

001

Action for Mental Health II. Improving Treatment for Individuals with Co-Occurring Substance Abuse and Mental Health Disorders. SAMHSA Conference Report, 1996

Abstract

This report, based in the proceedings of a national conference on Co-Occurring Disorders in November, 1995, is designed to create a National Strategy for Dual Diagnosis with specific goals, objectives, and action plans. The document includes a vision statement and problem statement, identifying approximately 10 million people with dual disorders, of which only a small minority receive integrated treatment. Specific needs and recommendations are identified regarding: data and research; child and adolescent services (including prevention); best practices; education and training; homelessness; criminal justice; managed care and financing. The recommendations are generally highly specific yet manageable, and give clear direction to organizations struggling with implementation of integrated programs.

Strengths

Powerful statement of broad national principles for dual diagnosis treatment. The executive summary is a must read for all panel members. (See Appendix A)

Limitations

Standards are stated broadly, without definition. (Standards require evaluation of dual diagnosis workforce "competencies", but where are those competencies defined?) The document is cumbersome and repetitive; should be edited down, and an enhanced executive summary distributed.

Relevance

Provides the overall vision and direction for our project. The report says, "Let there be standards;" our job is to define the content of those standards.

002

Mee-Lee D: Managed care and dual diagnosis, in Treating Co-Existing Psychiatric and Addictive Disorders: A Practical Guide. Edited by Miller NS. Center City, MN, Hazelden, 1994, pp 257-269

Abstract

This article specifically focuses on orienting dual diagnosis providers to the needs of the managed care environment. Dual diagnosis treatment is placed under one umbrella of holistic, integrated behavioral health care. Patients receive a comprehensive biopsychosocial assessment and treatment plan. The article outlines what managed care is looking for: the least intensive, least restrictive care matched to illness severity, clinically driven treatment, flexible lengths of stay, individualized treatment plans, and good outcome data. Providers must take on the mission of efficient and effective care. Good managed care begins with a multi-dimensional assessment. Assessment of severity of illness (SI) leads to determination of intensity of services (IS). Reviews current ideas about levels of care and treatment modalities. Implications for clinicians: dual competency clinicians will be skilled in assessment, diagnosis, both addiction and psychiatric theories, and in relevant modalities of treatment. Treatment will be provided with innovative program structures.

Strengths

Well written and concise. Good overview of the issues faced both by the integration of mental health and substance abuse as well as by the forces of managed care. Speaks to attitudinal competencies, and to general principles of assessment and treatment from both perspectives.

Limitations

Competencies are more general in nature. Individual competencies have to be extracted from the material.

Relevance

Extremely valuable for development of practice guidelines and clinician competencies.

003

Mee-Lee D: Dual Diagnosis: Clinical Dilemmas in a Managed Care Environment, 1996. Workshop Outline: (available from the author)

Abstract

The purpose of this outline is to describe principles for dual diagnosis assessment and treatment in a managed care environment. Even though this is not a published document, it is included here because there is so little material that is specific to both dual diagnosis and managed care. This document describes general treatment strategies, including vigorous treatment of all known diagnoses, and specifies the 5 M's: motivate, manage, medication, meetings, monitor.

Strengths

The most valuable section describes level of care assessment in a managed care setting using the ASAM assessment dimensions (see p.7) to match treatment intensity.

Relevance

This material is close to the state of the art in developing managed care oriented clinical paradigms and competencies for dual diagnosis.

004

Minkoff K: Integration of addiction and psychiatric services, in Managed Mental Health Care in the Public Sector: A Survival Manual. Edited by Minkoff K, Pollack D. The Netherlands, Harwood Academic Publishers, 1997, pp 233-246

Abstract

This chapter reviews the rationale for integration of addiction and psychiatric services in the managed care environment. First, the author identifies the importance to provider organizations of integrating mental health and substance abuse services to meet the demands of managed care contracts. Second, the author describes a methodology for developing an organization into a successfully integrated provider of services to the full continuum of customers who may be singly diagnosed with a substance abuse disorder or mental illness, or dually diagnosed.

Strengths

1. directly addresses meeting the needs of the managed care environment.
2. strong focus on systems of care as the essential unit of change.
3. focus on providing a high quality of care.
4. some consumer orientation.
5. well organized and presented.

Limitations

Does not address individual clinician level competencies or training issues.

Relevance

This chapter would be useful in developing practice guidelines for treating individuals with dual diagnoses at the organizational level.

005

Minkoff K: CHOICE-Dual (Choate Outline for Intensity of Care Evaluations for Dual Diagnosis Patients), 1997. Unpublished.

Abstract

Manual utilized in integrated psychiatric and addiction managed-care oriented system to describe a comprehensive range of acute and subacute programs for people with dual diagnosis. Describes multidimensional service intensities, and method for categorizing "level of care" as a matrix of service intensities. Program models include inpatient, crisis residential, day hospital, and intensive outpatient types of programs, with specific Severity of Illness (IS) and Intensity of Service (IS) criteria for each. See Appendix B for listing of program types.

Strengths and Limitations

Only available tool which describes a continuum of integrated acute services in a well-developed managed care-oriented format, with careful attention to service intensity. Model is heuristic only, and not supported by data.

Relevance

Very relevant for developing standards for integrated systems of care. Has implications for clinical competencies for dual diagnosis intensity of service evaluations and utilization management decisions in a managed care environment.

006

Minkoff K, Rossi A: Treatment Interventions By Phase Of Recovery And Type Of Dual Diagnosis, 1996. Unpublished workshop outline and table

Abstract

This material combines dual diagnosis typology based on the work of Minkoff (SPMI and substance abuse; SPMI and substance dependence; psychiatrically-complicated substance dependence) and Ries (High-high; high-low; low-high; low-low) with phase-specific interventions based on the work of Minkoff (acute stabilization, engagement, prolonged stabilization, rehabilitation/recovery), Osher and Kofoed, and Drake (engagement, persuasion, active treatment, and relapse prevention). Clear outlines and tables are presented which describe recommended interventions for each subtype in each phase (e.g., motivational interviewing in the engagement phase).

Strengths

Best practices described in the literature are brought together in a format that is easily accessible, yet comprehensive.

Limitations

There is no data to support the validity of this typology.

Relevance

Presents a systemic overview of how to develop practice guidelines that reflect state-of-the-art treatment matching; and outlines basic competencies required for each subtype in each phase. See Appendix C.

007

ASAM PPC-2 Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd Edition, American Society of Addiction Medicine, 1996

Abstract

A comprehensive and meticulous description of admission, continuing stay, and discharge criteria, as well as descriptions of treatment services offered for a full array of adult and adolescent addiction treatment programs, ranging through five broad levels: level 0.5 early intervention, level I outpatient, level II intensive outpatient/partial hospital, level III residential, level IV medically managed intensive inpatient, and incorporating six independent dimensions of assessment:

1. acute intoxication/withdrawal potential
2. biological conditions/complications
3. emotional/behavioral conditions/complications
4. treatment acceptance/resistance
5. relapse/continued use potential
6. recovery/living environment

Specific ranges of program intensity exist at each "level" (e.g. level III.1 low-intensity residential, level III.3 moderate intensity, level III.5 high intensity, (e.g. therapeutic community), level III.7 medically monitored residential.) and the concept of "unbundling" is introduced, so that medical interventions for detoxification can occur at a variety of "levels" of care; all services can conceptually be separated and individualized.

Strengths

This is the most complete description of criteria for "placement" in a comprehensive continuum yet devised, and really illustrates the type of precise conceptualization that is necessary in managed care systems. Clearly incorporates adjustments for addressing dual diagnosis in the form of emotional/behavioral complications of primary addiction treatment.

Limitations

Addiction is the only substance disorder addressed; abuse is not really dealt with. Further, despite the attempt to develop very specific criteria, many guidelines are distressingly circular: e.g. "needs service that require the level of care." Also, the service array is incomplete, and still uni-dimensional, without true unbundling. Most problematic, however, is the lack of adequate acknowledgment of the need for integrated treatment settings and cross-trained clinicians for people with two primary disorders.

No examples of such program types are offered.

Relevance

ASAM PPC-2 is, despite its weaknesses, state of the art. Familiarity with not just the content but the conceptual framework of PPC-2 is essential to developing similar service standards for dual disorders of all types.

008

Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse. Treatment Improvement Protocol (TIP) Series. U.S. Department of Health and Human Services. Center for Substance Abuse Treatment, 1994

Abstract

Treatment Intervention Protocols (TIPS) for individuals with a co-occurring disorder.

Content of Chapters

Chapter 1. Introduction. An overview of the Treatment Improvement Protocol (TIP) and a description of the content of the remaining chapters.

Chapter 2. Dual Disorders: Concepts and Definitions. Definitions of dual disorders; terminology: abuse, addiction, dependence, while stressing that any AOD use among persons with psychiatric problems can have adverse consequences.

Chapter 3. Mental Health and Addiction Treatment Systems: Philosophical and Treatment Approach Issues. Strengths and weaknesses of mental health, addiction treatment and medical systems; long term stabilization requires a four step approach; individual case management, and engagement, persuasion, active treatment and abstinence support groups.

Chapter 4. Linkages for Mental Health and AOD Treatment. Nine areas of primary concern are identified, along with problems and suggested solutions, including extensive linkages, consolidated funding and planning processes, greatly expanded case management, and unification of federal AOD efforts.

Chapter 5. Mood Disorders. How to assess for AOD and mood disorders, and an excellent description of the treatment process in the acute, subacute, and long term phase from an addiction, psychiatric, and medical treatment perspective.

Chapter 6. Anxiety Disorders. The relationship between psychoactive drugs and anxiety disorders, the high prevalence of anxiety among people with AOD disorders, assessment and treatment protocols in the three above named phases, stresses the critical need for 12-Step program participation, and support needed for the socially anxious person.

Chapter 7. Personality Disorders. AOD use among persons with personality disorders results in slow progress, written and oral contracts can be useful, suicidal behavior or threats must be watched closely, excellent TIP's for treating each personality disorder.

Chapter 8. Psychotic Disorders. High prevalence of schizophrenic patients have an AOD disorder. Assertive case management and personalized planning are essential.

Chapter 9. Pharmacologic Management. Pharmacological management including a stepwise management approach for addicted individuals without SPMI: try nonpharmacologic approach, then add psychoactive medications if unsuccessful.

Strengths

Provides practical and realistic information about assessing and treating individuals with a dual diagnosis. Excellent description of treatment protocols for those diagnoses most commonly associated with the seriously mentally ill. There are numerous recommendations for system reform and coordination at the federal, state and local level. The last chapter provides a pharmacological overview.

Limitations

While suggestions on treatment protocols are well described, the manual does not account for the absence or scarcity of some of these services in local communities.

Relevance

A comprehensive guide for assessment and treatment of persons with a dual diagnosis, that provides excellent material for practice guidelines and standards of care, and by implication, clinical competencies.

009

Baker F: Coordination of Alcohol, Drug Abuse, and Mental Health Services. Rockville, MD: DHHS Publication No. (SMA) 93-1742, 1991

Abstract

To review current knowledge about coordination of alcohol, drug and mental health (ADM) services, to describe the major models and mechanisms available for this purpose, and to make recommendations regarding the process of developing coordinated ADM services. Included in this document is a brief historical overview of previous attempts to coordinate services, characteristics of patients with ADM that make it necessary to develop coordination of services, working principles of services coordination, specific mechanisms and models of coordination (including case examples), and recommendations for the future.

Strengths and Limitations

Easy reading that is very applicable to the field. Really walks people through how to coordinate services. It does reflect the state of the field; not the state of the art.

Relevance

Should be mandatory reading and a resource manual for all in the ADM field.

010

Drake RE, Mueser KT, Clark RE, Wallach MA: The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry 1996;66(1):42-51

Abstract

This article reviews the longitudinal course of dual disorders in traditional treatment systems which provide separate mental health and substance-abuse programs, and describes the movement toward programs that integrate both types of treatment at the clinical level, and health care policy changes that would encourage effective treatments. Major points are as follows: Most dually diagnosed persons are in and out of each kind of treatment, with little cross-monitoring. In the parallel model (separate mental health and addiction treatments) the burden of integrating treatments falls on the patient. Studies (30) of integrated treatment have significant limitations, in that randomization to compare integrated treatment to parallel and sequential models is very difficult to do in reality. However, studies are available that support the effectiveness of integrated treatments in leading to lower hospitalization costs, reduced substance use, and other improvements in quality of life. Unfortunately, current policy and reimbursement focus on short-term, and not long-term treatment programs, and most persons with dual disorders require long-term treatments. We need to change organizational structures which contribute to low rates of detection and funding for long-term, integrated treatment for dual disorders.

Strengths

Clearly written and supported with data. The authors argue persuasively for the merits, necessity, and cost effectiveness of long-term integrated treatment for dual disorders.

