded substance dependence then the person may need medication for the psychosis. However, the psychosis may, in fact, be a result of substance dependence. In the latter case, the person does not necessarily need medication. The fifth article (Malloy) is a personal account of the impact of a dual disorder on a family, with particular focus on the difficulty of access to effective treatment and, yet, despite all the chaos and barriers, the hope of recovery.

Chapter 2 includes three articles on assessment. Effective treatment is dependent upon valid and reliable assessment. Despite the high base rates, a substance use disorder is often undetected. Two articles (Carey & Correia; Rosenberg et al.) present the many factors that contribute to the problem of a valid and reliable assessment, along with possible solutions. Christie Cline, M.D, as medical director of the New

Mexico Department of Health's Behavioral Services Division, discovered that by introducing a more valid assessment tool (in this case, part of Minkoff's CCISC model) they were able to increase identification of people with dual disorders from 8 to 20 percent. The third article (Barry et al.) presents an assessment tool developed for detection of a substance use disorder in people with a severe mental illness.

The treatment chapter contains ten articles outlining effective treatment strategies that clinicians can utilize in treating people with dual disorders. The consensus is that individuals with dual disorders require interventions that simultaneously address both mental health and substance use disorders, i. e., integrated treatment. The first article (Minkoff) reviews a four-step intervention strategy for engagement of people in the treatment and recovery process. The second article (Drake & Mueser) provides an overview of research on the epidemiology, adverse consequences, and phenomenology of dual diagnosis, followed by a more extensive review of approaches to services, assessment, and treatment. The third article (Mueser et al.) provides a brief summary of problems related to traditional treatment approaches for people with dual disorders. Integrated dual-disorders treatment is described including common components of these programs, e.g., assertive outreach, comprehensiveness, long-term perspective, shared decision-making, stage-wise treatment, and pharmacotherapy. The authors also discuss the stages of treatment. The fourth article (Bellack & DiClemente) discusses assumptions about treatment of substance abuse and reviews the features of a transtheoretical model of change based on the view that behavior change is a longitudinal process consisting of several stages. The fifth article (Mueser & Noordsy) describes what is considered a core component of integrated treatment program, i.e., group-based interventions. The sixth article (Weiss, et al.) describes a 20-session relapse prevention group therapy approach for people with coexisting bipolar disorder and substance use disorder. The treatment uses an integrated approach, discussing topics relevant to both disorders and highlighting common aspects of recovery from, and relapse to, each disorder. The seventh article (Mueser et al.) assesses the lifetime prevalence of traumatic events and current posttraumatic stress disorder in patients with severe mental illnesses. Their findings suggest that PTSD is a common comorbid disorder in people with severe mental illnesses and that it is frequently overlooked in mental health settings. The eighth article

(Moggi et al.) study examines a model of treatment for patients with substance use disorders and concomitant psychiatric disorders. The model describes five interrelated sets of variables (social background, intake functioning, dual diagnosis treatment orientation, patients' change on proximal outcomes, and aftercare participation) that are hypothesized to affect people with dual diagnoses with 1-year of post-treatment outcomes. The ninth article (Humphreys & Weisner) evaluates the use of exclusion criteria in alcohol treatment outcome research and the effect of use of exclusion criteria on the comparability of research subjects with real-world individuals seeking alcohol treatment. The final article (Fleshner) is a first person account of the "terror and hell" experienced by a person with schizophrenia and depression.

Chapter 4 is comprised of three articles examining specific treatment components and strategies within the cognitive-behavioral arena. Treatment and recovery for alcohol and drug addiction usually includes both addiction treatment and participation in Alcoholics Anonymous (AA). This first article (Steigerwald & Stone) examines the 12-Step process from the perspective of cognitive restructuring. The second article (Finney et al.) evaluates substance abuse treatment process models and outcome during 12-Step and cognitive-behavioral treatment. The final article (Triffleman et al.) presents an integrated cognitive-behavioral approach to co-occurring substance dependence and PTSD.

Clinical issues are addressed in chapter 5. The first article (Minkoff) discusses common dilemmas faced by clinicians and then describes seven principles that can guide treatment interventions. Consistently recognized within the field of dual disorders is the need for a collaborative relationship between client and therapist. The second article (Fisher & Goldsmith) presents guiding principles of the relationship between staff members and people with mental illnesses. The third article (Connors et al.) explores factors predicting therapeutic alliance in alcoholism treatment. They found the strongest relationship between clients' motivational readiness to change and their ratings of the therapeutic alliance. A second issue crucial to recovery is medication. The fourth article (Laudet et al.) presents interview data from people with dual diagnoses in self-help groups concerning the challenges confronting them in their recovery. Their findings indicate that people struggle with emotional and socioeconomic issues, which bear significantly on their ability to handle adequately other aspects of their recovery. The last two

articles (Wilkins; Fenton et al.) address factors impacting use of medication. The issue of medication is especially complex given that the person with a dual disorder is recovering from the abuse of drugs and, yet, needs to learn how to take prescribed medications responsibly.

Chapter 6 includes five articles on role recovery. To be sustained, recovery needs to include more than abstinence from alcohol and drugs and symptom management. Recovery involves obtaining meaningful roles. In order for clinicians to help people attain these life goals, clinicians need data clarifying the barriers to role attainment and retention, and these data come from outcome studies. And, yet, outcome studies can lack model fidelity, which leads to false conclusions regarding the efficacy of program components. For instance, assertive community treatment is the most widely tested model of community care for people with severe mental illnesses and, yet, only recently has program fidelity been an issue.

