INTEGRATED TREATMENT FOR DUAL DISORDERS

A Guide to Effective Practice

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Principles of Integrated Treatment

In order to develop better treatment programs for persons with dual disorders, it is crucial first to understand the limitations of traditional approaches to the management of these disorders. Only then can clinicians and program developers appreciate the need for integrated mental health and substance abuse treatment, and the necessary ingredients of such programs. We begin this chapter with a review of the problems associated with traditional sequential or parallel treatment approaches to dual disorders, and address how these problems are overcome by the integration of mental health and substance abuse services.

Next, we address a core value that permeates the provision of all integrated treatment services: shared decision making. After reviewing the importance of developing a collaborative relationship with the client, we describe the principles of integrated treatment, including integration, comprehensiveness, assertiveness, reduction of negative consequences, a long-term perspective (time-unlimited service), motivation-based treatment, and multiple psychotherapeutic modalities. In our discussion of motivation-based treatment, we describe the stages of treatment for dual disorders, which provide a conceptual model for identifying clients' motivation to work on substance abuse and tailoring treatment based on their desire to change. We cite relevant research supporting the different components of integrated treatment for dual disorders. Chapter 20 contains a review of research on comprehensive integrated treatment programs. The principles of integrated treatment are included in a fidelity scale contained in Appendix A.

TRADITIONAL APPROACHES TO TREATING DUAL DISORDERS

There has been a historical division between mental health and substance abuse treatment services for many years. Consequently, two different treatment systems oversee and provide separate services for each type of disorder. Education, training, and credentialing procedures differ between the two systems, as do eligibility criteria for clients to receive services. As a result of the bureaucratic separation between mental health and substance abuse treatment services, two general approaches to the treatment of dual disorders have predominated until recently: the sequential treatment approach and the parallel treatment approach. Each of these approaches is associated with a variety of difficulties, including administrative and organizational problems, philosophical differences between providers, and clinical hurdles inherent to nonintegrated treatment, as summarized in Table 2.1 and discussed below.

Sequential Treatment

The sequential treatment approach is a common clinical justification for exclusion from treatment, rather than an explicit treatment model. In this approach, a client with dual disorders is not eligible for treatment in one part of a system until the other problem is resolved or suitably stabilized. This approach defends programmatic boundaries while ignoring individual clients' and larger systems' needs. For example, a man with schizophrenia and an alcohol use disorder is informed by a substance
TABLE 2.1. Disadvantages of Traditional Sequential and Parallel Treatment Approaches to Dual Disorders

Sequential treatment
- The untreated disorder worsens the treated disorder, making it impossible to stabilize one disorder without attending to the other.
- There is a lack of agreement as to which disorder should be treated first.
- It is unclear when one disorder has been “successfully treated” so that treatment of the other disorder can commence.
- The client is not referred for further treatment.

Parallel treatment
- Mental health and substance abuse treatments are not integrated into a cohesive treatment package.
- Treatment providers fail to communicate.
- Burden of integration falls on the client.
- Funding and eligibility barriers to accessing both treatments exist.
- Different treatment providers have incompatible treatment philosophies.
- A client “slips between the cracks” and receives no services, due to failure of either treatment provider to accept final responsibility for the client.
- Providers lack a common language and treatment methodology.

abuse counselor that his alcohol problem cannot be treated until his schizophrenia has been successfully stabilized, or that he cannot be treated with antipsychotic medication and participate in the substance abuse program. Alternatively, a woman with bipolar disorder and drug abuse who comes for treatment to a mental health professional is informed that mood-stabilizing medications for her bipolar disorder cannot be prescribed until her drug abuse ceases.

The most important problem with the sequential treatment approach is that it ignores the interactive and cyclical nature of dual disorders. Substance use disorders rarely remit spontaneously and often worsen the course of psychiatric illness. For example, stimulant abuse and heavy marijuana abuse can have potent effects on worsening the symptoms of schizophrenia (Serper et al., 1995; Treffert, 1978). Without attempts to address the substance abuse problem, successfully stabilizing these symptoms can be difficult or impossible. Furthermore, as psychiatric disorders become more severe, and clients experience greater amounts of distress, their substance abuse often worsens, leading to more substance abuse and even worse consequences. For example, acute mania is often associated with an increase in alcohol consumption (Bernadt & Murray, 1986), further worsening the manic episode. Unless the mania is pharmacologically stabilized, the substance abuse may continue unabated.

In addition to clinical problems related to sequential treatment, there are organizational and administrative obstacles. The most common problem is that clients are never referred to other treatment, or when they are referred, they fail to follow through. Problems making referrals may be due to a clinician’s belief that the “primary disorder” has not yet been sufficiently controlled, or lack of awareness of the other disorder’s severity. Clients often do not follow through on treatment referrals for their other disorder because of lack of motivation, lack of awareness of the problem, or difficulties establishing new relationships with treatment providers.

Parallel Treatment

In the parallel treatment approach, mental health and substance use disorders are treated simultaneously by different professionals (often working for different agencies, but sometimes within the same agency). In theory, providers of separate services should attempt to coordinate care by making regular contacts and reaching consensus on the essential elements of the treatment plan. However, in practice, organizational and administrative problems usually preclude active collaboration between professionals (Kavanagh et al., 2000), and often there is little contact between mental health and substance abuse clinicians. Consequently, the burden of integration is placed on the client, who is usually ill equipped to handle this responsibility. Cognitive impairments associated with severe mental illness may make this task impossible for a client.

A variety of explanations can account for the poor integration of services in parallel treatment approaches. One important factor is that the mental health and substance abuse professions espouse different philosophies of treatment. Traditionally, in the United States, clinicians in the substance abuse treatment field have often employed emotionally charged, confrontational strategies in order to convince clients that they have a substance use disorder. These strategies include direct confrontation during individual and group sessions, as well as the practice of conducting an “intervention,” in which various family members and friends are convened at a surprise meeting with the client to express their concern over his or her substance abuse and the importance of addressing this problem. In contrast, among mental health professionals there is widespread acceptance, supported by evidence (Butzlaff & Hooley, 1998), that emotionally charged, confrontational interactions can have deleterious effects on clients with severe mental disorders: They may precipitate social with-
drawal, symptom relapses, rehospitalizations, and even violence.

Another difference between mental health and substance abuse treatment professionals lies in their attitudes toward “enabling behaviors.” Mental health services attempt to help clients achieve and maintain stable housing, benefits, and social networks, whereas traditional substance abuse services often view such services as “enabling” clients by insulating them from the natural consequences of their substance abuse. These differences may make it more difficult for clinicians in different agencies who are attempting to provide parallel treatment to collaborate actively, as each group of clinicians retains an allegiance to its home agency. In addition, even well-intentioned efforts by clinicians to integrate mental health and substance abuse treatment within the same agency may be thwarted by differences in philosophy that translate into contradictory messages to clients, reducing the prospects of clinical improvement.

In addition to differences in philosophy, the parallel treatment approach often involves funding barriers that prevent access to treatment for one or the other of the disorders. For example, some treatment systems specifically prohibit clients from utilizing mental health and substance abuse services simultaneously. Furthermore, systems that employ parallel treatment methods often rely on the clients to seek services from both mental health and substance abuse treatment providers. As just discussed in the section on “Sequential Treatment,” clients often fail to follow through on seeking treatment, due to poor motivation, lack of awareness, or difficulties establishing relationships with treatment providers. An unfortunate result of this policy is that some individuals fail to receive treatment for either disorder—“falling between the cracks” of mental health and substance abuse systems, as providers deem them inappropriate for their type of service. Thus many people with dual disorders fail to receive care for one or both of their disorders in systems that provide these services in a parallel fashion.

**Poor Outcomes in Traditional Dual-Disorder Treatments**

By the end of the 1980s, reviews of traditional dual-disorder treatment services had documented the problems described above and others (El-Guebaly, 1990; Polcin, 1992; Ridgely, Goldman, & Willenbring, 1990; Wallen & Weiner, 1989). In addition, there has been growing evidence showing a poor prognosis for clients with dual disorders treated with traditional sequential and parallel approaches (Drake, Mueser, et al., 1996; Havassy, Shopshire, & Quigley, 2000), and suggesting higher rates of costly service utilization (Bartels et al., 1993; Dickey & Azeni, 1996). As these facts became more widely recognized, new programs began to be developed, with the primary aim of integrating mental health and substance abuse services in order to improve the long-term outcome of persons with dual disorders.

**INTEGRATED MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT**

Integrated treatment programs can overcome many of the disadvantages of traditional sequential and parallel approaches to dual disorders. First, organizational and administrative lapses are effectively eliminated with integrated treatment, because no coordination between different service providers is required; both mental health and substance abuse services are provided by the same team. Second, clinical problems related to treating one disorder first and the other disorder second are avoided with integrated treatment, as both disorders are viewed as “primary” and are targeted for concurrent treatment. Third, conflict over different philosophical perspectives of mental health and substance abuse professionals on treating dual disorders is minimized when the clinicians work side by side, on the same treatment team, and preferably for the same agency. Although philosophical differences between clinicians may exist, the need to work collaboratively as a team, and to present a consistent message to clients, often leads to compromises and gradual shifts toward shared perspectives and a unified treatment approach.

The health care delivery system has moved rapidly toward endorsing integrated treatment approaches for clients with dual disorders (Center for Mental Health Services, 1994; Osher & Drake, 1996; Smith & Burns, 1994; Woody, 1996). Various different integrated treatment programs have been developed to meet the needs of these clients (Brady et al., 1996; Carey, 1996; Drake, Antosca, Noordsy, Bartels, & Osher, 1991; Kavanagh, 1995; Minkoff, 1989; Osher & Kofoed, 1989; Rosenthal et al., 1992; Sithar than et al., 1999; Ziedonis & Fisher, 1996). Many of these treatment programs share common values, as well as fundamental organizational, assessment, and treatment components. The balance of this chapter introduces and then reviews the essential components of integrated programs, based on our experiences and those of our colleagues (Drake, Bartels, Teague, Noordsy, & Clark, 1993; Drake, Osher, & Wallach, 1989; Drake, Wallach, & Hoffman, 1989; Mueser, Drake, & Noordsy, 1998).
THE COMPONENTS OF INTEGRATED TREATMENT AND HOW THEY WORK TOGETHER

As noted at the beginning of the chapter, effective treatment for dual disorders is based on the core value of shared decision making, and it incorporates the following core components: integration of services, comprehensiveness, assertiveness, the reduction of negative consequences, a long-term perspective (time-unlimited services), motivation-based treatment, and the availability of multiple psychotherapeutic modalities. Each of these components represents a different dimension of integrated treatment; together, they result in effective treatment for clients with dual disorders.