Limitations

None

Relevance

Provides data which support the need for long-term integrated treatment as a standard in a managed care system.

011

Integrating Mental Health and Substance Abuse Services for Homeless People with Co-Occurring Mental and Substance Abuse Disorders - A Technical Assistance Report. Center for Mental Health Services Policy Research Associates. Delmar, N.Y. Undated

Abstract

This is a technical assistance report for states to use in developing proposals to develop care options for homeless individuals with dual diagnoses. The report outlines barriers to care for persons with dual diagnoses, how to organize the system of care, strategies for systems integration, and a section on principles of clinical care delivery for individuals with dual disorders. It draws on the literature on dual diagnosis in general, although the focus of the paper is how these principles apply to individuals who are homeless.

Strengths

1. The section on organizing a system of care (pp 8-15) provides an extensive review of the essentials for developing a comprehensive and functional system of care for individuals with dual diagnoses. Cost effective managed care will depend on creating such systems more than training individual providers. See Appendix D.
2. The clinical care section reviews the literature on treatment approaches to dual diagnosis, including special issues such as payeeships and housing. This review is relatively comprehensive.

Limitations

1. There is little mention of involuntary or coercive treatment methods in the clinical care section which are commonly required in treating individuals with homelessness and dual diagnosis.
2. There is little attention to individual staff development or training issues.
3. There is little attention to motivational development methods in the clinical care section which are essential with this population.
4. Does not address managed care or clinician competencies.

Relevance

This paper is a useful overview of systems issues and gives broad-brush description of clinical care issues that may be a helpful contributor to the practice guidelines and systemic standards of care.

012

Lehman AF: Heterogeneity of person and place: assessing co-occurring addictive and mental disorders. Am J Orthopsychiatry 1996; 66(1):32-41

Abstract

This article describes types of co-occurring disorders, considers common pitfalls in assessment across settings, and suggests approaches to identifying and meeting the needs of clients with co-occurring disorders.

Strengths and Limitations

Good description of different combinations of co-occurring disorders, but it is not clear if sub-typing criteria are clearly measurable or replicable.

Relevance

Helpful for developing competency in assessment, and for describing a typology which may be helpful for treatment matching and practice guidelines.

013

Lehman AP, Myers CP, Corty E: Assessment and classification of patients with psychiatric and substance abuse syndromes. Hospital and Community Psychiatry 1989;40:1019-1025

Abstract

This article provides an overview of a systematic approach to assessment and classification of individuals with co-occurring disorders. The authors divide treatment for dually diagnosed patients into two phases: acute treatment and stabilization, and maintenance and rehabilitation. Treatment during the former of these stages includes observation, management of acute intoxication and withdrawal, management of acute psychiatric symptoms and restabilization. Assessment during this phase should include a determination of dual diagnosis, or not, as evidenced by a number of contributing factors (e.g., symptom dissipation after detoxification, history of both problems, etc.). The authors discuss common difficulties that arise when attempting this classification, and they provide brief examples of cases that are diagnostically problematic. In the maintenance and rehabilitation phase, treatment efforts are aimed at preventing the recurrence of the disorder through pharmacological and psychosocial interventions. The assessment issue during this phase is more crucial, and deals with determining whether the disorders present have a hierarchical structure, as well as an identification of factors contributing to a risk for relapse. The authors propose four clinical hypotheses about how dual-diagnosis conditions develop, which are: primary mental illness with substance abuse sequelae, substance abuse with psychiatric sequelae, dual primary diagnosis, and common etiology.

Strengths

A thorough review of the issues related to assessment difficulties with this population. Indicates useful categories with which to conceptualize the development of dual disorders, as well as treatment related issues pertaining to these different groups. Emphasizes the importance of a consistent classification system in treatment planning, professional communication, as well as for future research with different classificatory systems.

Limitations

It would have been helpful to include more elaborate case examples and discuss the assessment and diagnostic implications of each. The authors do not provide guidelines to follow in order to make classification easier and more consistent.

Relevance

The article is useful as a review of many of the issues that a provider needs to be familiar with in order to effectively assess and diagnose individuals with co-occurring disorders, and can be utilized in the development of practice guidelines for assessment and diagnosis.

014

Mee-Lee D: Dual diagnosis and the ASAM patient placement criteria. The Counselor 1992; 14-17

Abstract

Discussion of the application of ASAM's PPC-I to dual diagnosis, which argues that "dual diagnosis" is one of many "subtypes" of addiction clients, the placement of which can be determined using the same types of criteria (e.g. emotional/behavioral, biomedical, etc.). Thus a whole new dual diagnosis continuum is not needed; rather a way of allocating such patients to existing "levels of care" within mental health and substance abuse systems.

Strengths

One of very few articles that addresses the application of managed care oriented utilization criteria to dual diagnosis patients.

Limitations

Focus on dual diagnosis as a subtype of addiction obscures the need to understand "patient placement" in a more integrated fashion in which service intensities are multidimensional.

Relevance

Offers some general principles for managed care assessment of dual diagnosis patients.

015

The Mental Health Center of Greater Manchester (New Hampshire) Practice Guideline: Substance Abuse. Undated. Submitted by Douglas Noordsy, MD

Abstract

Practice guidelines are geared primarily to a dual disordered population, and provide a detailed description of phase specific services and interventions based on the Prochaska change model, including assessment guidelines, criteria for inpatient referral, and services array for adult SPMI, and child/adolescent.

Strengths

One of the few dual diagnosis practice guidelines of any type available; incorporates five phases and three sub-populations.

Limitations

Interventions are not distinguished by sub-population; abuse and dependence are not distinguished; little discussion of utilization of continuum of care (i.e. multiple levels of care). No documentation of supportive data or outcomes.

Relevance

Useful to incorporate into the project's practice guidelines.

016

Miller NS: Prevalence and treatment models for addiction in psychiatric populations. Psychiatric Annals 1994; 24(8):399-406

Abstract

Prevalence data for co-occurring disorders. Between 50-80% of chronically mentally ill have substance use disorder. Description of treatment models: serial, parallel, integrated; and description of mental illness treatment in addiction settings and substance abuse treatment in psychiatric settings.

Strengths and Limitations

Good description, but very general.

Relevance

Provides overview of concepts necessary for development of practice guidelines and competencies on various treatment settings.

017

Minkoff K: An integrated treatment model for dual diagnosis of psychosis and addiction. Hospital and Community Psychiatry 1989; 40:1031-1036

Abstract

The article suggests the necessity to incorporate both mental health and substance abuse treatment into an integrated treatment philosophy for dually diagnosed individuals and describes a treatment model for dual diagnosis of psychotic disorders and addiction that has been implemented on an inpatient psychiatric unit. The author describes the establishment and treatment conceptualization for the unique unit on which he works (the Caulfield Center), treating dually diagnosed, psychotic/addicted individuals. The author describes the "integrated model" which they follow, which is based upon the 12-step disease and recovery model for the treatment of addiction, and the biopsychosocial illness and rehabilitation model for the treatment of serious psychiatric disorders. The article discussed the parallels that exist between the disease concept in the addiction model and the illness concept in the psychiatric model. The author outlines the application of these models into an integrative treatment, including the necessity of discerning between primary and secondary symptoms when attempting to identify the primary disease (or two primary diseases). The author describes the parallel concepts of recovery in the addiction and

psychiatric models within this theoretical framework, and discusses the phases they share in common which are: acute stabilization, engagement, prolonged stabilization, and rehabilitation. The treatment schedules for the unit are described (full addiction, full psychiatric, mixed addiction, mixed psychiatric), as well as the process underlying the selection of a treatment program for each patient. Finally, the author raises some of the common concerns that should be addressed in such a comprehensive system, including the usefulness of AA-based treatment, usefulness of medication, etc.

Strengths

A relatively complete illustration of a working unit that has seemingly successfully brought together two areas of service. Gives providers some theoretical background for choosing this distinct protocol. Describes a program that allows for the simultaneous treatment of primarily psychiatric individuals, primarily addicted individuals, and those with two primary diagnoses, all within one treatment unit.

Limitations

The article is focused on the dual diagnosis of addiction and psychotic disorders only. In addition, the program the author describes is based in AA philosophy and the medical model of addiction which may limit its usefulness with certain populations. Limited information is provided on the actual treatments being implemented, no outcome data for this program is provided.

Relevance

May be a useful example for conceptualizing the development of integrated program models within a system of care.

018

Minkoff K: Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1991, pp 13-27

Abstract

Describes a model comprehensive system of care, in which the role of individual program models is defined by the illness being treated and on the associated acuity, severity, disability, and phase of recovery. The author discusses issues to consider in designing treatment programs for the dually diagnosed. The need to balance care vs. confrontation, abstinence orientation vs. mandated abstinence, and recovery vs. rehabilitation is stressed. Common concepts to addictions and mental illness are identified and used to develop an integrated program model emphasizing continuity and comprehensiveness. The relevance of the concepts to the phases of acute stabilization, engagement, education, persuasion, and rehabilitation are discussed.

Strengths and Limitations

The strength of the chapter lies in the identification of common themes within addictions and mental illness. The chapter confuses the reader by mixing program principles, goals, objectives, and components.

Relevance

The chapter provides a template for designing an integrated system of care for all types of dual diagnosis, and all phases of treatment. As such, it can be very useful in developing system-wide standards of care in a public managed care arena.

019

Minkoff, K: Models for addiction treatment in psychiatric populations. Psychiatric Annals 1994; 24(8):412-417

Abstract

Describes barriers to the development of models of addiction treatment for psychiatric populations and the process of "ping-pong therapy" of patients referred back and forth between two systems of care. Offers a unified theoretical framework for integrated treatment and a description of some treatment program models.

Strengths

Good, practical framework. Describes some specific program models.

Limitations

Does not describe a comprehensive continuum of integrated programs.

Relevance

Theory should be part of core competencies; integrated program models can be included in standards for development of a system of care.

020

Minkoff K, Drake RE: Homelessness and dual diagnosis, in Treating the Homeless Mentally Ill. Edited by Lamb HR, Goldfinger S. Washington, DC, American Psychiatric Press, 1994, pp 221-247

Abstract

A comprehensive overview of epidemiology and barriers to care for homeless dual diagnosis populations using Minkoff's conceptual framework; regards homelessness as a third primary "diagnosis" with its own independent phase-specific recovery process. Uses this concept to outline a model system of care which includes intensive, integrated case management, phase-specific interventions (including wet, damp, dry housing), and family support.

Strengths

Very comprehensive and inclusive in integrating approaches from housing, psychiatric, and substance abuse fields. Outlines elements of a complete system of care. Extensive bibliography.

Limitations

Focus on serious and persistent mental illness. Model is theoretical; not supported yet by data.

Relevance

Useful for developing standards for care that incorporate what is needed in a comprehensive continuum.

021

National Community Mental Healthcare Council. Principles for Behavioral Healthcare Delivery, 1996

Abstract

Consensus documented by NCMHC establishing principles for public mental health agencies pertaining to delivering services in the current managed care environment. Principles are identified in 16 areas: vision values, governance, personnel, public advocacy, public responsibility, consumer-centered care, family support, service array, utilization management, care coordination, linkage and integration, pay management and finance, quality management, accountability, information management, and networking. Specific dual diagnosis related principles include:

Service Array - Treatment of consumers with dual diagnosis requires an array of services not normally used when dealing with a mental health or substance abuse problem alone. Achieving a successful outcome with dually diagnosed individuals is contingent upon the adequate evaluation, assessment, and selection of treatment modalities. Development of a comprehensive treatment plan must include coordination of mental health and substance abuse services.

Integration - The behavioral healthcare system should actively move toward clinical coordination and integration of mental health and substance abuse services at the service delivery level. This may necessitate integration at the payment levels.

Strengths

Well-articulated set of principles, that include specific dual diagnosis standards.

Limitations

Principles are at times redundant, and are not always well organized. Stronger statements on the necessity of service integration and continuity for dual diagnosis would be welcome.

Relevance

There are few sets of principles for service delivery, and fewer that specify dual diagnosis principles. Those standards are a beginning and a valuable point of departure.

022

Osher FC: A vision for the future: toward a service system responsive to those with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry 1996;66(1):71-76

Abstract

The article proposes a vision whereby there is a change toward integrated systems of care that will benefit the mental health and addiction treatment needs of all people, not just those with co-occurring disorders. Primary points are as follows:

1. It is ill-advised to develop a third system for persons with co-occurring illnesses in addition to those for mental health and addictions that would create new boundaries.
2. A truly integrated system would provide a truly seamless delivery of mental and addictions services through a variety of agencies across all behavioral health fields.
3. An ideal system is longitudinal, continuous, individualized, comprehensive, flexible, personal, accessible, and cohesive.
4. Ongoing psychiatric and addictions training is provided to all staff. Minkoff emphasized the importance of leadership and ongoing process and outcome evaluation to ensure continued progress toward identified goals for service integration.