The first article (Anthony) describes the importance of recovery as a vision for mental health systems. He describes how recovery needs to become embedded at all levels of the system. The second article (McHugo et al.) points up the importance of program fidelity showing that faithful implementation of, and adherence to, the assertive community treatment model for people with dual disorders was associated with superior outcomes in the area of substance use. The third article (Osher & Dixon) discusses housing barriers and suggests housing, treatment, and support services to overcome these barriers. The fourth article (Anthony et al.) overviews the people served, outcomes, and types of interventions that characterize the field of psychiatric rehabilitation. It also discusses current and future research issues. The fifth article (Shern et al.) is a study that tested a psychiatric rehabilitation approach for organizing and delivering services to street-dwelling persons with severe mental illnesses. It found that with an appropriate service model, it is possible to engage people who are disaffiliated, expand their use of human services, and improve their housing conditions, quality of life, and mental health status.

Seven articles comprise the section on family and self-help support. Without the support of family and self-help, the likelihood of sustained recovery drops. As discussed in the first article (Clark), families are critically important sources of housing, financial support, and direct care. Substance abuse appears to play a primary role in families pulling

back their support from people with dual disorders. Poor family support and substance abuse are both associated with homelessness. The second article (Dixon et al.) found that substance abuse is associated with low levels of satisfaction with family relationships among persons with severe mental illnesses. Family interventions need to meet the stated needs of people with mental illnesses and a comorbid substance use disorder and this might help to engage people with co-occurring disorders and their family members in treatment. The third article (Noordsy et al.) indicates that support also comes in the form of self-help groups such as AA and Double Trouble, developed specifically for those with dual disorders. However, clinicians often do not know how to determine if a client is benefiting from attendance at self-help meetings. The fourth article (Laudet, et al.) provides further evidence of the importance of support, finding that people with higher levels of support and greater participation in dual recovery reported less substance use and mental health. The fifth article (Vogel) describes a self-help approach for people with co-occurring disorders. The last article, a first person account, is written by the parents of a child who is diagnosed with schizophrenia and abusing substances. They recount the pain in dealing with their son's chronic relapses.

Chapter 8 contains four articles that focus on the legal aspects of co-occurring disorders. Legal system involvement is discussed through four articles. The first article (Swartz et al.) examines the combined impact of substance abuse and medication noncompliance on the risk of serious violence among people with severe mental illnesses. The combination of medication noncompliance and abusing alcohol or substances was significantly associated with serious violent acts in the community. Reduction of such risk requires carefully targeted community interventions, including integrated mental health and substance abuse treatment. In the second article (Clark et al.), people with co-occurring severe mental illnesses and substance use disorders were studied to understand how they are involved with the legal system and to identify factors associated with different kinds of legal system involvement. The third article (Goodman et al.) reviews the research literature on the prevalence, symptomatic and behavioral correlates, and treatment of abuse among women, particularly women with schizophrenia. Within each topic, the authors discuss relevant research findings, limitations of available studies, and key questions that remain unanswered. They also discuss mech-

anisms that may underlie the relationship between trauma and schizophrenia spectrum disorders. The authors conclude by outlining directions for future research in this area. The last article (Soyka) evaluated the literature to assess whether people with schizophrenia who use substances have an increased risk for violence and disturbed behaviour. They found that male gender, more severe psychopathology, a primary antisocial personality, repeated intoxications, and non-adherence with treatment are important confounding variables. Abusing substances has been shown to be a significant risk factor for violence and disturbed behavior.

The articles in the eight sections clearly show that there is significant support for an integrated approach to treatment. Integration can occur on many levels, from cross-training clinical staff to systemic integration. Clearly, reducing substance abuse in people with serious mental illnesses reduces negative consequences associated with such use such as from victimization to hospitalizations. It is not clear how widespread integration at any level is today. Anecdotal evidence presents itself to us on a weekly basis. Ten or fifteen years ago, people on psychiatric medications were told at AA meetings that they are "chewing their booze." Today, there is more acceptance of medication. Ten or fifteen years ago substance abuse program managers were reluctant to accept into treatment people with serious mental illnesses. Today, they are more likely to accept them into treatment. However, they do lack knowledge around best treatment practices once they are admitted. Case managers in substance abuse settings are more likely to accept people with dual diagnoses and refer them out for mental health treatment than in the past. Substance abuse counseling is provided in-house, and mental health counseling at a local outpatient setting. Even "old timers" are able to see that advice such as "go to a meeting," has its limitations. Treatment must be individualized.

Recently, Dr. Doyle Pita had the opportunity to treat a person who had relapsed many times, was referred by a recovery home, and who for the first time in his life agreed to take an anti-depressant. From an attitude of apathy, "I don't care if I drink," to a strong motivation for recovery miraculously occurred within one month. This person is now in sustained full remission from alcohol and drugs. On the mental health side, we have witnessed an increase in requests for trainings in substance abuse treatment, and we see more offerings of dual disorder trainings.

Progress in the field is slow, but it is happening. Hopefully, this book, through its compassionate and dedicated readers, will create further impetus for change.

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