The integration of services represents the organizational dimension of treatment: Services for both mental illness and substance abuse need to be provided simultaneously by the same clinicians within the same organization, in order to avoid gaps in service delivery and to ensure that both types of disorders are treated effectively. Comprehensiveness addresses the scope of dual-disorder interventions: Services are directed not only at the problem of substance abuse, but at the broad array of other areas of functioning that are frequently impaired in clients with dual disorders, such as housing, vocational functioning, ability to manage the psychiatric illness, and family/social relationships. Assertiveness addresses the location of service provision and how clients are engaged in treatment: Effective treatment programs for clients with dual disorders do not wait for (often reluctant) clients to seek treatment on their own, but instead use assertive outreach and legal mechanisms to involve them in treatment. The reduction of negative consequences represents the philosophical dimension of integrated treatment: Given the damaging impact of dual disorders on the lives of clients, the first and foremost goal of clinicians is to reduce the harmful effects. This should be done without judging them or imposing clinicians’ own personal values on them regarding causes or moral responsibility for these consequences.

The long-term perspective addresses the need for time-unlimited services: Artificial constraints on the duration of services can prematurely terminate intervention for clients with dual disorders who would otherwise improve with continued integrated treatment. The motivation-based treatment component orients interventions to the clients’ desire to change their behavior. This needs to be done to avoid unnecessary and potentially destructive conflict, and to maximize treatment gains through collaborative work. Multiple psychotherapeutic modalities provide psychological treatment services for dual disorders in as many formats as needed (and several usually are). Individual, group, and family therapy modalities are all useful approaches to treating dual disorders, each with its own unique advantages.

The ability to incorporate each of these core components into treatment is critical for achieving the best possible outcomes for clients with dual disorders, and inattention to any one component can undermine the overall effectiveness of a treatment program. A narrow focus on substance abuse, and neglect of other important areas of functioning (e.g., housing, work, social relationships, quality of life), can make it difficult or impossible for clients to develop lifestyles worth living without alcohol and drugs. Lack of integration of treatment can result in clients’ receiving services for one type of disorder but not the other, or receiving services from clinicians whose efforts are inconsistent with one another. Lack of assertiveness can make a program unable to engage clients, leading to continued substance abuse and dismal outcomes. Inattention to reducing the negative consequences of substance abuse can likewise condemn clients to poor outcomes (including victimization, disease, and mortality) and can squander important opportunities for engaging clients in treatment. Lack of a long-term perspective can result in premature termination of effective services and a consequent reversal of treatment gains. Poor attention to motivation-based treatment can lead to ineffective services as clinicians attempt to change the substance use behavior of clients who are not yet motivated to address those problems. Unavailability of multiple treatment modalities can limit the flexibility of a treatment program for using different strategies to help clients understand the effects of substances on their lives, reduce their substance use, and make progress in other important life areas.

Thus the different components of treatment work in harmony by addressing different dimensions of service delivery, including organization, focus, locus, philosophy, and specific treatment modalities. Because integrated treatment programs are flexible, with treatment planning and intervention based on clients’ unique needs, effective programs may differ in the specific array of services they offer. However, organization commitment and resources, quality assessment, and an adequate range of services (including all different treatment modalities) are required to optimize client functioning. This means that while integrated programs will differ, the more components of integrated treatment that are incorporated into a program, the better the outcomes are likely to be. We now focus in more detail on each of these dimensions of integrated treatment, starting with the core value of shared decision making.
SHARED DECISION MAKING

At the core of integrated treatment is shared decision making among all critical stakeholders. A major premise of integrated treatment is that clients with dual disorders, like those with either severe mental illness or substance use disorders, are capable of playing a vital role in the management of their disorders and in making progress toward achieving their goals. Such a philosophy is consistent with an emphasis on consumerism, illness self-management, community integration, quality of life, rehabilitation, and recovery for persons with severe mental illness (Anthony, 1993; Copeland, 1997; Deegan, 1992; Fisher, 1992). In addition, the emphasis on self-help is consistent with a long tradition in the substance abuse field.

Shared decision making also recognizes the critical role that many families play in the lives of persons with dual disorders. Since family members are often involved as caregivers for clients with severe mental illness, and serve to buffer them from many of the negative effects of stress, families also need to be engaged and involved in making decisions (Clark, 1996). Family members may also suffer the negative effects of dual disorders in a loved one, and decreasing this stress and tension is often critical to maintaining their support and involvement with the client (Hatfield & Leffley, 1987, 1993).

For a number of medical illnesses, shared decision making has resulted in better educated clients, greater treatment adherence, higher satisfaction with care, and improved biomedical outcomes (Wennberg, 1991). Similar benefits occur in mental health care. Making decisions collaboratively requires that clients and their families have as much information as possible about illnesses and their treatment to facilitate better decision making. Providers accept the responsibility of getting information to clients and their families so that they can become more effective participants in the treatment process.

Shared decision making maximizes the chances that treatment plans will be followed up, as different stakeholders are involved in selecting and implementing solutions to identified problems that they believe will work. Over the long run, clients and families become more able to advocate for themselves and to work collaboratively with professionals. The goal is for people with dual disorders to become responsible for recognizing and managing their own illnesses, using their family members for support and professionals for specific consultations and treatment. Clients and families are more satisfied with care as they learn more and take responsibility for implementing treatment plans that they understand and have chosen. Shared decision making assumes that more knowledge, greater choice of treatment, increased responsibility for self-management, and higher satisfaction with care will produce better outcomes, including less severe symptoms, better social and vocational functioning, and a better quality of life.

CASE EXAMPLE

Sharon was a 30-year-old woman with bipolar disorder and alcohol dependence. She had been in treatment for 5 years, and although she took her prescribed medications, she continued to drink and was repeatedly hospitalized for both severe depression and mania. Her case manager recognized that alcohol was a problem for her, and transferred her to the dual-diagnosis treatment team at the agency. Sharon's new case manager began to conduct outreach with Sharon at her home, where she lived with her parents. He spent several meetings educating her family about alcoholism and describing how substances like alcohol interact with mental illness. Over time, Sharon and her parents were able to see that her frequent hospitalizations were related to her drinking. Sharon planned with her case manager to attend Alcoholics Anonymous (AA) meetings and a substance abuse group at the agency. After a few months of regular attendance and some reductions in her alcohol use, Sharon was ready to try a period of abstinence. She worked collaboratively with her case manager to develop a treatment plan that focused on maintaining her abstinence and included obtaining a part-time job.

In addition to the overriding value of shared decision making, effective integrated intervention for dual disorders requires attention to the core set of treatment components introduced earlier. Each of these components is operationalized in a behaviorally anchored fidelity scale, which is included in Appendix A. We discuss these components in more detail below.

Integration

An integrated treatment program is a program in which the same clinician (or team of clinicians) provides treatment for mental illness and substance use disorders at the same time. As treatment for severe mental illness is typically provided by multidisciplinary treatment teams that include a range of different professionals (e.g., psychiatrist, nurse, master's-level clinicians, case managers), treatment for dual disorders will also most often be given by teams of professionals rather than a single clinician (see Chapter 3 for a discussion of the composition and staffing of dual-disorder treatment teams). Clinicians on these teams assume the responsibility of integrating the treatments so that interventions are selected, modified, combined, and tailored for each specific client. Because the educational and prescriptive message is integrated, there is no need for the client to
reconcile two messages, and the approach is seamless. There is ample evidence supporting the effects of integrated over nonintegrated dual-disorder treatment (Barrowclough et al., 2001; Carmichael et al., 1998; Drake, Yovetich, Bebout, Harris, & McHugh, 1997).

In addition to the integration of services, it is important to integrate several other aspects of treatment, including assessment, treatment planning, and crisis planning. Integrated assessment is critical to understanding the interactions between mental illness and substance abuse. Substance abuse worsens the outcome of severe mental illness; yet clients often continue using substances for other reasons related to their mental illness, such as coping with symptoms or increasing social contact and acceptance. Identifying how substance abuse and mental illness interact can lead to treatment plans that specifically address these areas. For example, clients whose substance abuse is related to coping with persistent symptoms or facilitating social opportunities may benefit from learning more effective coping strategies or developing other social outlets.

People with dual disorders are at increased risk for experiencing crises, such as substance abuse or mental health relapses, housing instability and homelessness, and legal problems. Assessment and treatment planning needs to take these increased risks into account, and develop crisis plans for responding to problems of either disorder. At a minimum, such plans should identify the early warning signs of relapse for any disorder in remission, should consider the interactions between the client's disorders, and should specify the steps to be taken in the event of a crisis (such as whom to contact and where to go).

Comprehensiveness

Although a major goal of integrated treatment is to decrease or altogether eliminate substance abuse, achieving this goal usually involves more than changing behaviors directly related to substance use. To reduce substance abuse or to achieve the long-term goal of abstinence, individuals must not only decrease or stop using alcohol and other drugs, but must also develop a lifestyle that is no longer centered around substance use. Decreasing or eliminating one's involvement in substance use for more than a few days is difficult precisely because this involves changing habits, activities, expectations, beliefs, friendships, and ways of dealing with internal distress—indeed, almost everything about one's life.

Individuals with dual disorders typically have a wide range of needs, such as finding work or other meaningful activity; improving the quality of family and social relationships; developing a capacity for independent living, leisure, and recreation; and developing skills for managing anxiety, depression, and other negative moods. Integrated treatment programs need to be comprehensive, because the recovery process occurs longitudinally in the context of making many life changes. In addition, even before clients have acknowledged their substance abuse or developed motivation to reduce alcohol and drug use, they can make progress by improving their skills and supports. These improvements can increase clients' hopefulness about making positive changes and facilitate their subsequent efforts to change their destructive involvement with substances.

Comprehensive treatment requires comprehensive assessment that spans the range of areas affected by mental illness and substance abuse. Such assessment requires the evaluation of psychosocial history; symptoms; history of psychiatric and other emergency/crisis services; social and vocational functioning; leisure and recreational activities; family contact and other social supports; housing and safety, independent living skills; medical needs; and insight into/understanding of the mental illness. It also involves the evaluation of history of substance use and abuse; treatment history; current/recent use of alcohol and specific drugs (including patterns and amounts of use); social context, motives, and consequences of use; insight into substance abuse problems; and motivation to address substance abuse.

Seven types of services need to be considered to determine the comprehensiveness of a treatment program: residential services, an appropriate model of case management, supported employment, family psychoeducation, social skills training, training in illness management, and pharmacological treatment. The rationale for including each type of these services is provided below.