Strengths

The author emphasizes a comprehensive, integrated system of mental health and addictions treatment for all patients, and outlines and discusses features of an ideal integrated system.

Limitations

The author only briefly discusses barriers to integration, and does not provide a discussion of where energy and momentum for integration will arise - levels, fields, people, policy, legislation, managed care, etc.

Relevance

Establishes general standards for an ideal system of care.

023

Osher FC, Drake RE: Reversing a history of unmet needs: approaches to care for persons with co-occurring addictive and mental disorders. Am J Orthopsychiatry 1996; 66(1):4-11

Abstract

This article presents an overview of the prevalence and clinical correlates of co-occurring disorders, and of the historical development of separate care systems for mental and addictive disorders. Describes positive efforts toward integration in current federal policy, and implies that managed care may have a positive impact on reuniting the service systems.

Strengths

Good review; makes a case for inadequate treatment if care is not integrated.

Limitations

History focuses on policy issues more than clinical or research issues promoting separation.

Relevance

Supports the potential value of managed care in creating integrated service systems, which is an important standard of care.

024

Osher FC, Kofoed LL: Treatment of patients with psychiatric and psychoactive substance abuse disorders. Hosp and Community Psychiatry 1989;40:1025-1030

Abstract

This article outlines a conceptual model for treating dually diagnosed patients within a mental health setting, proposing integrated treatment which balances the mental health and chemical dependency approaches for treating such patients. The authors provide a brief overview of treatment including the usefulness of the aforementioned integration, the appropriateness of an inpatient versus an outpatient setting, as well as which substances of abuse one may encounter and their effects upon treatment efficacy. The authors outline four different phases of illness and recovery through which an individual may progress in treatment. The engagement phase involves the process of convincing patients that the mental health provider has something desirable to offer them. The persuasion phase is the process of convincing engaged patients to accept long-term abstinence oriented goals. The active treatment phase is focused upon the development of attitudes and skills needed to maintain sobriety, and the final phase is relapse prevention. The authors describe each of these phases in some detail and relate them all to an abstinence based form of treatment. Finally, the authors identify the core treatment components that should be included throughout the treatment process. These include: a highly structured program milieu promoting impulse control, case management, group therapy, use of medication, detoxification, toxicological screening, family involvement, and the use of self-help groups.

Strengths

The phases described in this article are the most commonly utilized schema in the current literature, and provide an easy to follow treatment overview for working with dually diagnosed individuals with severe psychiatric symptoms. The authors address many of the concerns that may arise for a provider when attempting to design a treatment regimen, and enables the reader to understand the different stages of treatment readiness.

Limitations

The authors promote an abstinence-based treatment program for all individuals without providing an adequate research base to support this position. Theoretical text is extremely similar to the "Stages of Change" theory (Prochaska and DiClemente, 1986) at times, but this body of related research is not explored, or positive findings for such a program discussed.

Relevance

Important schema for developing phase-specific practice guidelines and systems of care.

025

Ries R: Clinical treatment matching models for dually diagnosed patients. *Psychiatric Clinics of North America* 1993;16(1):167-175

Abstract

Describes three models of combining addiction and psychiatric treatment for dually diagnosed individuals (serial treatment, parallel treatment and integrated treatment) and suggests which types of dually diagnosed would do best in which model. The serial treatment model, where one treatment (either addiction or psychiatric) precedes the other is the prevailing model today. While administratively simpler, it is problematic for people dually diagnosed with a chronic mental illness or with severe addiction. It works for individuals whose psychiatric problems are episodic, and who are able to achieve significant periods of stability, or for people with mild or moderate addictive problems. Parallel treatment may be useful for chronic mentally ill patients who are stable, or individuals who are relatively stable in their addiction. It does not work for both acute and subacute major psychiatric problems and chronic addictive disorders. It does not work for those people with stable psychiatric problems or people with primary addictive problems.

Strengths and Limitations

Although he makes a convincing argument for his thesis, he does not provide empirical evidence for the efficacy of this schema for treatment/patient matching. In the absence of empirical data this may be all we have to go on, and as such it is clear and well written.

Relevance

For developing practice guidelines or standards of care, it is very useful for clinicians to know about the different models of treatment, and what current thinking is regarding matching, keeping in mind that there is little empirical evidence.

026

Ries RK, Miller NS: Dual diagnosis: concept, diagnosis, and treatment, in *Current Psychiatric Therapy*. Edited by Dunner DL. Philadelphia, W. B. Saunders, 1993, pp 131-138

Abstract

Chapter provides overview of dual diagnosis problem, and introduces a model for treatment matching based on three phases: (acute, subacute, long-term) and four types of patients: (high severity psych - high severity substance; high-low; low-high; low-low). Implementation of integrated outpatient programs using this typology is discussed.

Strengths

Interesting section on phases typology is key to "guidelines for treatment matching."

Limitations

Much of the chapter repeats material from other sources. The specific treatment interventions for each phase and type are not clearly delineated.

Relevance

See "Strengths"

027

Ryglewicz H, Pepper B: Lives at Risk. New York, The Free Press, 1996

Abstract

Through four case studies of people with different types of dual disorders (schizophrenia, mood disorder, borderline personality/PTSD, multi-problem crack addiction) the problems of this population are sensitively illustrated. This leads to a discussion of diagnosis, sub-types of dual disorders, and the impact of social issues on treatment, and phase-specific/sub-type specific treatment planning. There follows a broad discussion of personality and personality disorder, the brain, biopsychosocial treatment, and various treatment challenges of the managed care era. The book closes with guidelines for clinicians, families, and consumers.

Strengths

Wonderfully comprehensive and readable; integrating a wide range of philosophies and viewpoints, with specific case examples. Very consumer-centered in its values and recommendations.

Limitations

By and large, the treatment recommendations and competencies described are presented more briefly in other material. Addiction treatment is less well-described than psychiatric rehabilitative treatments.

Relevance

Guidelines for clinicians (pp 209-214), and guide for treatment planning that is phase-specific (pp 88-89) are particularly useful for our project. The latter table is included in Appendix E.

028

Sciacca K, Thompson CM: Program development and integrated treatment across systems for dual diagnosis: mental illness, drug addiction, and alcoholism (MIDAA). J Mental Health Admin 1996; 23(3): 288-297

Abstract

Describes the implementation of a system-level dual diagnosis treatment and cross training intervention in a local catchment area in Michigan. Intervention emphasized inter-system cross-training to develop basic dual diagnosis group interventions for clients in various phases of treatment, using Sciacca's group model. Demonstrates the process of implementation of a low-cost targeted intervention that has significant systems impact and demonstrable clinical benefit.

Strengths

Very succinct and concrete description of clinical philosophy and type of dual diagnosis intervention. Describes the pragmatics of systems implementation that created significant progress toward integration in a manner that is accessible to any system of care. There is a focus on cross-training professionals, describing a non-confrontational approach to dual diagnosis treatment, stages of treatment, and motivational development. There is also a focus on longitudinal training, with concurrent training and supervised service provision, and development of inhouse trainers who then train other individuals at the site.

Limitations

Does not indicate mechanisms for providing emergency evaluations, implementing continuity of care, defining roles of component programs for client matching, and progressing to next phase of implementation. One intervention for all clients/all sites. The outcome data are quite weak.

Relevance

Valuable for indicating what might be a basic standard for implementation of beginning systems integration. The program philosophy section and training strategies sections are very useful. The program philosophy section may be helpful in developing practice guidelines. The training strategies section may be helpful in developing training curricula for dual diagnosis clinicians.

029

Sciacca K: MIDAA Service Manual for Mental Illness, Drug Addiction, and Alcoholism. New York, Sciacca Comprehensive Service Development, 1990

Abstract

This proprietary product was developed as a specific procedural manual for use by either mental health or addiction agencies wishing to implement dual diagnosis programming.

Strengths

The greatest strength of this manual is that it provides a detailed, systematic structure for implementation of a group program for dually diagnosed individuals at various stages of treatment readiness. It includes specific policies, guidelines for work assignments, assessment tools, outcome tools, group formats, guidelines for presentations, and so on. These are highly valuable for agencies that need help getting started, and may be useful as indicators of program implementation in other settings.

Limitations

One limitation of this manual is that it utilizes only Kathleen Sciacca's proprietary material, not all of which has been systematically validated and tested. Consequently, the user must be cautious of over-reliance on specific instruments. Also, the manual emphasizes a specific group treatment approach, and the user must be aware both that there are other group models, and that there are other necessary service elements in treating dual diagnosis.

Relevance

Many elements of the manual (e.g. program outline) serve as descriptive standards for dually diagnosis treatment programs; further, interspersed in the manual are procedures and materials which address specific clinician competencies in providing dual diagnosis treatment.

030

Thacker W, Tremaine L: Systems issues in serving the mentally ill substance abuser: Virginia's experience. Hospital and Community Psychiatry 1989;40:1046-1049

Abstract

This article describes issues that may impede the progress of state service delivery systems in addressing the needs of dually diagnosed individuals, summarizing literature, as well as reports from directors of state mental health and substance abuse services who attended meetings addressing problems with service delivery to mentally ill substance abusers. The issues that the authors list are as follows; 1) excessive boundaries, exclusion, and territoriality within service systems, 2) inadequate assessment and diagnosis by service providers, 3) lack of trained staff, 4) an inadequate array of services, 5) rigid funding streams, 6) lack of a strong shared constituency, 7) limited dissemination of effective program models, and 8) fragility of the limited success achieved thus far. The authors offer the recently adapted state of Virginia's service system as a model for other states to follow in addressing these problems in providing services for mentally ill substance abusers. Although mental health and substance abuse services are directed by separate offices in Virginia, they do share a common agency management structure. In order to ensure that these two groups effectively collaborate, the authors state that certain assumptions are maintained by the agencies. First, development of services for the dually diagnosed is given high priority due to a lack of service in the past. Second, this priority must endure through lack of funding due to the frequent use of services by these individuals. Third, mental health and substance abuse services must assume that their values are compatible. Finally, due to the common management structure, these two divisions were interdependent.

Strengths

The article provides helpful insights from first-hand experience on developing or adapting service delivery systems for dually diagnosed individuals. A useful description for program directors and policy makers of what works and what does not.

Limitations

The article may be limited by the nature of Virginia's current departmental layout. The authors do not offer advice concerning the development of dual diagnosis programs and how integrated programs may diminish disciplinary boundaries.

Relevance

Helpful for establishing principles or standards for systems integration, at the state wide level, under public managed care.

031

Weiss RD, Collins DA: Substance abuse and psychiatric illness: the dually diagnosed patient. Am J of Addictions 1992; 1(2):93-99

Abstract

Brief review of comorbidity data; typology of relationships between substance abuse and psychopathology (after Meyer): (1) mental illness is a risk factor for substance abuse (2) substance abuse causes transient psychopathology (3) substance abuse causes persistent psychopathology (4) substance abuse and psychopathology are mutually linked over time (5) substance abuse and psychiatric disorders coexist but are independent; brief description of treatment issues, emphasizing treatment of two primary disorders.

Strengths

Typology of interactions with case examples is of interest.

Limitations

Treatment discussion is very sparse.

Relevance

Typology may be helpful in characterizing heterogeneous sub-populations.

032

Weiss R, Mirin S, Frances R: The myth of the typical dual diagnosis patient. Hospital and Community Psychiatry 1992; 43:107-108

Abstract

The authors propose that the myth of a "typical" dual diagnosis patient has perhaps interfered with the provision of effective treatment. Describing different diagnostic combinations and the resultingly different clinical approaches, they report the various diagnostic combinations found in a sample of 350 hospitalized drug abusers. Different nondrug axis I disorders were found to be associated with different substances of abuse. For example, cyclothymic disorders and ADD, residual type were found to be frequently associated with cocaine abuse. It is emphasized that even persons with the same diagnosis do not represent a homogeneous group. They emphasize that each disorder should receive a specific treatment while interaction effects are considered. Homogeneous subgroups of patients are described as critical to treatment planning. Components of a comprehensive treatment program are briefly outlined.

Strengths

Makes the point that not all diagnostic subgroups should be treated similarly nor will they respond to interventions that are designed for persons with whom they have little in common, other than the title "dually diagnosed."

Limitations

Offered as a brief report - no opportunity to offer differential programming suggestions for different subgroups of patients.

Relevance

Emphasizes the need to conceptualize dually diagnosed individuals individually within practice guidelines, competencies, or standards of care.

033

Wilens TE, O'Keefe J, O'Connell JJ, et al.: A public dual diagnosis detoxification unit. Part I: organization and structure. Am J Addictions 1993; 2:91-98

Wilens TE, O'Keefe J, O'Connell JJ, et al.: A public dual diagnosis detoxification unit. Part II: observation of 70 dually diagnosed patients. Am J Addictions 1993; 3:181-193

Abstract

These articles describe a publicly funded dual diagnosis detoxification unit, developed with joint mental health and substance abuse funding as a psychiatrically-enhanced ASAM Level III detox in Boston, with a slightly enhanced rate. Characteristics of the unit included psychiatrically-trained nursing leadership and part-time on-site psychiatric consultation. This unit was designed to accommodate detoxing patients with clear-cut psychiatric disorders (e.g. schizophrenia) and/or acute psychiatric symptomatology related to intoxication (e.g. suicidality). The second article describes the demographic characteristics of the dual population, and their specialized clinical needs.

Strengths

These articles are one of the few data-based descriptions of innovative acute dual diagnosis treatment models. The articles are thorough and extremely well presented.

Limitations

None

Relevance

This integrated program model is characteristic of the innovative types of service delivery that should be developed in managed care systems.

034

Program Standards for Mentally Ill, Chemical Abuse (MICA) Treatment Facilities in Arkansas. Arkansas Department of Human Services, Division of Mental Health Services, 1996

Abstract

Defines goals, values, treatment standards, training procedures, and outcome measures for MICA facilities in Arkansas.

1. Goals: includes assertive community treatment and developing a panel of competent clinicians to treat this population.
2. Treatment Standards: pertinent standards include abstinence as a primary goal, recognition of harm reduction as a valid objective, simultaneous attention to both substance abuse and mental health needs, MICA training for staff, use of self-help groups.
3. MICA Training Certification Standards: 80 hours of training and passing a written exam, 240 hours of on-site training.
4. Job descriptions for MICA staff.
5. Outcomes Assessment: discusses assessment tools and procedures.

Strengths

This is among the best examples of comprehensive dual diagnosis standards at the state level. Outlines values and goals. Emphasizes integration and training. Standards are fairly comprehensive. Approach appears fairly consistent with contemporary knowledge. Includes specific job descriptions and certification standards. (See Appendix F)

Limitations

Does not really define specific competencies for dual-competency clinicians.

Relevance

Very valuable in developing systemwide standards for dual diagnosis treatment.

035

Sciaccia K: Integrated treatment for mental illness, drug addiction and alcoholism across Alaska. [Review of the video]. Sciaccia Comprehensive Services Development for Mental Illness, Drug Addiction, and Alcoholism, New York, NY

Abstract

A video developed by SCSO to orient administrators, program directors, and others to an effective way to engage and treat consumers with co-occurring disorders. The 55 minute video describes how Alaska started a state training program on co-occurring disorders, provider and consumer reports of the helpfulness of MICCA and CAMI groups, brief samples of the training, and brief descriptions of use of teleconference training.

Strengths

This model of integration clearly provides hope for treaters of and consumers with co-occurring disorders. Illustrates value of teleconferencing to disseminate dual disorder competencies in rural areas.

Limitations

Describes the process and shares too little of the model. However, the model is described in the Companion Service Manual.

Relevance

Clearly states that competencies of 1) being able to integrate treatment, and 2) being persistent, non-judgmental, and flexible, are essential to providers. Illustrates state leadership in setting standards for development of competencies.

036

Los Angeles County Department of Mental Health Dual Diagnosis Policy. Los Angeles, California, 1995

Abstract

Clear dual diagnosis policy establishes responsibility of Los Angeles County Department of Mental Health for clients with SPMI and any substance disorder. This includes responsibility to not exclude such clients from assessment and other services, to provide thorough evaluation of both disorders, and associated medical/organic problems. Dual diagnosis training, program development, and service coordination are mandated.

Strengths and Limitations

Such clearly proactive dual diagnosis policies are rare. This one is a useful model for developing system-level standards. Many aspects are locally relevant only. (See Appendix G)

Relevance

See "Strengths"

037

Report to General Assembly: Progress in Developing Common Policies for Persons with Substance Abuse and Mental Health Problems. Colorado Department of Human Services, Alcohol and Drug Abuse Division, Department of Mental Health, 1994

Abstract

Describes progress in systems integration in response to state legislation, including: developing a unique client identifier, integration of performance outcome measures, cross training initiatives (including the following competencies: dual diagnosis assessment, basic dual diagnosis treatment, motivational interviewing, medical disorders complicating both mental health and substance abuse disorders, common clinical assessment and documentation criteria - format included). It also includes an interagency agreement that defines three subtypes of dual diagnosis, and defines responsibilities of each agency for each type.

Strengths

Identifies useful elements for standards of care, including interagency definition of responsibilities. Integrated assessment tool is well done.

Limitations

Many elements are specific to Colorado, and require adaptation.

Relevance

As above, useful for defining elements to be addressed within a standard of care at the policy level.

038

Hills H, Cox A, Burton D: Florida Department Of Corrections Dual Diagnosis Program: Cross-Training Curricula

Abstract

This document is a proposal for developing a cross-training curricula for the Florida Department of Corrections. It outlines a curriculum for cross-training to be used by the Florida Department of Corrections and identifies 16 topic areas for discussion in a didactic format.

Strengths

It outlines a variety of topic areas to be addressed in training line clinicians to prepare them for dual diagnosis work. As such, it is a unique document.

Limitations

1. "There is no meat on the bones." This is an outline without any of the details filled in to guide a trainer
2. Fails to discuss the training needs of clinicians beyond didactic presentation.
3. Does not in any way address the critically important issues of motivational development and stages of treatment for individuals with dual diagnosis

Relevance

This paper may have limited value in helping us to develop training guidelines.

039

Standards for Regional Dual Diagnosis Services. Division of Mental Health and Substance Abuse. Georgia Department of Human Resources, 1996

Abstract

Delineates admission criteria, service components, and standards for the state's dual diagnosis programs. Outlines requirements for initial assessment, medical and psychiatric services, transitional and rehabilitative/skill building services, and clinical recovery/addictions treatment.

Strengths

Few states have developed any standards for dual diagnosis, and as such these are valuable. They do emphasize the importance of community support and integration, rehabilitation and skill building, include family support and behavioral interventions, and view treatment as occurring via a treatment team.

Limitations

Do not require clinical accountability by a dual-competency clinician or mention anywhere competencies for such a clinician or even the need for such a clinician. The standards lack mention of the need for structures for integrating and coordinating treatment with social service agencies, primary care, and gateway agencies. These standards are essentially more of the same without mentioning needed innovations to truly improve the quality of care provided to dual disorder patients.

Relevance

Illustrates the limitations of the current "state-of-the-art" in developing dual diagnosis standards; some elements will be useful to include in national standards.

040

Godley SH: A Treatment System United for Persons With Mental Illness and Substance Abuse. The Illinois MI/SA Project, Bloomington, IL: Lighthouse Institute, 1995

Abstract

The purpose of this manual is to provide a historical account of the Illinois Mental Illness and Substance Abuse (MISA) project. This project sought to bring together a divided service system that sometimes worked at cross purposes. It describes the genesis of the project, the development of Local Service Networks, what case managers did, and what case managers and others involved with the project believed were important considerations in designing programs to work with the target population.

Much was learned from the Illinois MISA project about local area networking and about working with people who have diagnoses of both mental illness and substance abuse. The need for the mental health and substance abuse treatment systems to come together and develop a unified approach for addressing the needs of this population was reinforced. Collaboration between the two systems remains a significant challenge. There is a large gap in the knowledge base regarding techniques that are effective with this population. Case manager experiences confirmed repeatedly the deleterious effects of alcohol and other drug use/abuse for persons with severe and persistent mental illness. These individuals often have a sparse set of external motivators for engaging in substance abuse treatment. While there are many recommendations regarding engagement and relapse prevention techniques with this population, there is very little research that addresses the use of these engagement and relapse prevention techniques. Researchers should address these gaps and case managers and other service providers should remain open to new findings in this area.

Strengths

Includes basic how-to information for case managers (including engagement techniques and relapse prevention) and has a succinct background section on case management. Refers to two training manuals which would be worth getting for this activity. Lists 12 training strategies for professionals that treat this population.

Limitations

Would have been helpful if there was an executive summary.

Relevance

Very valuable resource for developing competencies and curricula for case managers.

041

Illinois Departments of Alcoholism and Substance Abuse (DASA) and Mental Health and Developmental Disabilities (MHDD). Task Force Report For The Mentally Ill Substance Abuser. 1990

Abstract

This monograph is the product of a unique interagency task force empowered to address the MISA problem. The report addresses issues throughout the system, and developed an interagency agreement, mission and goal statement, common definitions for MISA, methods for addressing regulatory barriers, and a pilot project to jointly fund local integrated service networks with cross-trained case management teams to address difficult MISA clients.

Strengths

An excellent, replicable example of a state-wide systemic approach to integration, clearly identifying certain values, standards, and competencies. The definition of the priority population is very well done.

Limitations

Principles are very broad; details are sparse. Treatment recommendations are unsupported by data.

Relevance

Valuable example of efforts to develop standards of care for integrated services, at the state level.

042

Maine Dual Disorders Monographs, Volumes I-XIII. Department of Mental Health, Mental Retardation, and Substance Abuse Services, Office of Substance Abuse, Augusta, Maine, 1989-1996

Abstract

The purpose of these monographs is to describe the Maine Office of Substance Abuse's initiative to improve services to persons with co-existing mental health and substance use disorder. The initiative began in 1988. It provides a description of a three year demonstration project, The Cumberland County Dual Diagnosis Collaborative, that has ended and data is being analyzed. The project looked at service needs and barriers to services for people with co-occurring disorders. Through collaboration with county agencies, the project increased services assessed to be more essential (i.e., housing, integrated case management, non-hospital level crisis care, and agency coordination), provided dual treatment training, and produced training reports.

Volume I: Relapse Prevention - Conference Briefing. Tammy Bell, ACSW, 1989

Volume II: Psychoeducational Groups- a Seminar Briefing. Bert Pepper, MD, 1989

Volume III: Dual Disorder Treatment. Bert Pepper, MD and Hilary Ryglewicz, ACSW, 1989

Volume IV: Assessment - Seminar Briefing. Bert Pepper, MD and Hilary Ryglewicz, ACSW, 1990

Volume V: Psychoeducational Groups for the Dual Disorder Client - Seminar Briefing. Bert Pepper, MD and Hilary Ryglewicz, ACSW, 1990

Volume VI: Maine - States Helping States - Technical Assistance Project - Final Report, 1990

Volume VII: Final Report of the Maine Dual Disorders Reimbursement Task Force, 1992

Volume VIII: Psychoeducational Groups - Demonstration Project - Final Report, 1992

Volume IX: Normal Adolescent Development and Motivating Adolescents to Recover - Seminar Briefing. Tammy L. Bell, LCSW, MSW, CAC, 1991

Volume X: Adolescent Development and Dual Disorders. Mary Katherine Evans, CDAC and J. Michael Sullivan, PhD, 1991

Volume XI: Adolescent Dual Diagnosis- Multi-Dimensional Assessment and Treatment - Client- Treatment Matching. David Mee-Lee, MD, 1991

Volume XII: Running Effective Treatment Groups for Adolescents & Preventing Relapse in Adolescents. Tammy L. Bell, LCSW, MSW, CAC, 1991

Volume XIII: Final Report - Maine's Dual Diagnosis Collaborative Project. Andrea Goodman and Robert G. Croce, EdD, 1996

Strengths

Excellent, useful, easily usable, motivational. A model for other states or counties to consider.

Limitations

Some material is specific to Maine only.

Relevance

Identifies a broad range of dual diagnosis competencies, and provides well-elaborated training curricula. Prioritized integrated services for systems development, which can be adapted to develop system-wide standards.

043

Acute Substance Abuse Treatment Services: An Integrated System of Care for Massachusetts' Acute Substance Abuse Treatment Services. Department of Public Health, Bureau of Substance Abuse Services, May 1996

Abstract

The purpose of this document is to describe an integrated acute substance abuse inpatient treatment service system involving 20 detoxification programs and 8 intensive residential programs. It provides a description of the services, and criteria for admission, continued stay, and discharge. Co-occurring mental disorders are mentioned as one of the criteria to be considered for inclusion or exclusion depending on the severity.

Strengths

Clear and specific criteria for substance abuse level of care.

Limitations

Not designed for consumers with co-occurring disorders.

Relevance

Probably not helpful in developing specific criteria for co-occurring disorders, but illustrates a continuum of addiction services in a public managed care environment that, if psychiatrically enhanced, could be a foundation for a dual diagnosis continuum.

044

Residential Recovery Program Patient Placement Criteria. The Quality Improvement Collaborative (QIC), a Division of Health and Addictions Research Inc. Funded by Massachusetts Department of Public Health, Bureau of Substance Abuse Services. Draft 1996

Abstract

Describes three modalities of recovery homes: 1) recovery homes, 2) social model recovery homes, and 3) therapeutic communities. The criteria are presented in a narrative outline format, with an accompanying checklist tool.

Strengths

Clear and specific. Attempts to apply managed care oriented placement criteria to a recovery home continuum in a specific state.