Residential Services

Clients living in environments replete with substance use and abuse face special challenges in achieving sobriety (Trumbetta, Mueser, Quimby, Bebout, & Teague, 1999). As elaborated in Chapter 16, in order to protect clients from either street life or substance-abusing social networks, residential services are needed that do not exclude clients with ongoing substance abuse (Osher & Dixon, 1996). Research indicates that integrated dual-disorder services attending to the residential needs of clients result in better housing and substance abuse outcomes than traditional, nonintegrated services do (Drake et al., 1997). Furthermore, there is evidence that long-term residential treatment for clients with dual disorders improves substance abuse outcomes more than short-term programs do (Brunette, Drake, Woods, & Hartnett, 2001).
Case Management: The Assertive Community Treatment Model

The assertive community treatment (ACT) model of case management was developed to meet the needs of clients with severe mental illness who have histories of very high service utilization (e.g., multiple or prolonged psychiatric hospitalizations) or extremely impaired psychosocial functioning. The essence of the ACT model is that instead of waiting for clients to come to the clinic for treatment, most services are delivered to them in the community, in their natural living settings. The ACT model is characterized by the following: low clinician-to-client caseload ratios (1:10, rather than the usual 1:30 or higher in standard case management); shared caseloads across clinicians, rather than individual caseloads; most services provided in the community; most services provided directly by the ACT team and not brokered to other service providers; and 24-hour availability of the ACT team (Allness & Knoedler, 1998; Stein & Santos, 1998).

Extensive research on the ACT model documents that for clients who frequently utilize hospital and emergency services, it is effective at reducing hospitalizations, stabilizing housing, decreasing symptom severity, and improving quality of life (Bond, Drake, Mueser, & Latimer, 2001; Mueser, Bond, Drake, & Resick, 1998). Research on ACT-delivered integrated treatment for clients with dual disorders indicates modest benefits in terms of substance abuse and some quality-of-life outcomes, compared to integrated treatment provided by standard clinical case management (Drake, McHugo, et al., 1998). Clients with dual disorders who have frequent hospitalizations or severe psychosocial impairments may benefit from ACT-level case management.

Supported Employment

Helping clients with dual disorders develop meaningful lives is an important goal of treatment. One common goal of clients is to obtain competitive work. The approach to vocational rehabilitation for clients with severe mental illness that has the strongest evidence is supported employment. As elaborated in Chapter 18, supported employment programs emphasize helping clients obtain competitive jobs in the community (working alongside nondisabled workers) by minimizing pre-vocational assessment and training, emphasizing rapid job search based on client preferences, and providing follow-along supports to help clients maintain jobs or move on to other jobs (Becker & Drake, 1993). Multiple controlled studies show that supported employment is more effective at improving vocational outcomes in clients with severe mental illness than other approaches are (Bond, Becker, et al., 2001; Bond, Drake, Mueser, & Becker, 1997). Furthermore, even clients with dual disorders are capable of getting and keeping jobs in supported employment programs (Sengupta, Drake, & McHugo, 1998).

Family Psychoeducation

Families play a crucial role in providing support to clients with dual disorders (Clark, 1998), and such support is associated with improvements in substance abuse outcomes (Clark, 2001). Family psychoeducation for severe mental illness has been shown to improve outcomes (Dixon et al., 2001), and family intervention is associated with better outcomes for substance use disorders as well (Stanton & Shadish, 1997). As described in Chapters 13–15, family psychoeducation is aimed at teaching families (including clients) basic information about dual disorders and the principles of their treatment, as well as reducing stress and improving coping. Psychoeducational handouts for families are included in Appendix B.

CASE EXAMPLE

Sandy, a 35-year-old married woman with diagnoses of major depression with psychotic features and posttraumatic stress disorder, had a long history of alcohol abuse with occasional suicide attempts. Sandy’s episodes of drinking were usually precipitated by exacerbations of her depression and anxiety, interpersonal conflicts with her husband, or both. In addition to providing Sandy and her husband with information about the interactions among alcohol abuse, depression, and anxiety, her comprehensive treatment also involved teaching her cognitive-behavioral strategies for managing her anxiety and depression (e.g., relaxation strategies, challenging self-defeating thoughts that led to depression) and engaging her and her husband in couple counseling to help them develop more effective skills for handling their conflicts. This approach to treatment was successful in decreasing Sandy’s reliance on alcohol during times of distress and conflict, and enlisting her husband’s support in her pursuit of treatment goals.

Social Skills Training

As described in detail in Chapter 11, social skills training involves teaching new interpersonal skills through the systematic application of social learning theory (e.g., modeling, role playing, positive feedback, etc.). Research indicates that such training for clients with severe mental illness is effective at improving social functioning (Dilk & Bond, 1996; Heinssen, Liberman, & Kopelowicz, 2000). This is of crucial importance, con-
2. Principles of Integrated Treatment

Considering that impairments in social functioning are defining characteristics of some severe mental illnesses (e.g., schizophrenia; American Psychiatric Association, 1994), and that poor social functioning predicts a worse course of mental illness (Rajkumar & Thara, 1989; Strauss & Carpenter, 1977). Furthermore, social skills training has been found to be an effective intervention for persons with substance use disorders (Miller et al., 1995; Monti, Abrams, Kadden, & Cooney, 2002). Skills training may be an especially important treatment strategy for clients with dual disorders, because of the important role social relationships play in maintaining ongoing substance abuse (Trumbetta et al., 1999), and clients’ need to develop new relationships with persons who do not abuse substances if they are to be successful in achieving sobriety.

Training in Illness Management

Illness management programs have been developed to teach clients with severe mental illness strategies for managing their disorders in collaboration with others and getting on with their lives (Ascher-Svanum & Krause, 1991; Copeland, 1997; Weiden, 1999). This training typically incorporates a variety of methods, including psychoeducation about the mental illness and its management; teaching the recognition of early warning signs of relapse and the development of a relapse prevention plan; coaching in methods for taking medication as prescribed; and teaching strategies for coping with persistent symptoms and pursuing personal goals. Research on teaching illness management skills indicates that it is effective at improving clients’ knowledge about mental illness, improving medication adherence, and reducing relapses and symptom severity (Mueser, Corrigan, et al., 2002). A central goal of treating clients with dual disorders is to improve their ability to manage their psychiatric disorder through such strategies as training in illness management.

Pharmacological Treatment

Antipsychotic, antidepressant, and mood-stabilizing medications continue to be mainstays in the treatment of severe mental illness, with more effective and more benign new medications becoming available every year. Abundant research documents the effects of psychotropic medications on reducing symptom severity and relapses in clients with severe mental illness (Schatzberg & Nemeroff, 1998). As described in Chapter 19, it is crucial that clients with dual disorders (including those clients with active substance abuse) have access to pharmacological treatment for their mental illness. Furthermore, clients with dual disorders may benefit from trials of medications that decrease substance abuse, such as disulfiram for alcoholism and naltrexone for alcoholism or opiate abuse.

Assertiveness

Clients with dual disorders often drop out of treatment, due to the chaos in their lives, cognitive impairment, low motivation, and hopelessness (Miner et al., 1997; Swartz et al., 1998a). An assertive approach to treatment recognizes that clinicians cannot passively wait for clients to demonstrate the initiative and motivation to seek out dual-disorder treatment on their own; rather, clinicians must make every effort possible to actively engage reluctant clients in the process of treatment. One important assertive strategy is to reach out to clients and provide them with services in their natural living environments—such as their homes, local parks, restaurants, or homeless shelters—rather than in the clinic. By connecting with clients in their natural environments and providing practical assistance with immediate goals defined by the clients (such as housing, medical care, crisis management, and legal aid), assertive outreach is a means of developing trust and a working alliance between clinicians and clients.

In addition to facilitating engagement, assertive outreach is helpful in monitoring and improving the course of dual disorders. By meeting with clients regularly in their own natural environments, clinicians are able to obtain more information about their day-to-day functioning, and about the social and environmental factors that may influence the outcome of dual disorders. Furthermore, assertive outreach can provide clinicians with an important opportunity to enhance clients’ adherence to their prescribed medications. Medication is important in stabilizing the psychiatric symptoms of clients with dual disorders, but many clients have difficulty following through on taking prescribed medications. Rather than relying on clients’ going to a pharmacy for medication and taking it, clinicians can deliver medications to the homes of clients, watch them take some or all doses, and teach them how to incorporate taking medication into their usual routines (Mueser, Corrigan, et al., 2002). Without assertive outreach, many clients are never effectively engaged in integrated treatment and continue to suffer severe symptoms due to poor medication adherence. Assertive outreach is a core component of several dual-disorder programs supported by research (Drake et al., 1997; Drake, McHugo, et al., 1998).

Assertive outreach to clients with dual disorders requires sufficient staffing to account for clinicians’ increased travel time. The average staffing required to accomplish these tasks is a ratio of 1 clinician to 30 clients.
Lower clinician-to-client ratios may be required (e.g., 1:15 or lower) if the clients are extremely impaired, or if they have been experiencing especially problematic consequences of their substance abuse (e.g., involvement with the criminal justice system or homelessness). Further consideration of the staffing required to deliver integrated dual-disorder services is provided in Chapters 3 and 6.

CASE EXAMPLE

Jerome, a 23-year-old client with a diagnosis of schizophrenia and severe cocaine and marijuana abuse, took his antipsychotic medication inconsistently and refused to come to the mental health center for appointments other than with his psychiatrist; he frequently missed even these meetings. His substance abuse, compounded by medication nonadherence, resulted both in housing instability and in multiple relapses and rehospitalizations. Soon after Jerome was assigned to an integrated dual-disorder program, members of his treatment team began to conduct brief daily visits to his residence. During these visits, clinicians spent time getting to know Jerome better, assessing his immediate needs, and providing him with medication that he took during the visit. These visits helped to engage Jerome in treatment, while stabilizing some of his most severe symptoms.

Although the term assertiveness frequently refers to outreach for the purposes of treatment engagement and service provision, the term may also be applied to the use of other legal mechanisms for involving clients in treatment. Clients with dual disorders often experience money problems, legal problems, and frequent hospitalizations, which may meet criteria for using coerced or involuntary interventions to involve them in treatment. As addressed in Chapter 17, thoughtful coerced or involuntary interventions can make a critical difference in engaging clients with dual disorders in treatment and ensuring ongoing access to them. A variety of such interventions may be available to clinicians, and effective treatment involves using those interventions appropriate to each client’s needs. In addition to the use of civil commitment to the hospital when clients present a grave danger to themselves or others, the most common types of involuntary or coerced interventions include outpatient commitment to treatment (or, alternatively, discharge from a hospital that is conditional upon participation in outpatient treatment); payeeships; coordination with child welfare and protective services; and coordination with parole or probation officers. Though research on the effects of involuntary interventions on clients with dual disorders is limited, evidence suggests that outpatient commitment can increase treatment adherence and reduce rehospitalizations, violence, and victimization in clients with severe mental illness (Hiday, Swartz, Swanson, Borum, & Wagner, 2002; Swanson et al., 2000; Swartz et al., 1999, 2001).