Limitations

Does not address dual diagnosis.

Relevance

Criteria suggest competencies the clinician must have. With provision for psychiatric enhancement, might provide an outline for a dual diagnosis continuum of staffed residential programs.

045

- 1. Michigan Department of Mental Health Final Report: NIMH, MISA Dual Diagnosis Program, 1991**
- 2. Unpublished Report: State Policy Areas for Improving Health Care Services for Persons with Coexisting Substance Abuse and Mental Illness, 1994**
- 3. Macomb County SAMI Outreach Substance Abuse Project - Admission Criteria, 1994**

Abstract

The final report of the NIMH Project describes the implementation of a dual diagnosis assertive community treatment program, incorporating the following elements: integrated assessment, assertive outreach, 24-hour availability, provision of basic needs, psychoeducation about mental illness and addiction, promoting independence, developing socialization and leisure skills, vocational counseling, group, individual, family therapy, referral to community resources, promote utilization of residential addiction management. Outcomes were positive. The program staff believed they would develop a "new integrated treatment model", however, they discovered instead that substance abuse philosophies and ideologies "work as well for mentally ill people...both treatment ideologies are relevant at different problems with different clients...(thus), ongoing empirical experiments with different variations...is in fact a successful and workable way of dealing with dual diagnosis clients." The policy document covers recommended initiatives for emergency inpatient services, and general principles of interagency collaboration at state and local levels. Both of the latter two documents incorporate relatively specific definitions of sub-populations of dually diagnosed to which various programs are addressed.

Strengths

Some very specific and concrete program descriptions, policies, and standards, plus very helpful insights into integration and collaboration issues.

Limitations

Much of this material has only local relevance.

Relevance

Can be used in developing standards, policy guidelines, and population definitions.

046

Certification Standards, Comprehensive Substance Treatment and Rehabilitation (CSTAR) Programs. Missouri Department of Mental Health Division of Alcohol and Drug Abuse, 1996

Abstract

Outlines certification standards for substance abuse treatment facilities in Missouri.

1. Sections 3.810-3.880 focus on program standards.
2. Section 3.890 address staff qualifications, which include education, experience, and specialized training in substance abuse.
3. Sections 3.900-3.970 again focus on standards, program and administrative.

Strengths

Comprehensive, specific, and objective standards for accreditation of substance abuse treatment facilities. With respect to dual competency clinicians, stresses the importance of training.

Limitations

Do not address dual diagnosis specifically.

Relevance

Illustrates absence of specific dual diagnosis standards in most states.

047

MICA Specialist Certification Requirements. Addiction Professionals Certification Board of New Jersey, Inc. 1997

Abstract

Defines general education requirements for specialty certification as dual diagnosis counselor. Involves CADC; master's degree in human services, and various amounts of educational hours in mental health and substance abuse.

Strengths and Limitations

One of few examples of state MICA certification requirements. Does not define any specific competencies or curricula content.

Relevance

Some relevance to competencies for MICA counselors, but limited.

048

Oklahoma Department of Mental Health and Substance Abuse Services: Standards and Criteria for Adult Residential Treatment for Dually Diagnosed. DMHSAS OAC 450:18-3-141-143

Abstract

Service standards, admission, and discharge criteria for individuals who require ASAM level III residential treatment for addiction, and who have "a coexisting mental health diagnosis" and meet criteria for emotional/behavioral instability. The criteria are based on ASAM dimensions of assessment, but clearly require both psychiatric and addiction assessment and treatment by cross-trained staff.

Strengths

These are the only specific state standards for acute dual diagnosis residential treatment we have found to date, and they are well thought out, reasonably clear, and well grounded in ASAM methodology.

Limitations

Although addiction treatment needs are well-described, the extent of psychopathology appropriate for this level of care is unclear - is it any mental health diagnosis, or is it only active disturbance/disability? Are psychotic individuals appropriate for this service? These could be clarified. Also, unfortunately, no other program standards were developed in Oklahoma.

Relevance

These criteria are good enough and unique enough to serve as a template for national standards, and as such are included in Appendix H.

049

Pennsylvania's Client Placement Criteria for Adults. Pennsylvania Department of Health, Office of Drug and Alcohol Programs, 1997

Abstract

Based on the format of the original ASAM patient placement criteria (PPC-I). Produced in 1991, this document was developed as a collaborative project to adapt ASAM criteria to the real world public addiction treatment system. As such, it includes assessment tools and level of care criteria for a range of services within ASAM levels I-IV. It also includes sections on methadone maintenance, cultural relevance, gender-specific programs, and gay and lesbian programs. In particular, there is an excellent statement on treatment principles for people with substance disorder and coexisting mental illness. (See Appendix I)

Strengths

Excellent description of continuum of public-sector addiction services from a managed-care perspective, and statement of dual diagnosis principles.

Limitations

No description of integrated programs at any level of care.

Relevance

See "Strengths"

050

South Carolina Department of Mental Health Adult Community Rehabilitation and Support Work Group Report, 1995

Abstract

This report catalogues both knowledge and skill competencies for mental health clinicians.

Knowledge Competencies include:

- characteristics of mental disorders
- human development, relations, and learning
- diagnosis
- treatment elements
- documentation
- legal/ethical concepts
- community resources/systems

Skill Competencies include:

- general or basic skills: communication, organizational/management, political, teaching
- treatment: intake, assessment, treatment planning, treatment implementation, treatment evaluation, discharge planning and implementation, treatment follow-up
- attitudes/characteristics such as caring, honesty, non-judgmental, etc.

Strengths

This is a relatively complete listing of core competencies for a dual-competency clinician, and provides a useful categorization scheme.

Limitations

Does not include competencies specific to dual competency clinicians, such as the ability to do abstinence-oriented vs. abstinence-mandated treatment, motivational interviewing, etc. The list is very general.

Relevance

This listing is useful for developing workforce competencies. (See Appendix J)

051

South Carolina Department of Alcohol and Other Drug Abuse Services: Reimbursement Standards for Dual Diagnosis Day Treatment Programs (DDDTP), 1996

Abstract

This policy describes admission criteria, staffing standards, and treatment content for long-term DDDTP, which is an enhanced addiction IOP, that was developed collaboratively between mental health and substance abuse departments. The DDDTP daily rate is \$150, compared to \$108 for addiction IOP. The program identifies eligibility for DMH priority clients as well as addicted clients, implies the presence of both licensed mental health counselors and addiction counselors, and establishes a cross-credentialing mechanism. A rather comprehensive array of groups and individual sessions, addressing both disorders, are identified.

Strengths

To date, this is the only state standard for integrated day treatment we have found, and provides a reasonable prototype for this long-term treatment intervention. It describes a true interagency collaboration.

Limitations

Describes only one type of dual diagnosis treatment program; eligibility criteria are much less precise than would be required in a tightly managed system. Some of the groups described are all mental health focused and more substance treatment integration would be desirable.

Relevance

Despite its limitations, this is still a useful prototype for designing service standards.

052

Washington State Division of Alcohol and Substance Abuse and Mental Health Division

1. "Step One: Toward understanding the treatment and systems issues related to the MICA Person," 1990
2. "Guidelines for MICA Pilot Project," 1993
3. "Assessment of MICA Pilot Projects," 1994

Abstract

"Step One" provides a literature review, problem statement, and general systems overview. "Guidelines" lists characteristics and needs of MICA individuals, and defines MICA for the purposes of the project (serious mental illnesses-psychotic or major affective disorder only). There is then a unique listing of three types of "dual diagnosis" clinicians - MICA counselor, MICA specialist, MICA professional - and training and supervision requirements for each, plus staffing and programming standards for a variety of MICA program types (inpatient, residential, intensive outpatient). The project report summarizes implementation and findings of each of 8 county based pilot projects, and compiles lessons and overall recommendations for interagency collaboration. Good local coordination of services was correlated with success.

Strengths and Limitations

Definition of MICA clinician competencies and program standards is especially valuable. Illustrates thoughtful progression of a state initiative to further integration. Much of the content is of local interest only, or repetitive of other sources.

Relevance

Valuable for developing workforce competencies and training standards.

053

Washington State Materials (submitted by R. Ries, MD)

1. **Regulations Governing MICA Providers , Draft 1992**
2. **MICA Case Management Curriculum Model. Final Report. Eastern Washington University Alcohol/Drug Studies Program, July 1993**

Abstract

1. Draft regulations include staffing and service intensity criteria for MICA "residential differential diagnosis," "intensive outpatient differential diagnosis," "intensive outpatient," and outpatient services. Also included are credentialing criteria for CD counselors to become MICA counselors (2,000 hours of MICA experience); MICA specialist (MICA counselor and BA degree plus five years experience with MICA); MICA professional (MICA specialist and master's degree).

2. Final report of a special project funded by mental health and substance abuse departments to develop a model curriculum for training “MICA case managers” to achieve a MICA case management certificate. Includes minimum course content on “alcohol and drug problems,” “physiology and pharmacology of drugs,” “abnormal psychology,” “MICA,” “counseling theory and skills,” “human growth and development,” plus descriptions of three specialized courses: MICA advanced psychopathology, MICA case management - psychopharmacology and MICA case management - community resources. (See Appendix K)

Strengths

Well-developed, specific criteria and competencies for MICA specialist addiction counselors, and MICA specialist mental health case managers. Some criteria for a MICA continuum of care.

Limitations

Maintains distinction between “addiction” MICA counselors and “mental health” MICA case managers. Continuum of care criteria appear arbitrary; lengths of stay are long, and service intensities low by managed care standards.

Relevance

The MICA curriculum is the best available elaboration of counselor/case manager competencies.

054

Guidelines for Mental Illness, Chemical Dependency, and Dual Diagnosis Level of Care Decisions for Adults and Children and Adolescents. U.S. Behavioral Health Guidelines for Level of Care Decisions - Revised July 1996. Coordinated by Joyce McCulloch, MS, Manager for Data Analysis and Integration, U.S. Behavioral Health.

Abstract

The purpose of these guidelines are to aid case managers as they work with the provider community and patients in the process of determining appropriate levels of care. The guidelines define dual diagnosis as co-occurring substance use disorder and psychiatric disorder (Axis I or II). Briefly presents two different conceptual models for treatment (R. Ries and K. Minkoff) and key variables that must be considered. The assessment of the key variables and their relationship to each level of care is specifically described.

Strengths

Clear, specific; considers the co-occurring disorders and the interaction between them. These are the only “dual diagnosis” level of care criteria we found.

Limitations

Does not describe a truly comprehensive continuum of dual diagnosis services.

Relevance

Would be helpful in the development of competency guidelines for clinicians treating co-occurring disorders. The assessment of key variables for levels of care are necessary competencies. Also useful in developing standards for program components in a system of care.

055

1996 Utilization Management Guidelines. Merit Behavioral Care Corporation. Park Ridge, NJ, Merit Behavioral Care

Abstract

Outline of guidelines for assessment and placement of psychiatric and addiction patients, includes a section on clinical philosophy, an assessment format based on the six dimensions of the ASAM criteria: detoxification/withdrawal; biomedical; psychiatric/emotional; treatment acceptance/resistance; relapse potential/recidivism; recovery support, and a description of intensity of service criteria for a wide range of psychiatric and addiction service types.

Strengths

The assessment format is state of the art, and permits integrated psychiatric and substance assessment. Utilization management guidelines define a fairly well-conceived continuum of services.

Limitations

Despite the integrated assessment, none of the program models are integrated. All are separate psychiatric or separate addiction.

Relevance

Provides useful adaptation of ASAM dimensions to develop an integrated "multidimensional severity profile" that can be a basis for a dual diagnosis assessment "practice guideline."

056

Kay DA, Jospe M: Guidelines for Mental Health and Substance Abuse Care. CMG Health Clinical Management Guidelines, 1994

Abstract

Utilization guidelines.

Strengths and Limitations

Detailed, clear. Section on treatment guidelines for people over 65. No co-occurring disorders information.

057
Levels of Care and Inpatient, Partial, and OPD. Comprehensive Behavioral Care, Inc. , Tampa, Florida, 1996

Abstract
Criteria for level of care and practice parameters for several diagnosis.

Strengths and Limitations
Detailed, had one question regarding substance abuse in psychiatric disorder assessments. Did not address co-occurring disorder.

058
Corphealth, Inc. Provider Resource Manual, 1996

Abstract
Utilization review, levels of care, complaint and grievance procedure, performance standards, site survey, substance abuse added into Axis V sub-scale.

Strengths and Limitations
Has some consumer focus. No provision for concurrent disorders.

059
Miller G: Foundation Health Psychcare Services MHN Division Clinical Services Manual, April 1996

Abstract
Description of how their utilization review works and guidelines for level of care.

Strengths and Limitations
Clear, separate guidelines for mental illness and substance abuse. Nothing regarding co-occurring disorders.

060
Green Spring Health Services, Inc. Provider Reference Manual. Advocare of Oklahoma, 1994. Advocare of Tennessee, 1996

Abstract
Description of application criteria, levels of care criteria, utilization review, appeals process, filing claims, performance standards for mental health and substance abuse agencies.

Strengths
Detailed criteria. One instance of acknowledging co-occurring disorders - for psychiatric hospitalization of substance abuse treatment you must have a mental illness.

Limitations
Mental health and substance abuse level of care criteria are described as separated and non-interactive in most cases.

061
Intensive and Primary Care Management: Mental Health and Substance Abuse. Human Affairs International, 1993

Abstract
Clinical guidelines and policies, level of care criteria, utilization review guide.

Strengths
Clear, detailed criteria.

Limitations
Criteria for mental illness, chemical dependency, and eating disorders are described with levels of care that are separate and exclusionary.

062

Bartlett J, et al.: MCC Preferred Practices - References. Second Edition. September, 1992. MCC Managed Behavioral Care, 1992

Abstract

Provides clinicians with "explicit supportable standards of care for a wide variety of mental health and substance abuse problems," based on sound clinical and research for the approaches and treatments which are documented.

Strengths

Readable guidelines based on research.

Limitations

Only brief mention of prevalence of co-occurring disorders, no standards for co-occurring disorders.

063

Options Mental Health Clinical Criteria. Norfolk, Virginia. No date.

Abstract

Guidelines for treatment.

Strengths

Very specific criteria for length of stay . Considers substance use disorder as a factor and considers it as a comorbid factor in guidelines for some diagnoses.

Limitations

Co-occurring disorders not considered in treatment guidelines, patient often excluded from psychiatric treatment if abusing substances.

Relevance

May be of limited value in designing utilization guidelines for dual diagnosis.

064

The Value Behavioral Health Manual: Clinical Protocols and Procedures. Value Health, 1996

Abstract

Criteria for level of care and justification for treatment.

Strengths

Specific detailed criteria and treatment guidelines. Treatment of dually diagnosed patients is defined as a problem area, advises psychiatric screen for substance abuse disorders. When a patient with addiction is in psychotherapy, VBH expects the provider to be a mental health professional with expertise in recovery issues.

Limitations

Mental health and substance abuse criteria for level of care separate in most cases.

065

Vista Behavioral Health Plans Policy and Procedure (Eileen Innecken, Director of Quality Improvement)

Abstract

Procedures for authorization of services, appeals, grievance, emergency procedures, including bombs and earthquakes, program evaluation, and criteria for level of care.

Strengths

Clear procedures for utilization review to follow.

Limitations

No utilization review provisions for co-occurring disorders. No criteria for co-occurring disorders levels of care.

066

Alexander MJ: Women with co-occurring addictive and mental disorders: an emerging profile of vulnerability. Am J Orthopsychiatry 1996; 66(1):61-70

Abstract

This article reviews the literature on alcohol and drug problems in women and on women with severe mental illness who are at high risk for substance abuse - as well as other forms of abuse and deprivation, due to poverty and victimization.

Strengths

Good literature review, thoughtful questions.

Limitations

Not much data available on gender-specific interventions for dual patients.

Relevance

Very useful in developing competency criteria for treating dually diagnosed women.

067

Brown VB, Huba GJ, Melchior LA: Level of burden: women with more than one co-occurring disorder. Journal of Psychoactive Drugs 1995;27(4):339-346

Abstract

This article focuses on treatment retention and outcomes of women with multiple problems. Level of burden is defined as the number and severity of problems, including psychological problems, cognitive impairment, chronic health problems, HIV/AIDS status, and substance abuse. In clinical trials, high-burden clients tended to be most at risk for early termination. Many treatment outcomes are significantly correlated negatively with initial levels of burden.

Strengths

The paper's strengths include discussion of implications for treatment providers and potential directives for future research. Providers may be reinforced in their efforts to provide comprehensive diagnoses and integrated service delivery, which includes primary health care, as well as efforts to understand the social context of psychological problems in substance abuse treatment.

Limitations

No specific treatment models.

Relevance

Emphasizes that dual disordered women have increased need for integration of social and medical services, as well as integration of psychiatric and substance treatment.

068

Cornelius JR, Fabrega H Jr, et al.: Racial effects on the clinical presentation of alcoholics at a psychiatric hospital. Comprehensive Psychiatry 1996;37(2):102-8

Abstract

Focuses on impact of race and socio-economic status (SES) in treatment facilities. The effect of race was evaluated on the clinical profile of 604 alcoholics who presented for initial evaluation and treatment at a psychiatric hospital. After controlling for SES and other factors, no significant difference was detected between ethnic groups in the prevalence of major depressive disorder or antisocial personality disorder. Yet alcohol and other drug use were more severe in African American alcoholics. Among white alcoholics, reverse neurovegetative symptoms, anxiety-related symptoms, and some personality-related symptoms were more severe.

Strengths

One of few studies examining the effects of race on comorbidity and symptom patterns.

Limitations

Descriptive only.

Relevance

Links between comorbidity, SES, and race are relevant to treatment standards, criteria for training, and impact of service delivery.

069

Cuffel BJ: Comorbid substance use disorder: prevalence, patterns of use, and course, in Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. Edited by Drake RE, Mueser K. San Francisco, Jossey-Bass, 1996, pp 93-105

Abstract

The prevalence of comorbid substance use disorder is reviewed with the evidence suggesting that severe mental disorder affects the manifestation of substance use disorder broadly by increasing the persons' vulnerabilities to a wide variety of substances. Patterns of substance abuse in severe mental illness are described. The course of substance use disorder in severe mental illness is still largely unstudied. However, what is learned to date is that without intensive targeted interventions, substance use disorders have a higher likelihood of persisting and may have deleterious effects on treatment outcome, functioning, and quality of life. Longitudinal data shows that decreases in substance use appear to provide relief from depressive symptoms and to significantly lower use of psychiatric inpatient care. A case is made for targeting the people with schizophrenia and bipolar disorder for substance use disorder prevention.

Strengths

Good data. Well-written.

Limitations

No specific data regarding treatment.

Relevance

Supportive epidemiological data for developing standards that view dual diagnosis as an expectable occurrence.

070

Drake RE, McLaughlin P, Pepper B, Minkoff K: Dual diagnosis of major mental illness and substance disorder: an overview, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 3-12

Abstract

This review of literature explores the emergence of the problem of dual diagnosis, efforts to solve the problem, and the current state of the art. The authors review the epidemiology of dual diagnoses and hypotheses for why the rates of co-occurrence are so high. Clinical correlates are briefly reviewed, as are responses of federal agencies and the development of treatment interventions.

Strengths and Limitations

Provides useful overview of dual diagnosis issues but is too superficial to be of much use in developing competencies.

071

Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ: The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. Am J Orthopsychiatry 1996; 66(1):17-31

Abstract

This article investigates co-occurrence of mental illness and substance use disorder, and associated service utilization. General population data from the national comorbidity survey are presented on co-occurring DSM-III-R addictive and mental disorders. Co-occurrence is highly prevalent in the general population and usually due to the association of a "primary" mental disorder with a "secondary" addictive disorder. It is associated with a significantly increased probability of treatment, although the finding that fewer than half of cases with twelve month co-occurrence received any treatment in the year prior to interview suggests the need for greater outreach efforts.

Strengths

Well-designed study, focusing on anxiety, affective, and personality disorders.

Limitations

Does not address psychotic illness.

Relevance

Demonstrates the importance of promoting access for dual disordered individuals without SPMI.

072

Miller NS, Eriksen A, Owley T: Psychosis and schizophrenia in alcohol and drug dependence. Psychiatric Annals 1994; 24(8):418-423

Abstract

Epidemiological studies reveal high prevalence of comorbidity of schizophrenia and alcohol/drug dependence.

Strengths and Limitations

Comprehensive review. No specifics regarding programming.

Relevance

Documents necessity of integrated programming for psychotic and substance disorders.

073

Milling RN, Faulkner LR, and Craig JM: Problems in the recognition and treatment of patients with dual diagnoses. Journal of Substance Abuse Treatment 1994: 267-271

Abstract

A study demonstrating high prevalence and under-recognition/under-treatment of dual diagnosis of patients admitted to a psychiatric hospital. Study recommends cross training of all psychiatric staff and the use of more formalized substance abuse assessment instruments.

Strengths

Supportive of the research literature, which generally calls for additional training of mental health professionals to more effectively assess and treat both disorders presented by dually diagnosed patients.

Limitations

No use of collateral contacts or urinalysis for assessment - patient self-report only. It does not add anything new.

Relevance

Provides some data to support the need for substance abuse assessment competencies in psychiatric inpatient settings.

074

Regier DA, Farmer ME, et al.: Comorbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area (ECA) study. JAMA 1990; 264(19):2511-2518

Abstract

This classic comorbidity study established the high prevalence of dual disorders using sound epidemiological methodology. Among those with alcohol disorders, 37% had a comorbid mental disorder; among those with drug disorders, 53% had a comorbid mental disorder. For individuals with schizophrenia, 47% had some substance use disorder (55% for schizophrenics in treatment). For people with bipolar disorder, substance disorder comorbidity is 56%; 62% for those in treatment.

Strengths and Limitations

Probably the best comorbidity data available, despite the constraints on reliability of self-report surveys.

Relevance

Data supports the principle that dual diagnosis is an expectation, not an exception, and that developing integrated systems, standards, and competencies is a necessity not an afterthought.

075

Roman RM, Blum TC: National Treatment Center Study - Summary Report. National Institute on Alcohol Abuse and Alcoholism, 1997

Abstract

Results of survey of 450 random sample private sector addiction treatment facilities in U.S. during 1995-1996. 79.8% reported a dual diagnosis "component"; 60% offered psychiatric treatment; 77.6% prescribe antidepressants; and 8.7% were "entirely dual diagnosis facilities."

Relevance

Dual diagnosis data is limited, but of interest in benchmarking what is currently available in the private sector service system.

076

Clark RE: Family support for persons with dual disorders, in Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. Edited by Drake RE, Mueser KT. San Francisco, CA, Jossey-Bass, 1996, pp 65-78

Abstract

Review of the literature on family involvement with persons with dual disorders, covering the value of family support (housing, money management, and monitoring of substance use) versus the burden for the family of the dually disordered. Families are often dissatisfied with treatment resources, but there are specific family interventions for people with dual disorders now being tested. Discussed goal of "effective interdependence."

Strengths

Thorough review. Good bibliography. Nice balance of family vs. clinical perspectives.

Limitations

No clear conclusions or recommendations.

Relevance

Adds to the limited data base which helps to define family needs from the treatment system.

077

Green VL: The resurrection and the life. American Journal of Orthopsychiatry 1996; 66(1):12-16

Abstract

A consumer's viewpoint of the problems she experienced, as an individual with bipolar and substance disorder, because of a dichotomous instead of an integrated approach to her treatment. The article describes:

1. Conflicting experiences in a psychiatric setting and absence of a full evaluation, treatment plan, and treatment when a psychiatric patient also has an alcohol and drug problem.
2. Lack of psychiatric expertise in an addiction setting for patients with both psychiatric and addictive disorders.
3. Need for integrated or dual treatment for both categories of disorders - comorbid psychiatric and addictive disorders.
4. Hopelessness resulting from the lack of adequate treatment and from the disorders themselves.
5. Misunderstanding in the approach to both psychiatric and addictive disorders by professionals and family members.
6. Poor reimbursement for integrated treatment and lack of sites/programs for integrated treatment.
7. Emphasis, in the current system, on diagnoses over functionality.
8. Burden of integrating proper treatment for dual diagnosis falling on the patient.

Strengths

Eloquent personal account. Gives rare - and accurate - consumer perspective. Clearly identifies problems for patients with dual diagnosis in the current system.

Limitations

Does not address psychiatrist's role; her physician was an internist.

Relevance

This type of description is vital for developing consumer-oriented standards of care.

078

Hazelden Foundation. The Dual Disorders Recovery Book. Center City, MN, Hazelden, 1993

Abstract

Defines a Twelve-Step program for "those of us" with dual disorders. This book includes chapters on "A Comprehensive Approach to Dual Disorders," "Twelve-Steps and Dual Disorders," "Recovery and Relapse," "Abstinence and Sobriety," and about 20 personal stories of recovery, encompassing a wide range of psychiatric disorders. The book concludes with a blueprint and meeting format for Dual Recovery Anonymous. The stories and chapters present a consistent picture of the hope and possibility of dual recovery through addressing both disorders together, usually with medication and Twelve-Step programs.

Strengths

One of the best collections of consumer generated material on dual recovery. Presents a powerful view of the value of integrated treatment and self-help recovery for dual disordered individuals. Valuable blueprint for Dual Recovery Anonymous meetings.