Reduction of Negative Consequences

An important goal in the treatment of persons with dual disorders is to reduce the negative consequences of their substance abuse. This goal is based on the fact that many people with addictions lack the motivation to endorse abstinence early in treatment, or even to decrease their use of alcohol or drugs; yet significant gains can be made initially by focusing treatment on reducing the negative consequences of alcohol and drug use (Denning, 2000; Des Jarlais, 1995; Marlatt, 1998). Furthermore, in the absence of motivation to work on substance abuse, clients’ continued use of alcohol and drugs may pose serious threats to their physical and psychological well-being. The essence of focusing on reducing the harmful effects of substance abuse is to protect clients from the most dire consequences of their substance use, while developing a good working alliance with them that can ultimately help them perceive the negative effects of substance abuse and develop the motivation to address it (Marlatt & Witkiewitz, 2002).

Reducing the negative effects of substance abuse is especially important early in treatment with clients with dual disorders, when substance abuse tends to be most destructive and may impair insight, and clients are least motivated to reduce their use of substances. Examples of strategies for reducing the negative effects of substances include supplying clean needles to a client who shares needles when using drugs with others; securing stable housing; limiting access to money for purchasing substances; accessing food or vitamins; teaching safe-sex methods for persons who exchange sex for money or drugs; and obtaining needed medical treatment (e.g., for infectious diseases, such as hepatitis C).

Attempting to reduce the negative consequences of substance abuse sometimes leads to debate among clinicians about whether such efforts protect clients from the natural consequences of their substance abuse, and actually impede the long-term goal of encouraging clients to address their substance abuse. Sometimes it is argued that people with substance use disorders need to “hit rock-bottom” before they become truly motivated to work on their substance abuse problems. However, considering the negative consequences of substance abuse, delaying until clients with dual disorders “hit rock-bottom” is tantamount to sitting back and watching as they experience relapses and rehospitalizations, contract infectious diseases, fail to receive proper attention for medical conditions, become violent, are victimized, become homeless or imprisoned, or even die. In addi-
tion, exacerbations of symptoms and cognitive impairment from excessive use of substances may impair clients' ability to perceive and learn from the negative consequences of their substance use behavior. The effects of unchecked substance abuse on clients with severe mental illness are so drastic that methods for reducing the negative consequences of substance abuse at the earliest possible time are essential to achieving positive outcomes in this population.

CASE EXAMPLE

Angela was a 23-year-old woman with schizoaffective disorder who was addicted to crack cocaine. To support her habit, she often prostituted herself—either exchanging sex for money from customers she met walking the street, or trading sex for cocaine with other addicted individuals at crack houses. Although Angela knew that her behavior increased her risk for HIV and other infectious diseases, she incorrectly believed that her chances of contracting these diseases were small because she used the "withdrawal method" when having sexual intercourse, and because she did not engage in anal sex. Angela's clinician provided her with more accurate information about risk behaviors for infectious diseases. Angela said that she was not ready to give up crack cocaine at that time; however, she expressed an interest in learning how to reduce her risk of contracting infectious diseases through sex. Her clinician discussed with Angela the use of condoms as an effective strategy for reducing risk. Angela said that when she had mentioned condoms to men before, they usually did not have one, and nearly always complained that they did not want to wear one. Angela's clinician talked over the importance of carrying condoms with her. To help her be more successful in getting her partners to wear condoms, Angela's clinician did several role plays with her of the skill "requesting that your partner use a condom" (Bellack, Mueser, Gingerich, & Agresta, 1997). Angela began using this skill, and reported feeling good about reducing her sexual risk behaviors. As Angela and her clinician continued to work together, they began exploring the effects of her cocaine addiction on her life.

A Long-Term Perspective
(Time-Unlimited Services)

As we have reviewed in Chapter 1, when clients with dual disorders are not treated, or they are treated via traditional parallel or sequential service approaches, the longitudinal course of the disorders is both chronic and severe, with fewer than 5% of clients achieving stable remission of their substance use disorders each year. Available research on integrated treatment programs suggests that such programs have a beneficial effect on decreasing substance abuse and related negative outcomes in clients with dual disorders (Drake, Mercer-McFadden, Mueser, McGhoo, & Bond, 1998). However, research also suggests that integrated treatment programs do not produce dramatic changes in most clients over short periods of time; rather, clients gradually improve over time, with approximately 10–20% achieving stable remission of their substance use disorders per year.

Adopting a healthier lifestyle—just like developing the skills and supports needed to manage one's illnesses, to work, and to attain satisfaction with activities and relationships—requires major life changes over months and years. It makes no sense to believe that recovery from two intertwined disorders might be faster than from either disorder alone. Thus effective integrated programs for dual disorders provide time-unlimited services, recognizing that each individual recovers at his or her own pace, given sufficient time and support. Furthermore, clinicians have good justification for being optimistic that in the long run, most clients with dual disorders respond to treatment, get better, and achieve stable remissions of their substance use disorders.

CASE EXAMPLE

Maria, a 49-year-old remarried mother of five, struggled for many years with her bipolar disorder and polysubstance abuse. During her 20s, Maria experienced over 25 hospitalizations, was divorced, and lost custody of her children, due largely to the effects of substance abuse on worsening her bipolar disorder. For many of these years, her substance abuse was ignored by her mental health providers, and she did not perceive it to be a significant problem. In her 30s, Maria began to receive integrated treatment for her dual disorders. Over a period of 4–6 years that involved many setbacks, Maria gradually began to achieve her goals of abstinence from alcohol and putting her life together. Ten years later, Maria had remarried, was working full time, had rekindled her relationships with her children, and had not had a major relapse of her alcoholism.

Motivation-based Treatment

In order to treat dual disorders most effectively, interventions must be motivation-based—that is, adapted to clients' motivation for change. The concept of stages of treatment is central to integrated dual-disorder treatment, as it provides a framework for assessing clients' motivational states, setting goals, and selecting interventions appropriate to achieving those goals. For many years, clinicians and researchers have proposed that changes in maladaptive behavior occur over a series of stages (DiClemente & Prochaska, 1998; Mahoney, 1991;
Prochaska, 1984). These stages differ in terms of clients' motivational states, orientation toward change, goals, and interventions most likely to be effective. Recognition of the stages of treatment can provide clinicians with valuable information about the immediate goals that need to be the focus of collaborative work, and therefore which interventions are most likely to be successful at a particular point in the course of recovery from dual disorders.

The stages of treatment for dual disorders reviewed here were first described by Osher and Kofoed (1989). Osher and Kofoed observed that clients who recover from dual disorders by participating in treatment progress through a series of four stages: engagement, persuasion, active treatment, and relapse prevention (although relapses and returns to prior stages are common). Each stage can be defined in terms of a client's abuse of alcohol or drugs and the nature of his or her relationship with a dual-diagnosis clinician. When a client's stage of treatment is determined, appropriate goals can be identified and a treatment plan formulated. Clinicians have a wide variety of treatment options they can use at each stage to help clients progress through the stages.

The concept of stages of treatment is closely related to that of stages of change (Connors, Donovan, & DiClemente, 2001; Prochaska, 1984). The latter concept is based on the observation that people who change maladaptive behaviors progress through a series of distinct stages, including precontemplation, contemplation, preparation, action, and maintenance, each characterized by different motivational states. The stages of change differ from the stages of treatment mainly in that the former are not specific to the change process that occurs in the context of a helping (therapeutic) relationship, whereas the latter are specific to changes that occur over the course of dual-disorder treatment. The overlap between the stages of treatment and the stages of change is summarized in Table 2.2.

We describe each stage of treatment below, including characteristic behaviors and treatment goals, and provide examples of interventions that can be used to achieve those goals. Table 2.3 summarizes the definitions and goals of each stage. Following this, we highlight the clinical utility of the stages concept.

**Engagement**

*Definition and Goals.* The engagement stage is defined by the lack of a working alliance between the client and the dual-diagnosis clinician. Without first establishing a therapeutic relationship, the clinician cannot help the client to modify his or her substance use behavior. Therefore, the goal of the engagement stage is to establish a working alliance between the clinician and the client.

The terms *working alliance* and *therapeutic relationship* are used widely in the psychotherapy literature, and have recently been adapted to address the relationship between the client and a case manager. For example, Bordin (1976) provides a broad definition of these terms as including (1) the perceived relevance of the cognitive-behavioral tasks involved in collaborative work; (2) agreement as to the goals of the intervention; and (3) the strength of the interpersonal bonds between the clinician and client (e.g., mutual trust and acceptance). Although a long-term goal of integrated treatment is to establish a close working relationship between the clinician(s) and the client, as described by Bordin and exemplified by the importance of shared decision making previously discussed in this chapter, for the purposes of engagement in dual-disorder treatment, we adopt a simpler and more behaviorally specific definition of a working alliance. We define a client as *engaged in treatment* (and hence as having a working relationship with the clinician) if he or she is, seeing the clinician on a regular (e.g., weekly) basis.

There are two reasons for defining a working relationship in terms of regular contact between the client and the clinician, rather than the richer and more complex definition of Bordin (1976). First, it is easier for clinicians to agree with each other about the frequency of contact between a clinician and a client than about the level of agreement, trust, and acceptance between the two. Therefore, a simpler definition is less likely to result in disagreement between clinicians about a client's stage of treatment, reducing the possibility of inconsistencies in how different clinicians work with a client. This is especially important, considering that much of dual-disorder treatment is provided by multidisciplinary treatment teams. Second, the willingness of the client to see the clinician on a regular basis indicates a level of interpersonal or therapeutic involvement that is sufficiently robust and stable to begin exploring goals related to substance abuse, and thus to begin work on the next stage of treatment—the persuasion stage.

<table>
<thead>
<tr>
<th>TABLE 2.2. Overlap between Stages of Treatment and Stages of Change</th>
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<tbody>
<tr>
<td><strong>Stages of treatment</strong></td>
</tr>
<tr>
<td>Engagement</td>
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<tr>
<td>Persuasion</td>
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<tr>
<td>Active treatment</td>
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<tr>
<td>Relapse prevention</td>
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2. Principles of Integrated Treatment

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Client does not have regular contact with dual-diagnosis clinician.</td>
<td>To establish a working alliance with the client.</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Client has regular contact with clinician, but does not want to work on reducing substance abuse.</td>
<td>To develop the client's awareness that substance use is a problem, and increase motivation to change.</td>
</tr>
<tr>
<td>Active treatment</td>
<td>Client is motivated to reduce substance use, as indicated by reduction for at least 1 month but less than 6 months.</td>
<td>To help the client further reduce substance use and, if possible, attain abstinence.</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>Client has not experienced problems related to substance use for at least 6 months (or is abstinent).</td>
<td>To maintain awareness that relapse can happen, and to extend recovery to other areas (e.g., social relationships, work).</td>
</tr>
</tbody>
</table>

**Engagement Interventions.** Clients who are not actively engaged in dual-disorder treatment often attend clinics on an inconsistent, sporadic basis and never establish a trusting relationship with a clinician. Therefore, in order to establish a therapeutic relationship with a client, outreach is often necessary.