Limitations

Emphasizes 12-Step treatment but has a less consistent message regarding other treatment interventions. Few of the stories relate to people with SPMI.

Relevance

Valuable for providing data to define consumer-oriented standards of care, and the importance of dual recovery meetings.

079

Rubinstein L, Campbell F, Daley D: Four perspectives on dual diagnosis: an overview of treatment issues, in Managing The Dually Diagnosed Patient. Edited by O'Connell DF. Binghamton, NY, Haworth Press, Inc., 1990, pp 97-113

Abstract

This chapter approaches understanding the dually diagnosed patient from the patient's point of view, his/her family's perspective, the counselor/therapist's view, and the perspective of other systems involved in the treatment. The chapter's primary focus is from the perspectives of patients and their families. It describes the difficulties in treating patients with dual disorders, such as inaccurate diagnosis, medication noncompliance, general resistance to treatment, and the self-medication hypothesis, and suggests denial as a major barrier to treatment within this population. Identifies patient education, management of feelings, better compliance with medication and use of the 12 Step programs as strategies leading to better outcomes. Issues to be considered from the family perspective include: evaluating the impact of the patient's illnesses on the family and vice versa; engaging the family in the treatment process when appropriate, and delineating family treatment goals. Suggests that counselors keep the following in mind when assessing the impact of a patient's illnesses on families: severity of problem, length of problem, behavior of the family member with the disorders, unique relationship between the person with the dual disorders and family members, and the family member's unique perceptions of the illnesses. A process by which families might become engaged in the treatment process is delineated.

In addition, dually diagnosed patients are defined as multi-problem patients requiring the involvement of numerous human service systems simultaneously. Other systems have similar problems as the mental health and substance abuse systems in addressing the needs of this population, and case management can be useful in connecting dually diagnosed patients with the appropriate community agencies.

Strengths

Good practical guideline in understanding dual disorders from the perspective of persons most impacted by the illnesses. The family section is especially significant since most treatment efforts neglect to include them in the process. Very good guide for clinicians, administrators and policy makers to review and consider in terms of program designs and specific treatment efforts.

Limitations

Somewhat dated. Little discussion of the needs of counselors and how systems might work better together to more effectively respond to the needs of this population.

Relevance

Valuable for defining consumer/family oriented standards of care.

080

The Substance Abusing Mentally Ill (SAMI) Peer Advocate Training Project Concept Paper. Los Angeles County, 1996

Abstract

Project description and competency list for training dual diagnosis peer counselors. (See Appendix L)

Strengths

The peer counselor program for dual diagnosis is unique, and the expected skills are very useful.

Limitations

Many aspects are locally relevant only.

Relevance

See "Strengths"

081

Sciacca K: Peer support for people challenged by dual diagnosis: "helpful people in touch," in Consumers as Providers in Psychiatric Rehabilitation. Edited by Mowbray CT, Moxley DP, Jasper CA, Howell LL. Columbia, MD, IAPSRs, 1997, pp 82-94

Abstract

Describes the process of implementation and ongoing functioning of a long-term consumer-developed, consumer-led, self-help group for seriously mentally ill individuals with substance abuse disorders.

Strengths

Emphasizes the value of consumer participation in a self-help dual diagnosis recovery process that is an adjunct or alternative to traditional 12-Step or psychiatric programs. Describes very concretely specific implementation and maintenance issues and how they were resolved by consumers, with staff assistance.

Limitations

Describes one group in one setting. Generalizability may be limited. No outcome data.

Relevance

Illustrates that self-help dual diagnosis groups, implemented with staff assistance, may be a reasonable and practical component of a set of consumer-oriented service system guidelines for dual diagnosis treatment.

082

Vogel HS: Double Trouble in Recovery (DTR). Albany, NY Mental Health Empowerment Project, 1993

Abstract

A very basic manual for forming a DTR group, and establishing a meeting format. Emphasizes the value of 12 Step-oriented dual recovery programs.

Strengths

Consumer-oriented: illustrates the basic steps in dual recovery for providers and consumers.

Limitations

Does not discuss other treatment interventions in any detail.

Relevance

Familiarity with dual self-help recovery is a necessary competency.

083

Alfs DS, McClellan TA: A day hospital program for dual diagnosed patients in a VA medical center. Hospital and Community Psychiatry;43:241-244

Abstract

The article describes the 6-8 week psychiatric day hospital treatment program at the Veterans Affairs Medical Center in Minneapolis, which has offered specialized treatment for dually diagnosed patients since 1987. The authors state that the primary treatment goals for program are to reduce substance abuse, improve medication compliance, and to reduce frequency of hospitalizations. Nonconfrontational group therapy is the primary treatment modality, and groups are held daily. In addition, the program includes the use of psychotropic medication, as well as patient education on topics of mental health and substance abuse. While the program encourages attendance at abstinence based AA meetings and other community-based self-help groups, they do recognize less frequent substance abuse with improved functioning as a realistic goal. The authors report that the patients' ability to function in a group appeared to be the most influential factor affecting outcome.

Strengths

Clearly describes how the dual diagnosis program is put together, including staff, size of groups, etc. The case examples provide an honest illustration of how responses to treatment may vary tremendously between individuals. The reporting of data for the patients of the program will allow comparisons to be made by other professionals on other units.

Limitations

The authors do not provide a detailed rationale for the selection of their treatment design, and do not discuss alternative levels of care.

Relevance

Describes one program model within a dual diagnosis system of care. The article may allow providers to gain insight into the structure of a treatment unit, as well as learn about what outcomes may be expected from a particular treatment protocol.

084

Blankertz LE, Cnaan RA: Assessing the impact of two residential programs for dually diagnosed homeless individuals. Social Service Review 1994; 68(4):536-560

Abstract

Compares effectiveness of two residential programs for dually diagnosed homeless, a "hybridized psychosocial rehabilitation model" and a "modified therapeutic community model". The experimental program (the former) emphasized individualization, flexibility, and strengths; level system progressed as follows: engagement, "transition", interpersonal growth, community resources, self-management. The comparison program was more strict, confrontive, and regulated, requiring abstinence at the outset, with lower staff ratios (1:25), and less integration of mental health treatment, and more addiction counselor staff. In the experimental program, 29% of clients in treatment more than 60 days "exited successfully" (abstinent, no hospitalization, domiciled for 3 months); 8% of clients in comparison. Flexible expectations, "slow progress" orientation, multi-faceted interventions, and positive rewards were associated with better outcomes.

Strengths

The research helps to define characteristics of residential treatment more predictive of success with this population, and supports the value of long-term incremental interventions rather than one dose of intensive treatment.

Limitations

The "comparison" leaves many variables uncontrolled (level of staffing for example) that may relate to outcome independently of model.

Relevance

See "Strengths"

085

Comtois KA, Ries RK, Armstrong HE: Case manager ratings of the clinical status of dually diagnosed outpatients. Hospital and Community Psychiatry 1994; 45(6):568-73

Abstract

The study evaluated the construct validity of a rating scale used by case managers to assess the clinical status of clients in large outpatient treatment program for dually diagnosed persons. Case manager ratings were compared with data on clients' diagnoses and the structure required in their treatment program. Strong correlations were found between diagnosis and level of structure, between severity of substance abuse and noncompliance, and between severity of psychiatric disorder and level of dysfunction.

Strengths

This paper's strength is the value placed on utilization of accurate diagnoses by case managers based on a reliable rating scale.

Limitations

Primarily SPMI clients.

Relevance

One implication for developing competencies is that case managers' ratings on reliable scales are important for measuring clients' treatment progress, and the status of the entire client population in a given treatment program.

086

Corse SJ, Hirschinger NB, and Zanis D: The use of the addiction severity index in people with severe mental illness. Psychiatric Rehabilitation Journal 1995;19(1):9-18

Abstract

Evaluates the usefulness of the Addiction Severity Index (ASI) in populations with comorbid severe mental illness and substance abuse.

Although the psychometric properties of the ASI have been well established in addicted populations, it is unclear whether the ASI is either reliable or valid with the dually diagnosed. Using data from a large ongoing study of dually diagnosed individuals, the article concludes that the ASI does not adequately assess functioning in a number of areas relevant to this population, and that its administration with this population is problematic.

Strengths and Limitations

This is only one part of a two part study on this topic, and reports on the qualitative not the quantitative data. Would benefit by using both parts together. It is however an important topic of direct relevance to outcome measurement in dual diagnosis.

Relevance

Demonstrates the problems of using this very widely used assessment tool in a dual population. All clinicians working with this population should know about this.

087

Drake RE, Antosca LM, et al.: New Hampshire's specialized services for the dually diagnosed, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 57-67

Abstract

An integrated statewide dual diagnosis initiative has established continuous treatment teams providing intensive case management, along with specialized substance abuse groups and residential programs. The chapter describes New Hampshire's mental health service system and a statewide effort to integrate treatment for dually diagnosed people. The core intervention, a multi-disciplinary intensive case management team, is described in depth. Case examples are used to illustrate treatment principles. A particular focus is on the use of group interventions tailored to the patient's stage of treatment.

Strengths and Limitations

The strength of this chapter is in describing an effective intervention easily generalized to other community mental health settings. The only limitation is that it refers only to SPMI dually diagnosed, and does not clearly distinguish interventions for abuse and dependence.

Relevance

The entire model defines valuable practice guidelines, standards of care, and treatment models. Also, therapies could be used to develop specific competencies in this area, e.g., the clinicians should be capable of titrating confrontation in group interventions based on the patient's stage of treatment.

088

Drake RE, Bartels SJ, et al.: Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disorders 1993; 181:606-41

Abstract

Reviews the New Hampshire continuous treatment team model and its application to treatment of dual diagnosis, as well as reviewing the outcome literature on treating this population. Indicates that these individuals can be successfully treated, and identifies principles of treatment that are associated with success: assertiveness, outreach, continuity, integration, optimism, flexibility, stable housing.

Strengths

Excellent review which establishes principles for state-of-the-art treatment. Applies for SPMI, but applies to other populations as well.

Limitations

Focus on SPMI, and focus only on abuse rather than dependence.

Relevance

These principles can be incorporated into standards of care and practice guidelines.

089

Drake RE, Mueser KT (eds): Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. San Francisco, Jossey-Bass, 1996

Abstract

A summary of recent findings and approaches directed toward public chronically mentally ill outpatients who can be involved in case managed intensive outpatient therapy.

Content of Chapters

Chapter 1. Drake RE, Rosenberg SD, Mueser KT: Assessing substance use disorder in persons with severe mental illness, pp 3-17. Three phases of assessment--detection, diagnosis, and specialized assessment for treatment planning - have important clinical implications.

Chapter 2. Carey KB: Treatment of co-occurring substance abuse and major mental illness, pp 19-32. Research findings from several fields support principles of treatment that should be incorporated into dual-diagnosis programs. Based on motivational interviewing, these principles include: establish a working alliance; evaluate cost/benefits of continued substance use; individualizing gears for change; lifestyle changes; coping with crises.

Chapter 3. Mueser KT, Noordsy DL: Group treatment for dually diagnosed clients, pp 33-52. Four types of group interventions are commonly used to address substance abuse among dually disordered persons. 12 Step, educational/supportive, social skills, stagewise groups.

Chapter 4. Osher FC, Dixon LB: Housing for persons with co-occurring mental and addictive disorders, pp 53-64. Because people with dual disorders frequently experience unstable housing and homelessness, attention to housing and the connection between treatment and housing must be part of the service plan.

Chapter 5. Clark RE: Family support for persons with dual disorders, pp 65-78. Families are critically important sources of housing, financial support, and direct care for people with dual disorders.

Chapter 6. Jerrell JM: Cost-effective treatment for persons with dual disorders, pp 79-92. The costs of caring for people with dual disorders are high: effective outpatient programs can reduce costs considerably.

Chapter 7. Cuffell BJ: Comorbid substance abuse disorder: prevalence, patterns of use, and course, pp 93-105. A review of epidemiologic studies of co-occurring substance use disorder and severe mental illness summarizes current knowledge regarding, rates, patterns, and longitudinal changes.

Strengths

Excellent resource, written toward behavioral and life-skill issues in outpatient treatment. The first three chapters are very strong, and the special chapters on housing and family support are also well done.

Limitations

Primary focus is on SPMI with substance abuse, little to no mention of acute or inpatient treatment, medications, addiction or withdrawal specific interventions.

Relevance

Provides useful material for the development of practice guidelines and clinical competencies.

090

Drake RE, Noordsy, DL: Case management for people with coexisting severe mental disorder and substance use disorder. *Psychiatric Annals* 1994; 24(8):427-431

Abstract

Review of studies which show that case management can be used to provide integrated treatment and that dually disordered clients can be successfully engaged in community-based services.

Strengths and Limitations

Specific examples and use of stages are clear and helpful. This is a more simplified outline of material that is covered in greater depth elsewhere.

Relevance

Stage model and engagement techniques important as core competencies, as elements of standards of care and practice guidelines for SPMI with substance disorders.