The process of engagement typically begins with practical assistance related to securing food, clothing, shelter, crisis intervention, or support. While a clinician is rendering this assistance, sensitivity and skill are required to understand and respond to the client's language, behavior, and unspoken needs, so that some trust and openness develop. Most fundamentally, the clinician tries to make something positive (either tangible or emotional) happen in the client's life, or tries to lessen or remove something painful or unpleasant. As these changes are brought about by the clinician, the client begins to see him or her as potentially useful, and eventually as someone who cares about the client. This emerging therapeutic relationship serves as the critical bond through which all other integrated treatment becomes possible.

During the engagement stage, the clinician usually does not address substance use directly; instead, he or she focuses on learning about the client's experiences and developing a relationship that will later serve as a basis for modifying substance use behavior. Premature attempts to push clients toward substance use reduction or abstinence are often unsuccessful, because they fail to recognize that the client must first develop the motivation, skills, and supports to lead a healthier lifestyle free of substance abuse. The therapeutic alliance should allow discussion of the client's substance use and mental illness symptoms by the end of the engagement stage to facilitate persuasion-stage work.

Many different interventions are possible for achieving the goal of the engagement stage. Table 2.4 provides examples of interventions for this stage.

**Persuasion**

**Definition and Goals.** After establishing regular contact and a working relationship with a dual-disorder clinician, many clients fail to acknowledge the negative effects of their substance abuse and do not modify their substance use behavior. Recognizing the effects of substance abuse and trying to change one's own substance use behavior constitute motivation, and clients who are behaviorally unmotivated are in the persuasion stage. Clinically, it is not helpful to attempt to change a client's behavior before he or she views that behavior as undesirable or otherwise problematic. Therefore, the goals of persuasion are to help the client recognize the negative effects of substance abuse, to develop hope that his or her life can be improved by reducing substance use, and to demonstrate motivation to address substance abuse by attempting to change behavior. The tasks of persuasion are distinguished from directly helping the client acquire skills and supports for reducing substance use, which are the focus of the next stage of treatment.

**Persuasion Interventions.** A variety of different strategies can be used to help clients understand the problematic nature of their substance use. Active psy-

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**Table 2.4. Examples of Clinical Interventions for the Engagement Stage**

- Outreach
- Practical assistance (e.g., food, clothing, housing, benefits, transportation, medical care)
- Crisis intervention
- Support and assistance to social networks
- Stabilization of psychiatric symptoms—medication management
- Help in avoiding legal penalties
- Help in arranging visitation with family
- Family meetings
- Close monitoring
Psychiatric symptoms need to be stabilized to the extent possible, in order to minimize impairment of insight and judgment due to grandiosity, psychosis, or thought disorder. Clients and family members often benefit from education about psychiatric illness, commonly abused substances, the interactions between psychiatric illness and substance use, and the principles of dual-disorder treatment. Individual counseling in the persuasion stage is based on motivational interviewing (Miller & Rollnick, 2002), which enables clients to identify their personal goals and to discover how their use of substances interferes with attaining those goals (see Chapter 7).

Group interventions help many clients develop the motivation to address substance-related problems. Persuasion groups are designed to provide an open forum for discussing experiences with alcohol and drugs among peers, including both positive and negative effects, in the absence of criticism (see Chapter 9). Social skills training groups (see Chapter 11) and individual cognitive-behavioral counseling (see Chapter 8) can help clients develop healthier skills for meeting needs that are otherwise met through substance use (such as socialization, coping with symptoms, and recreational/leisure activities). As clients acquire these skills, their reliance on substance use for meeting their needs decreases; their awareness of the negative effects of substances on their lives increases; and, finally, their motivation to change increases. Family intervention (Chapters 13–15) is also frequently used during the persuasion stage.

Coercive interventions, such as involuntary hospitalizations, guardianship, or commitment to community treatment, are sometimes necessary to stabilize a dangerously ill client with dual disorders (see Chapter 17). It is important to recognize that the prevention of harm and compulsive compliance that involuntary measures may provide does not constitute treatment, and that such controls can only keep a client static at best (O'Keefe, Potenza, & Mueser, 1997). The most helpful aspects of involuntary measures may be increased access to the client and psychiatric stabilization. For the client to progress through the persuasion process, the clinician must still establish a therapeutic alliance and proceed with motivational development.

The term persuasion is sometimes misleading. The essence of persuasion is empowering the client to have the insight, courage, hope, and desire to change his or her substance use disorder—not forcing the client to decrease or eliminate substance use by persistent badgering or instituting behavioral controls. Motivation to reduce reliance on substances or to achieve abstinence must reside in the client, not in the clinician or family. This distinction is often misunderstood and frequently leads to frustration on the part of clinicians, who prematurely try to convince their clients with dual disorders to endorse abstinence as a goal before sufficient motivation has been developed.

Understanding that motivation must exist in the client helps providers to recognize that many other important changes may occur during the persuasion stage. For example, obtaining work, improving social skills, and enhancing social supports can be accomplished before there is any expressed motivation for abstinence; these changes help to instill hope and nurture motivation that will be needed by the client in developing a healthier lifestyle that is not dependent upon substance use. In order to empower clients to make changes based on their own desires, rather than on coercive or involuntary interventions, clinicians need to trust that if the clients' substance use is in fact problematic, it will do the work of persuading the clients to change. The job of clinicians is to create conditions that facilitate awareness of the consequences of continued substance use, and, most importantly, attractive alternatives for clients to move toward.

Examples of intervention strategies for the persuasion stage of treatment are provided in Table 2.5.

**Active Treatment**

**Definition and Goals.** A client is considered to be motivated to reduce substance use, and hence is in the *active treatment* stage, when he or she has significantly reduced substance use for more than 1 month and is actively seeking to sustain or enhance these reductions. It is critical that "motivation" to reduce or eliminate substance use is determined from clients' actual behavior (i.e., successful reduction of substance use), rather than from verbal reports. Client self-reports are fraught with social and contextual factors that severely limit their va-

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**TABLE 2.5. Examples of Clinical Interventions for the Persuasion Stage**

- Individual and family education
- Motivational interviewing
- Peer groups (e.g., persuasion groups)
- Social skills training to address non-substance-related situations
- Structured activity (e.g., supported employment, volunteering, hobbies, church, social organizations, consumer committees, or task forces)
- Sampling constructive social and recreational activities
- Psychological preparation for lifestyle changes necessary to achieve remission
- Safe, "damp" housing (i.e., tolerant of some substance abuse)
- Use of medications to treat psychiatric illness that may have a secondary effect on craving/addiction (e.g., selective serotonin reuptake inhibitors [SSRIs], atypical antipsychotics, buspirone)
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d

ity in the absence of solid behavioral changes. Clients often verbally acknowledge the negative effects of substances on their lives and profess an interest in cutting down use or achieving abstinence in order to gain social acceptance or a clinician’s support, or because they fear losing their benefits or other forms of assistance, rather than because they genuinely desire to work on their substance abuse problems. Defining motivation in terms of real behavior change, instead of verbal statements, avoids the unnecessary frustration of trying to change substance use behavior before a client is ready.

The goal of the active treatment stage is to help the client reduce substance use to the point of eliminating negative consequences, or to attain abstinence for a prolonged period of time. Although research data indicate that abstinence is a much more successful remission strategy than occasional or moderate use (Drake & Wallach, 1993), the decision to pursue abstinence must come from the client. Often clients begin the recovery process by gradually reducing their use of substances. As they emerge from their physical dependence on substances, or as they have difficulty limiting their substance use, the goal of abstinence develops as a more realistic approach to eliminating their substance abuse problems.

Active Treatment Interventions. A wide variety of different clinical strategies can be used to help clients reduce their substance use or attain abstinence. Traditional rehabilitation-based approaches are used to increase skills and improve supports, and these strategies can be implemented in a number of different treatment formats (individual, group, family) in a variety of settings. Individual cognitive-behavioral counseling employs techniques for decreasing substance use or enhancing abstinence, and for developing social networks that support a healthier lifestyle (Chapter 8). Supported employment can help clients obtain and keep competitive jobs (Chapter 18), thereby improving their self-esteem, financial standing, and investment in psychiatric stability, and decreasing their free time for using substances.

Active treatment groups (Chapter 10) and social skills training groups (Chapter 11) can help clients reduce their substance use by developing skills for dealing with high-risk situations (e.g., coping with boredom) or compensatory skills for meeting needs in ways other than using substances. Self-help groups, such as AA, can be useful for clients who endorse abstinence as a goal, and who wish to take advantage of the wide availability of such groups in most communities (Chapter 12). Clients may affiliate most readily with self-help groups tailored to the dually diagnosed population (e.g., Double Trouble in Recovery or Dual Recovery Anonymous).

Family problem solving, conducted either with individual families in behavioral family therapy or in multiple-family groups, can be used to identify possible triggers of substance use or urges to use substances. It can also help clients to get involved in alternative activities, to structure their time so as to decrease opportunities to use substances, and to provide behavioral rewards for achieving targeted goals (Chapters 14–15). Although the explicit goal of the active treatment stage is to reduce substance use, clinicians must recognize that sustained behavioral change involves more than avoiding substances. It includes other lifestyle changes (such as work, social relationships, leisure and recreational activities, self-care skills, and housing), which reinforce sobriety and determine an individual’s quality of life. Therefore, interventions during active treatment may need to address the broader changes needed to achieve a different lifestyle that does not rely on alcohol and drugs. Clinicians expand upon the persuasion process to develop clients’ recognition and motivation for addressing these changes. This process determines which areas are addressed during active treatment and which are saved for future work.

Relapses or slips back into active substance abuse are common in the active treatment stage. Relapses are not viewed as failures, but rather as part of the course of a chronic illness. Relapses are used as opportunities to learn more about what the individual will need in order to achieve sustained remission of his or her substance use disorder. The client and clinician examine each relapse in microscopic detail, gaining information about relapse triggers and the sequence of events leading to substance abuse. They use this information to refine their active treatment interventions and to identify new areas of lifestyle change that need attention.

If the client has a relapse into sustained substance abuse, the clinician shifts back into persuasion-stage work, only returning to active treatment interventions when the client again demonstrates motivation for abstinence or reduced substance use. As noted earlier, many clients choose to reduce their use of substances rather than to adopt abstinence during early active treatment. This strategy often fails to sustain remission, but the experience can be helpful in the long-term process of recovery as a client learns experientially that moderate use of alcohol or drugs is not viable, and thereby develops motivation to pursue abstinence.

Examples of intervention strategies for the active treatment stage are provided in Table 2.6.

Relapse Prevention

Definition and Goals. The client is defined as having reached relapse prevention when he or she has
TABLE 2.6. Examples of Clinical Interventions for the Active Treatment Stage

- Family and individual problem solving
- Peer groups (e.g., active treatment groups)
- Social skills training to address substance-related situations
- Self-help groups (e.g., Alcoholics Anonymous)
- Individual cognitive-behavioral counseling
- Substituting activities (e.g., work, sports)
- Pharmacological treatments to support abstinence (e.g., disulfiram, naltrexone)
- Safe, “dry” housing
- Psychoeducation
- Stress management and coping skills

not experienced negative consequences related to substance use (or has been abstinent) for at least 6 months. The goals of this stage are to maintain an awareness that relapse of the substance use disorder is possible; to prepare a plan for responding to a relapse should it occur; and to continue to expand the recovery to other areas of functioning, such as social relationships, work, and health. Clients who have achieved an extended period of abstinence often attempt to resume controlled use of substances, either because they believe they will have the self-control to prevent their substance use from escalating, or because of an impulsive, desperate wish to use “just once.” These efforts at controlled use usually fail, resulting in partial or full-blown relapses. Therefore, helping clients maintain an awareness of their high vulnerability to relapse, and having them develop strategies for monitoring their inner dialogue as well as overt behaviors, are critical goals of the relapse prevention stage.

Relapse Prevention Interventions. As is true at every stage, the client’s choices are paramount in accomplishing the goals of relapse prevention and expanded recovery. Some clients attend self-help groups; some continue in dual-disorder groups; some review their substance use status regularly with their clinicians; and some use other community-integrated support networks to maintain their sobriety and improve functioning in other areas. Usually several different strategies are employed with each client.

The overarching goal of this stage is to develop a meaningful recovery process. Clinicians facilitate a shift in focus from giving up substances to gaining a healthy life. The more clients are able to derive natural rewards from normative activities, such as work, social relationships, and leisure pursuits, the less susceptible they will be to relapses of their substance use disorders. Therefore, such strategies as supported employment (Chapter 18) and social skills training (Chapter 11) may be used to help clients achieve goals related to meaningful life roles of employment and relationships. Clients in relapse prevention may benefit from serving as mentors for clients in earlier stages of treatment as well.

At the same time, preparing for relapses is also an important skill during this stage. A client must know how to expect relapses and begin working toward substance use reduction or abstinence immediately, rather than experiencing a prolonged relapse and accompanying sense of failure and hopelessness. Providing information to clients about the long-term process of recovery from dual disorders is often helpful in preparing them for the possibility of relapse, and formulating plans for either preventing relapses or minimizing their severity.

Examples of intervention for the relapse prevention stage of treatment are provided in Table 2.7.

Clinical Utility of the Stages of Treatment

The most important feature of the stages of treatment is that they provide a model for clinicians to identify appropriate goals and strategies at different points throughout the recovery process—especially early during intervention, when clients are often not engaged in treatment and fail to see their substance use as a significant problem. Attending to each client’s stage of treatment ensures that interventions are appropriate to the individual’s current motivational state, and avoids the negative effects of prematurely attempting to change behavior before the client is ready. For example, if a clinician attempts to help a client discover that his or her substance use is destructive (a goal of the persuasion stage) before a therapeutic relationship has been established (engagement stage), the client may be inadvertently driven away from treatment. Similarly, if the clinician tries to help the client reduce his or her substance use (a goal of the active treatment stage) before the client sees substance use as a problem (persuasion

TABLE 2.7. Examples of Clinical Interventions for the Relapse Prevention Stage

- Expanding involvement in supported or independent employment
- Peer groups (e.g., active treatment or relapse prevention groups)
- Self-help groups (e.g., Alcoholics Anonymous)
- Social skills training to address other areas
- Family problem solving
- Lifestyle improvements (e.g., smoking cessation, healthy diet, regular exercise, stress management techniques)
- Independent housing
- Becoming a role model for others (through group or individual peer counseling, mentoring or sponsor relationships, etc.)
stage), the client may become disenchanted and convinced that the clinician does not really understand him or her, and drop out of treatment. Therefore, the stages-of-treatment model helps clinicians increase the chances of selecting interventions that have the greatest immediate relevance for clients at particular points during their treatment.

Individual clinicians and treatment teams need to know each client's stage of treatment at all times, in order to treat the client's substance use disorder effectively. Stages of treatment should be discussed regularly at treatment team meetings; disagreements should be resolved based on consensus; and goals should be established that are consistent with each client's current stage of treatment. If clinicians are unaware of a client's stage of treatment, if there is significant and frequent disagreement among clinicians as to a client's current stage, or if discussion among treatment providers rarely alludes to a client's stage, then stage-wise treatment is probably not being provided. Consequently, treatment outcomes are not being optimized.

**Multiple Psychotherapeutic Modalities**

Within the field of substance abuse treatment, several different psychotherapeutic treatment modalities have been found to be effective in improving outcomes, including individual, group, and family approaches (Miller et al., 1995; Parks, Anderson, & Marlatt, 2001). Similarly, integrated dual-disorder treatment employing each of these therapeutic modalities has been found to be effective. Individual, group, and family approaches each have their own unique advantages. Individual work (described in Part III of this book) allows for the most attention to be focused on one person, with no distraction from others; it is thus especially conducive to developing a close working relationship, exploring personal motives and goals, and identifying individualized targets for intervention. Group approaches (described in Part IV of this book) offer the advantage of engendering social support among clients, providing positive role models for clients at earlier stages of treatment, and offering economy of teaching. Family intervention (described in Part V of this book) takes advantages of the natural supports available to clients, which can lead to creating an environment that is supportive of decreased substance use or abstinence. Although not all clients receive all treatment approaches, an array of different treatment modalities will optimize outcomes.

**Individual Counseling**

In addition to the informal counseling that takes place in the context of providing clinical case management to clients with dual disorders (see Chapter 6), two types of individual counseling are useful in the treatment of dual disorders: cognitive-behavioral counseling and motivational interviewing. Cognitive-behavioral counseling, as described in Chapter 8, involves using learning-based interventions to help clients develop more effective skills for achieving a variety of different goals—ranging from improved interpersonal relationships, to reducing or coping better with symptoms, to reducing substance use or avoiding relapses of substance abuse. Cognitive-behavioral approaches have a rich history of documented effectiveness in addressing both substance abuse (Heather, Peters, & Stockwell, 2001; Hester & Miller, 1995) and mental health problems (Caballo, 1998; Liberman, 1992).

As noted earlier in this chapter, motivational interviewing is a counseling approach designed to help clients become aware of their substance abuse problems and to develop motivation to overcome these problems through the process of articulating and pursuing their own personal goals. Motivational interviewing was originally developed for clients with substance abuse (Miller & Rollnick, 2002), and research supports its effectiveness both in this population (Foote et al., 1999; Miller, 1995; Project Matching Alcoholism Treatments to Client Heterogeneity [MATCH] Research Group, 1997) and in clients with dual disorders (Barrowelough et al., 2001). In addition to the use of motivational interviewing to address substance abuse in clients with dual disorders, as described in Chapter 7, motivational interviewing has been used successfully to improve attendance at aftercare appointments (Swanson, Pantalon, & Cohen, 1999), and to increase medication adherence in clients with severe mental illness (Kemp, Kirov, Everitt, Hayward, & David, 1999).

**Integrated Group Treatment**

There are several reasons for conducting group interventions for clients with dual disorders. First, there is a strong tradition of nonprofessional self-help groups, such as AA, in the primary addiction field. The group format is an ideal setting for capitalizing on the need for support and identification shared by persons with an addiction. Second, substance abuse among psychiatric clients frequently occurs in a social context (Dixon et al., 1991; Test et al., 1989). Addressing substance-use-related issues in a group setting makes it clear to clients that they are not alone, and provides an opportunity for the sharing of experiences and coping strategies. Third, there are economical advantages to offering group rather than individual therapy, because less clinician time is required.

Several different types of professional-based group
treatment for clients with dual disorders can be provided, including educational groups, stage-wise treatment groups (persuasion, active treatment, and relapse prevention groups), and social skills training groups. Although treatment settings may not provide all types of groups, effective programs offer several different options to ensure that some group interventions are available to all clients. In addition, self-help groups can provide another valuable source of social support to clients who recognize the destructive effects of substances on their lives, and who want to pursue an abstinence lifestyle. We briefly describe each of these types of groups here.

**Educational Groups.** Group-based educational interventions for clients with dual disorders are often time-limited (e.g., 4–8 weeks) and serve to inform clients about the nature of mental illness and its treatment, the interactions between substance abuse and psychiatric disorders, and strategies for addressing the problem of substance abuse (Alfs & McClellan, 1992; Kofod & Keys, 1988). Although education groups are appropriate for clients at all stages of treatment, they often serve a primary function of educating clients at the earlier stages of treatment (e.g., engagement and persuasion), in order to motivate them to address their substance use problems. Longer-term programs often combine education with group support (Bond, McDonel, Miller, & Pensec, 1991; Hellerstein & Meehan, 1987; Hellerstein, Rosenthal, & Miner, 1995; Lehman, Herron, Schwartz, & Myers, 1993).

An alternative to educational groups that we have used in most of our clinical settings is to provide basic information about dual disorders that is interwoven into a longer-term group approach, such as stage-wise or social skills treatment groups. For this reason, we do not provide separate guidelines in this book for conducting educational groups. A curriculum for conducting such groups can be created from the educational handouts contained in Appendix B.

**Stage-Wise Treatment Groups.** Stage-wise treatment groups focus on helping clients progress from one stage of treatment to the next (Mueser & Noordsy, 1996). In the treatment programs in which we have worked, the most common stage-wise treatment groups are persuasion and active treatment groups, with relapse prevention groups less common. As described in Chapter 9, persuasion groups are focused on clients in the persuasion stage, although clients at later stages are typically included in these groups to serve as role models. The primary aim of persuasion groups is to explore the interactions between substance use and mental illness, and to instill motivation to address substance use problems.

Active treatment groups, described in Chapter 10, are targeted for clients at the active treatment (or, sometimes, relapse prevention) stage. They focus on supporting members’ goals of reducing substance use or maintaining abstinence, through a combination of group support and teaching cognitive-behavioral strategies. Relapse prevention groups are similar to active treatment groups, but they include only clients who have attained sustained remission of their substance abuse, usually through abstinence. The principles for conducting relapse prevention groups are essentially the same as for active treatment groups, and we do not provide a separate chapter on them in this book. The clinical benefits of stage-wise treatment groups are supported by our research on integrated dual-disorder treatment programs conducted in New Hampshire (Drake, McHugo, & Noordsy, 1993; Drake, McHugo, et al., 1998).

**Social Skills Training Groups.** Although the availability of skills training groups is part of comprehensive treatment, social skills training groups that address the unique problems of clients with dual disorders can be especially useful (Bellack & DiClemente, 1999; Roberts, Shaner, & Eckman, 1999). As summarized in Chapter 11, such groups are appropriate for clients with dual disorders at the persuasion, active treatment, and relapse prevention stages of treatment. At the earlier stages of treatment, skills training aims to build clients’ social competence, to make them less reliant on using substances to achieve their interpersonal needs. These same goals, as well as the goal of helping clients improve their skills for handling substance-use-related situations, apply to the later stages of treatment. Controlled research supports the effects of social skills training groups in integrated treatment for dual disorders (Jerrell & Ridgely, 1999a).

**Self-Help Groups.** Self-help groups, such as AA, Double Trouble in Recovery, or Dual Recovery Anonymous play an important role in recovery from substance abuse for many clients with dual disorders. Social contacts with other members of self-help groups is associated with better substance abuse outcome in clients with dual diagnoses (Trumbetta et al., 1999). As described in Chapter 12, clinicians can facilitate clients’ exploration of self-help groups by recommending these groups to clients who are motivated to achieve or maintain abstinence, helping them identify and attend possible groups, and not pressuring reluctant clients to participate in self-help.
2. Principles of Integrated Treatment

Family Intervention

Similar to the inclusion of family psychoeducation as a part of comprehensive treatment, family intervention that specifically targets dual disorders can be an especially powerful approach for improving substance abuse outcomes (Barrowclough et al., 2001; Mueser & Fox, 2002). Furthermore, the provision of different formats of family psychoeducation, including single-family and multiple-family group approaches, can increase access to family services for clients with dual disorders and their relatives (who may take advantage of either or both formats). The principles of collaborating with families are summarized in Chapter 13; guidelines for conducting single-family intervention (behavioral family therapy) are presented in Chapter 14; and multiple-family groups are covered in Chapter 15.

Selection of Treatment Modalities

The selection of which interventions should be provided to which clients is based on a combination of the nature of the treatment goals, the ease with which a client can be engaged in a treatment modality, and the unique advantages of each approach. For example, the goal of developing motivation to address substance abuse (a persuasion-stage goal) can be approached through motivational interviewing in an individual counseling format, through participation in stage-wise treatment groups, and/or through participating in psychoeducational and problem-solving family intervention. The selection of treatment modality can be influenced by such factors as the quality of the client's relationship with a primary clinician, the degree of social comfort the client experiences with peers, and the involvement of family members in the client's life and treatment. Thus different treatment modalities may be used to work with clients at the same motivational states to achieve similar goals. Multiple treatment modalities are frequently used simultaneously, to maximize clients' ability to benefit from treatment.

SUMMARY

We have begun this chapter by reviewing problems with traditional sequential or parallel treatment approaches to dual disorders. The most significant limitation of sequential treatment approaches is that they fail to account for the interactive nature of mental illness and substance use disorders, in which each untreated type of disorder contributes to and exacerbates the other. The greatest problems with parallel treatment methods are that mental health and substance abuse interventions are usually not integrated by the different providers, and treatments are sometimes incompatible with one another (e.g., use of strong, emotionally challenging methods in substance abuse treatment programs for persons with severe mental illness).

Integrated treatment programs for dual disorders embody the common value of shared decision making. In addition, integrated treatment is effective to the extent that it incorporates the core treatment components of integration, comprehensiveness, assertiveness, reduction of negative consequences, long-term commitment (time-unlimited services), motivation-based treatment (utilizing the stages-of-treatment concept), and multiple psychotherapeutic modalities. The more attention a treatment program gives to each of these components, the better the outcomes. The rationale, definition, and empirical support for each component of treatment have been described in this chapter. A fidelity scale is provided in Appendix A for assessing program adherence to the core components of integrated treatment.
Research on Integrated Dual-Disorder Treatment

A substantial body of research has accumulated in recent years supporting the effectiveness of integrated treatment programs for dual disorders. In this chapter, we provide a brief synthesis of research on the treatment of these disorders. Almost all of the research on outpatient dual-disorder treatment has been conducted within mental health programs, because of the greater feasibility of adding substance abuse treatment to existing community support services (Mercer-McFadden, Drake, Brown, & Fox, 1997). Research on dual-disorder treatment in general can be divided into four different types of studies: (1) traditional substance abuse treatments in mental health settings; (2) early studies of integrated treatment programs; (3) controlled studies of long-term outpatient integrated treatment; and (4) controlled studies of integrated residential or intensive day treatment programs. We summarize the findings of these studies below, emphasizing the controlled research on integrated treatment programs. We conclude with a brief discussion of future directions for this body of research.

TRADITIONAL SUBSTANCE ABUSE TREATMENT IN MENTAL HEALTH SETTINGS

Early studies of dual-disorder treatment, most conducted in the 1980s, examined the effects of providing traditional substance abuse treatment in addition to ongoing psychiatric care in mental health settings—for example, incorporating group or inpatient programs based on Twelve-Step principles. Some of these studies were conducted with randomized designs (Hellerstein et al., 1995; Herman et al., 1997; Lehman et al., 1993; Mowbray et al., 1995), but none demonstrated strong positive effects on substance abuse outcomes. One possible explanation for the poor outcomes of these studies is that these programs failed to adhere to the basic values and the core components of integrated treatment outlined in this book. For example, none of the programs was based on the concept of stages of change (Prochaska, DiClemente, & Norcross, 1992) or the stages of treatment (see Chapter 2). Consequently, these programs focused on abstinence as the primary goal from the beginning of treatment, rather than on engaging clients, reducing the negative consequences of substance abuse, and gradually reducing substance use. Furthermore, most programs were time-limited and short-term, and were not comprehensive.

EARLY STUDIES OF INTEGRATED TREATMENT PROGRAMS

Coincident with research documenting the failures of simply incorporating substance abuse treatment into mental health services, other programs utilizing the principles of integrated treatment were being developed, with pilot findings suggesting better outcomes (Mercer-McFadden et al., 1997). Based on the success of these efforts, further exploratory studies were conducted that adhered to many of the principles of integrated treatment outlined in this book, such as reduction of substance abuse's negative consequences; comprehensive, long-term treatment; outreach for difficult-to-engage clients (see Chapter 2); the use of varied psychotherapeutic treatment strategies (e.g., individual, group, family; see Parts III, IV, and V); and incorporation of motivational (Chapter 7) and cognitive-behavioral (Chapter 8) treatment strategies. The results of these
latter studies were that clients generally showed substantial rates of substance abuse remission, accompanied by other positive outcomes (Detrick & Stiepock, 1992; Drake, Bartels, et al., 1993; Durell, Lechtenberg, Corse, & Frances, 1993; Meisler & Williams, 1998). The encouraging results of these uncontrolled studies served as an impetus for conducting more rigorous research to evaluate the benefits of integrated dual-disorder treatment.

**Controlled Studies of Long-Term Outpatient Integrated Treatment**

With the success of these early studies, subsequent controlled research was conducted to evaluate the benefits of integrated treatment programs more rigorously, and to compare different outpatient approaches to such treatment. As summarized in Table 20.1, six controlled studies of long-term outpatient integrated treatment have been conducted to date. Four of these studies compared integrated with nonintegrated treatment programs (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1997; Godley, Hoewing-Roberson, & Godley, 1994); the other two compared different types of long-term integrated treatment (Drake, McGugo, et al., 1998; Jerrell & Ridgely, 1995a).

Among the four studies comparing long-term outpatient integrated treatment with nonintegrated programs, several patterns emerge. All four studies reported more improvement in substance abuse outcomes for clients who received the long-term integrated treatment. Three of the studies found no differences between the integrated and nonintegrated treatment groups in psychiatric outcomes (Carmichael et al., 1998; Drake et al., 1997; Godley et al., 1994), whereas the fourth study found that integrated treatment resulted in fewer relapses and hospitalizations, as well as less severe symptoms (Barrowclough et al., 2001). It is notable that this fourth study was the only one in which the integrated treatment included a family intervention component for all participating clients (Barrowclough et al., 2001). Family treatment for dual disorders may serve to improve the monitoring of clients' psychiatric disorders, resulting in fewer relapses and rehospitalizations (Mueser & Fox, 2002), as it does in the primary population of clients with severe mental illness (Dixon et al., 2001; Fitches-Walz, Leucht, Bäuml, Kissling, & Engel, 2001).

The two studies comparing different models of long-term integrated dual-disorder treatment addressed rather different questions (Drake, McGugo, et al., 1998; Jerrell & Ridgely, 1995a). The study by Drake, McGugo, and colleagues (1998) compared two different case management approaches for integrated treatment: assertive community treatment (ACT) and standard case management. Outcomes tended to favor ACT over standard case management, and clients in both treatment groups improved considerably, but the magnitude of the differences between the groups was not great. This study suggests that the ACT model of case management may be beneficial to some clients with a dual disorder (e.g., clients prone to frequent crises, relapses and rehospitalizations, legal problems), and thus merits inclusion as a component of integrated treatment. However, as discussed in Chapter 3, ACT-level case management is not required for all clients with dual disorders.

The Jerrell and Ridgely study (Jerrell, Hu, & Ridgely, 1994; Jerrell & Ridgely, 1995a, 1995b) compared behavioral skills training, intensive case management, and a Twelve-Step approach. Overall, substance abuse and psychiatric outcomes favored the skills training approach the most and the Twelve-Step approach the least. It is noteworthy that one short-term (1-month) quasi-experimental study (not included in Table 20.1) comparing cognitive-behavioral group counseling to a Twelve-Step group approach for dual disorders also reported better substance abuse outcomes at 6 months posttreatment for the cognitive-behavioral treatment group (Fisher & Bentley, 1996). These studies support the importance of cognitive-behavioral counseling (see Chapter 8) as one important component of integrated dual-disorder treatment.

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**CONTROLLED STUDIES OF INTEGRATED RESIDENTIAL OR INTENSIVE DAY TREATMENT PROGRAMS**

Five studies examining the effectiveness of integrated residential or intensive day treatment programs have been completed to date (Blankertz & Cnaan, 1994; Brunette et al., 2001; Burnam et al., 1995; Penn & Brooks, 1999; Rehav et al., 1995). Four of these programs examined relatively short-term intensive treatments (e.g., 3–6 months), and all suffered from rates of client dropout exceeding 50% (Blankertz & Cnaan, 1994; Burnam et al., 1995; Penn & Brooks, 1999; Rehav et al., 1995). The fifth study (Brunette et al., 2001) employed a quasi-experimental design to compare the effects of a short-term residential program (3–4 months; see Bartels & Drake, 1996) with a long-term program (2 years), the Gemini House program (see Chapter 16 for an in-depth description of this program). In addition to its longer-term nature, Gemini House provided a gradual transition for all clients from the residence back into the community. The results indicated that more clients in the long-term program (Gemini House) were successfully engaged in treatment, and they had better substance abuse outcomes as well. Clients in the long-term and
### TABLE 20.1. Controlled Studies of Outpatient Integrated Treatment Programs

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<tbody>
<tr>
<td>Sample size</td>
<td>38</td>
<td>132</td>
<td>217</td>
<td>203</td>
<td>208</td>
<td>36</td>
</tr>
<tr>
<td>Mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Schizophrenia</td>
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<tr>
<td>44% schizophrenia</td>
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<td></td>
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<tr>
<td>39% affective psychosis</td>
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<td></td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>56% AUD</td>
<td>40% AUD</td>
<td>55% AUD</td>
<td>73% AUD</td>
<td>47% AUD</td>
<td>64% AUD</td>
</tr>
<tr>
<td>24% DUD</td>
<td>10% DUD</td>
<td>61% DUD</td>
<td>42% DUD</td>
<td>53% DUD</td>
<td>69% DUD</td>
<td></td>
</tr>
<tr>
<td>Other features</td>
<td>None</td>
<td>30% minority groups</td>
<td>89% African American</td>
<td>None</td>
<td>15% African American</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Homeless</td>
<td></td>
<td>14% Hispanic</td>
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<td></td>
<td></td>
<td></td>
<td>26% homeless</td>
<td></td>
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<tr>
<td>Interventions</td>
<td>ICM + IT vs. SS</td>
<td>BST vs. ICM vs. Twelve-Step</td>
<td>IT vs. SS</td>
<td>ACT + IT vs. SCM + IT</td>
<td>IT vs. SS</td>
<td>IT vs. SS</td>
</tr>
<tr>
<td>Research design</td>
<td>Experimental Integrated vs. nonintegrated</td>
<td>Quasi-experimental Integrated vs. nonintegrated</td>
<td>Experimental Integrated vs. nonintegrated</td>
<td>Experimental/quasi-experimental Integrated vs. nonintegrated</td>
<td>Experimental Integrated vs. nonintegrated</td>
<td></td>
</tr>
<tr>
<td>Follow-up period</td>
<td>2 years</td>
<td>18 months</td>
<td>18 months</td>
<td>3 years</td>
<td>1 year</td>
<td>1 year</td>
</tr>
<tr>
<td>Research attrition</td>
<td>21%</td>
<td>31%</td>
<td>14%</td>
<td>9%</td>
<td>45%</td>
<td>84%</td>
</tr>
<tr>
<td>Substance abuse outcomes</td>
<td>ICM &gt; SS on days of drug use</td>
<td>BST &gt; Twelve-Step</td>
<td>IT &gt; SS for treatment progress and decreased alcohol use severity</td>
<td>ACT &gt; SCM on treatment progress and decreased alcohol use severity</td>
<td>IT &gt; SS (alcohol)</td>
<td>IT &gt; SS on days of abstinent</td>
</tr>
<tr>
<td>Hospital use outcomes</td>
<td>ICM = SS for days of hospitalization</td>
<td>—</td>
<td>IT = SS for reduced days in hospital</td>
<td>ACT = SCM</td>
<td>IT = SS</td>
<td>IT &gt; SS</td>
</tr>
<tr>
<td>Symptom outcomes</td>
<td>ICM = SS</td>
<td>BST &gt; Twelve-Step</td>
<td>IT = SS</td>
<td>ACT = SCM</td>
<td>IT = SS</td>
<td>IT &gt; SS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICM &gt; Twelve-Step</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other outcomes</td>
<td></td>
<td>No difference for social functioning and role performance</td>
<td>IT = SS for QOL, legal, medical, and work status; and homeless days</td>
<td>ACT = SCM on QOL</td>
<td>IT &gt; SS in medication compliance, suicidal thoughts, income, arrests, and consumer satisfaction</td>
<td>IT = SS in community functioning</td>
</tr>
</tbody>
</table>

*Note: Dashes, no data; >, better than; ACT, assertive community treatment; AUD, alcohol use disorder; BST, behavioral skills training; CM, case management; DUD, drug use disorder; ICM, intensive case management; IT, integrated dual-disorder treatment; QOL, quality of life; SCM, standard case management; SS, standard services; SUD, substance use disorder.

*IT = family intervention, motivational interviewing, and cognitive-behavioral counseling.

*Some clients were randomly assigned to treatment groups, but not others.

*Random assignment to IT or SS at two sites (n = 144), but not the third site (n = 64).

*Research attrition refers to percentage of clients lost to research follow-up.
short-term programs did not differ in symptom and hospitalization outcomes.

The results of these five studies indicate that short-term programs tended to have very high dropout rates, due to both the brevity of the interventions and their lack of outreach. Clients who were retained in intensive programs did well while they were in these programs, mainly because of the restricted access to substances. However, once they were discharged, their relapse rates were high. In contrast, the study of the one long-term program, Gemini House (Brunette et al., 2001), indicated higher rates of engagement and better substance abuse outcomes—perhaps in part because it facilitated the transition of clients from the residence into the community. Thus research suggests a possible role for longer-term integrated dual-disorder treatment, but not for short-term, intensive programs.

SUMMARY OF THE RESEARCH ON INTEGRATED TREATMENT

There is substantial research supporting the effectiveness of integrated treatment programs for clients with dual disorders. The strongest evidence comes from the six controlled studies of outpatient integrated treatment (Table 20.1). Four of these studies showed that comprehensive, motivation-based, long-term integrated treatment programs resulted in significantly better substance abuse outcomes than those of standard, nonintegrated care (Barrowclough et al., 2001; Carnichael et al., 1998; Drake et al., 1997; Godley et al., 1994). Two studies compared different approaches to integrated dual-disorder treatment, with one study (Drake, McHugo, et al., 1998) reporting beneficial effects of ACT for some clients, and the other study (Jerrell & Ridgely, 1995a) reporting better outcomes with behavioral skills training compared to intensive case management, which in turn was better than a Twelve-Step approach.

In general, the effects of integrated short-term residential or intensive day treatment programs were not positive. Such programs had difficulty engaging and retaining clients, and relapse rates tended to be high following discharge into the community. One study (Brunette et al., 2001) found that Gemini House—a long-term residential program for dual disorders, with a gradual process for helping clients move back into the community—had good retention rates and better substance abuse outcomes following discharge than a short-term residential program did. These findings suggest that brief, intensive treatments for dual disorders are not helpful, and that treatment other than detoxification or stabilization should usually occur in the community (Drake & Noordsy, 1995; Greenfield, Weiss, & Tohen, 1995). However, some clients with dual disorders may benefit from longer-term residential programs.

FUTURE DIRECTIONS FOR RESEARCH

Given the magnitude of the dual-disorder problem, more controlled research is needed to examine the effectiveness of integrated treatment models, and to understand the critical components of treatment. Prior research in this area suggests several minimal standards for conducting research on integrated dual-disorder treatment. Programs need to be comprehensive—including assertive outreach and case management, as well as stage-wise, motivational interventions for substance abuse. Treatment interventions need to be guided by program manuals, and implementation should be assessed carefully with fidelity measures. Studies should have controls and enough clients to achieve statistical validity. Since substance use disorders, like severe mental disorders, are chronic and relapsing, programs and services need to span a time period of at least 2 years (Drake, Mueser, et al., 1996).

Another methodological issue in conducting research on dual disorder programs concerns the measurement of substance abuse. Research shows that reliance on self-report of substance abuse alone, especially single self-report measures, yields inadequate information (Corse et al., 1995; Drake et al., 1990; Galletly et al., 1993; Goldfinger et al., 1996; Shaner et al., 1993; Stone, 1993; Wolford et al., 1999). Self-report therefore needs to be supplemented by at least one other source of data about substance abuse, such as multiple instruments, clinical ratings, or laboratory tests (see Chapter 4). Furthermore, since most clients with dual disorders make progress and recover from substance use disorders in stages, assessment needs to measure clients’ stages of treatment (McHugo et al., 1985; Mueser, Drake, et al., 1995; see Chapter 5).

Programs’ fidelity to the integrated dual-diagnosis treatment model is also an important issue in need of further attention. Two studies indicate that across different program sites, fidelity to a specific integrated model is related to better substance abuse outcomes (Jerrell & Ridgely, 1999; McHugo, Drake, Teague, & Xie, 1999). In order to ensure proper implementation of an integrated treatment model, and to compare implementation fidelity across programs, standardized fidelity measures need to be employed, such as the fidelity scale included in Appendix A. In addition to verifying program implementation or identifying needs for further training or administrative support, the measure-
ment of program fidelity may lead to a better understanding of which treatment components are most crucial to improving dual-disorder outcomes.

Yet another critical issue is the heterogeneity of the dual-disorder population. More research is needed on various types of heterogeneity among clients: motivated versus unmotivated clients; men versus women; clients with diagnoses of substance dependence versus substance abuse; those with polysubstance use versus those with alcohol use alone; those with trauma histories versus those with none; and those with antisocial behavior versus those with none. The individual differences in clients’ treatment needs have only recently begun to be documented. For example, the treatment needs of women with dual disorders differ substantially from those of men (Alexander, 1996; Brunette & Drake, 1997, 1998).

Greater understanding of the organization and costs of these treatment systems is another important research need. The few existing data at this point suggest that community-based care for individuals with dual disorders is expensive (Bartels et al., 1993; Jerrell, 1996) and places burdens on families (Clark, 1994; Clark & Drake, 1994). Integrated dual-disorder treatment has the potential to reduce costs substantially (Jerrell et al., 1994), but this potential needs to be evaluated in controlled studies. Since clients with dual disorders consume extensive resources outside the mental health system, cost studies should also include a societal perspective (Clark, 2001; Clark & Fox, 1993).

A final area in need of more research concerns the specific components of integrated dual-disorder treatment, and the timing of the delivery of those components. Various psychotherapeutic strategies are employed in dual-disorder programs, including individual, group, and family interventions; however, the specific impact of different interventions remains unclear, because most studies have compared multiple interventions provided in integrated treatment programs with standard, nonintegrated care. As convincing evidence supporting integrated dual-disorder treatment has accumulated (Drake et al., 2001), there is a need for research that goes beyond the simple comparison of integrated versus nonintegrated programs to evaluating and comparing the specific components of integrated treatment programs, including individual, group, and family psychotherapeutic modalities.

SUMMARY

Research provides support for the effectiveness of integrated treatment programs for dual disorders. Six controlled studies have been conducted to date of long-term integrated outpatient programs, and these provide solid evidence supporting the integration of services. Research on short-term residential or intensive day treatment programs has been less encouraging, with problems due to poor retention and high dropout rates following discharge. Evidence from one study suggests that long-term residential treatment may be beneficial for severely ill clients with dual disorders, provided that the transition back to community living is very gradual.

Considerable progress has occurred in understanding the core components of integrated dual disorder treatment. Research provides encouragement for the effectiveness of long-term, stage-wise, motivational treatment. Clients, their families, and clinicians have reason to be optimistic over the long term concerning the potential for recovery from substance use disorders.