091

Drake RE, Noordsy DL: The role of inpatient care for patients with co-occurring severe mental disorder and substance use disorder. *Community Mental Health Journal* 1995; 31(3): 279-282

Abstract

This article discusses current quantitative research on the usefulness of inpatient hospitalization in SPMI substance disordered population. Suggests hospitalization more appropriate for stabilization and outpatient setting more suitable for ongoing treatment of chronic mental illness comorbid with substance abuse.

Strengths

Discusses quantitative research about cost effectiveness of acute hospitalization for severe mental illness and substance use disorders.

Limitations

Bibliography is dominated by authors' own work. Discusses substance abuse as if it were one disorder; did not address drugs of choice, stages of addiction or differentiation between use, abuse, and addiction.

Relevance

Provides some data relevant to developing system wide standards of care and program models regarding inpatient treatment.

092

Drake RE, Rosenberg SD, Mueser KT: Assessing substance use disorder in persons with severe mental illness, in *Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. Edited by Drake RE, Mueser KT. San Francisco, CA, Jossey-Bass, 1996, pp 3-17*

Abstract

A succinct, but thorough overview of the state-of-the-art in assessing substance use disorder in this population, including detection, diagnosis, and specialized assessment (e.g., stage of treatment; factors which sustain use).

Strengths

Up to date, clearly written, thorough literature review and excellent bibliography. Emphasizes the multi-factorial nature of the assessment process.

Limitations

Does not address assessment of substance dependence sufficiently, and does not cover assessment of relapse prevention skills.

Relevance

Relevant to practice guidelines and basic competencies for clinicians working with SPMI.

093

Greenfield SF, Weiss RD, Tohen M: Substance abuse and the chronically mentally ill: a description of dual diagnosis treatment services in a psychiatric hospital. Community Mental Health Journal 1995;31(3):265-275

Abstract

Describes an inpatient-based dual diagnosis program. Identifies factors contributing to poor outcomes for patients diagnosed with psychosis and substance use disorder: such as shorter hospital stays, difficulty in evaluating and assessing the symptomatology of dually diagnosed patients, and separate service delivery systems. Acknowledges the paucity of research data on outcomes for this population. Describes the implementation of an integrated model of treatment at McLean Hospital. Shares the manner in which care coordination can more appropriately be managed among various service units. Program design includes a variety of individual, family, and group therapies, psychoeducational groups, relapse prevention groups and urges a nonconfrontational approach.

Strengths

An excellent presentation on the epidemiology of patients with chronic mental illness and substance abuse problems, followed by a concise and significant statement of the barriers to effectively responding to the treatment needs of this population. The program description provides a useful guide for others planning services for this population.

Limitations

Lacks specifics around how administrative, training and treatment philosophies might move toward becoming compatible with the needs of dually diagnosed patients.

Relevance

Useful as a guide for establishing an inpatient treatment program for persons with chronic mental illness and substance use disorders, and in developing practice guidelines or program models.

094

Hanson M, Kramer TH, Gross W: Outpatient treatment of adults with co-existing substance use and mental disorders. Journal of Substance Abuse Treatment 1990;7:109-116

Abstract

Outcome study of abstinence oriented day program in New York City for people with dual diagnosis of serious mental illness and substance disorders. Approximately one third completed six months of treatment and were likely to stay in treatment. Demographics and past treatment history did not predict outcome, so much as treatment participation. Treatment included supportive psychoeducational model, with groups and activities, medication, AA, family services, and case management. The study supported the value of integrated, open-ended, supportive, low-demand day programming, and of group skills development strategies, for this population.

Strengths

Well-designed study supports positive value of this treatment modality, and measures outcomes in terms of both disorders. Succinct review of the literature thru 1990. Results reaffirm that 1) unified, open-ended treatment of both disorders in one setting produced positive effects; 2) patients responded to supportive, low demand treatment; and 3) group and skills development strategies were effective with dually disordered patients.

Limitations

Does not address reasons for high dropout rate, how to identify which clients will do well in this modality, and how to engage the others. The authors acknowledge that the results do not imply causation. This was an exploratory, descriptive study which has limitations and was based mostly on record review which allows that some treatment components were not examined. Closer examination of treatment specificity may have revealed more information about treatment response.

Relevance

This treatment option, and its components, may be incorporated into practice guidelines, with measures to help define expected outcomes.

095

Jerrell JM: Cost-effective treatment for persons with dual disorders, in Dual Diagnosis of Serious Mental Illness and Substance Disorder, Part II. New Directions for Mental Health Services, No 70. Edited by Drake RE, Mueser K. San Francisco, CA, Jossey-Bass, 1996, pp 79-91

Abstract

Compares cost and effectiveness of three substance abuse intervention approaches for treating person with co-occurring severe mental illness and substance abuse who were difficult to treat in traditional outpatient mental health clinics. The three interventions were 1) The 12 Step recovery model. Clinical staff offered transitional groups or mock Alcoholics Anonymous (AA) meetings within the mental health center, took or referred clients to community AA meetings, attempted to facilitate the development of a sponsor relationship for the client, and provided supportive counseling to help the client manage the 12-step recovery process; 2) The behavioral skills training model. A psycho-educational approach for teaching clients self-management skills in one time weekly group and then engaging them in repeated and proactive reinforcement of these skills; 3) The case management model. Intensive assistance in such areas as housing, daily living skills, legal problems, money management, personal relationships, and leisure time activities. All clients also received standard mental health care consisting of individual or group treatment, medication visits, and minimal case management to stabilize them in the community. (Sample was 132 clients). The ability to keep to the planned intervention was compromised by many factors, and this effects the research results. The outcomes for clients in the behavioral skills model were more positive on indicators of psychosocial functioning and symptoms reduction than either of the other two interventions. This model also cost less.

Strengths

A study with some useful results.

Limitations

The flaws in implementation were noted above. Also, there was a lack of specific treatment matching according to substance diagnosis and phase of treatment.

Relevance

Identifies a range of approaches to integrated treatment.

096

Kline J, Harris M, Bebout RR, Drake RE: Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services, No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1991, pp 95-106

Abstract

This chapter compares and contrasts the application of integrated and linkage models of care for homeless persons with dual diagnosis receiving services from a Washington, DC agency. Both models rely upon intensive case management, psychosocial rehabilitation, and a continuum of residential services and utilize a developmental phases model. The case management activities in each phase within each model were specifically described. The two approaches were acknowledged to have advantages and disadvantages for the target population.

Strengths and Limitations

This article gives clear direction to case managers employing different approaches to homeless persons with dual diagnosis. How this would generalize to non-homeless population is unclear. The chapter begins to address the complexity of working with a heterogeneous population across diverse settings.

Relevance

The article could be used to develop competencies for case managers working in different models of care for dually diagnosed individuals.

097

Kofoed L: Assessment of comorbid psychiatric illness and substance disorders, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1991, pp 43-55

Abstract

Assessment involves a systematic approach to concomitant evaluation of diagnosis, severity, and motivation regarding each disorder. The author reviews critical dimensions of assessment for patients with dual diagnosis. He reviews the utility and limitation of existing diagnostic instruments for both addictive and non-addictive disorders. The relevance of temporal relationships to diagnosis is discussed as are the dimensions of severity and motivation to planning and prognosis. The concept of assessment as treatment is thoughtfully presented.

Strengths and Limitations

This is a well-written and comprehensive chapter on assessment. It integrates key principles with important clinical considerations. Focus is only on SPMI, however.

Relevance

This chapter is extremely valuable in the development of competencies for dual diagnosis providers. A thorough understanding of this information could be established as a core competency for any clinician working with the dual diagnosis population.

098

Layne GS: Schizophrenia and substance abuse, in Managing the Dually Diagnosed Patient. Edited by D.F. O'Connell DF. Binghamton, NY, Haworth Press, 1990, pp 163-182

Abstract

The purpose of this chapter is to provide an overview of the problem of substance abuse in schizophrenia.

Strengths

The best section is in the last four pages, which summarizes three treatment programs (NY, NJ, and Oregon), and lists composite features:

- *Early Engagement
- *Peer-Oriented Group/Milieu Treatment
- *Life-Skill Rehabilitation
- *Self-Help Groups
- *Abstinence Orientation
- *Family Involvement
- *Psychiatric involvement, including continuing medication
- *Psychotherapy

Limitations

The discussion however is at best largely derivative of the work of others, and at worst relies on outmoded concepts of mental illness and substance disorder.

Relevance

The composite features of dual programs reflect common standards of care and practice program guidelines for dual diagnosis efforts in general.

099

Lehman AF, Dixon LB (eds): Double Jeopardy: Chronic Mental Illness and Substance Use Disorders. Switzerland, Harwood Academic Publishers, 1995

Abstract

The goal of this book is to provide information on the assessment and treatment of clients with SPMI and comorbid substance use disorders. This book is divided in three major sections:

Section I provides background on dual disorders with specific focus on epidemiology, ethnic and cultural factors, and assessment issues:

Introduction. Lehman AF, Dixon LB. Introduction and review of chapters.

Chapter 2. Mueser KT, Bennett M, Kushner MG: Epidemiology of substance use disorders among persons with chronic mental illness.

Chapter 3. Westermeyer J: Ethnic and cultural factors in dual disorders.

Chapter 4. Drake RE, Mercer-McFadden C: Assessment of substance abuse among persons with chronic mental illnesses.

Section II focuses on treatment and includes specific chapters on treatment principles applicable to dual disorders, and treatment of specific combinations of dual disorders:

Chapter 5. Schwartz R, Lehman AF: Overview of treatment principles. A discussion and comparison of separate treatments for mental illness and substance addiction.

Chapter 6. Carey KB: Treatment of substance use disorders and schizophrenia. Treatments for patients diagnosed with schizophrenia and substance use; discussion of how cognitive impairments impact treatment.

Chapter 7. Weiss RD, Wong EJ: Mood disorders and substance use. Treatments for patients diagnosed with mood disorders and substance use; special issues in diagnosis.

Chapter 8. Johnson JL, Posner NE, Rolf JE: The comorbidity of substance use and psychiatric diagnosis among adolescents. Special problems of adolescents with dual disorders; issues of early detection and prevention.

Chapter 9. Bartels S, Liberto J: Dual diagnosis in the elderly. Demographics suggest that as the population ages there will be new problems in treating the dually diagnosed elderly.

Chapter 10. Mahler JC: HIV, substance abuse, and chronic mental illness. A discussion of HIV infection and risks to dually diagnosed persons; emphasis on prevention and stress reduction.

Chapter 11. RachBeisel J, McDuff D: Mental disorders secondary to chronic substance use. Highlights special issues for persons whose psychiatric symptoms are induced by chronic substance use.

Section III includes six chapters on Social System Issues and includes:

Chapter 12. Sciacca K, Hatfield AB: The family and the dually diagnosed patient. Family perspective on dual diagnosis; presentation from the Maryland study and discussion of AA style family groups.

Chapter 13. Dixon LB, Osher FC: Housing for persons with mental illness and substance use disorders. Problems of housing dually diagnosed persons and possible solutions.

Chapter 14. Champlain LM, Herr SS: "Double jeopardy": some legal issues affecting persons with dual diagnoses. Full range of legal issues affecting dual diagnosis clients; relevant fair housing and anti-discrimination statutes and advocacy issues.

Chapter 15. Drake RE, Noordsy DL, Ackerson TH: Integrating mental health and substance abuse treatments for persons with chronic mental disorders: a model. Discussion of strategies (case management and assertive treatment) to bridge the two treatment systems.

Chapter 16. Fox TS, Shumway DL: Human resource development. Training and motivating staff to work with dually diagnosed clients.

Chapter 17. Ridgely MS, Dixon LB: Policy and financing issues in the care of people with chronic mental illness and substance use disorders. Systemic barriers to care.

Strengths

Chapters are written by both clinicians and researchers; treatment principles and the importance of integrated treatment are emphasized; much attention is given to social system issues affecting this dual diagnosis population; the helpfulness and importance of self-help groups for both patients and families are emphasized; and attention is given to often ignored populations such as adolescents, the elderly, and HIV positive individuals. The epidemiology, assessment, and schizophrenia chapters (emphasizing motivational interviewing) are particularly good. A specific chapter focusses on staff training.

Limitations

Focus on SPMI only. In addition, as an edited book there is inconsistency in the structure, quality and amount of useful information provided in each chapter (eg., only a brief paragraph is provided on psychotherapy in the chapter on mood and substance use disorders); there is repetition in some chapters (e.g., stating the problem of dual diagnosis, citing studies or prevalence, etc.); there is not enough emphasis on specific clinical issues and interventions (e.g., types of group treatments to use); and certain disorders or symptoms are not given sufficient attention (e.g., many dual diagnosis patients have severe personality disorders that interfere with the treatment participation; or persistent anxiety disorders that cause additional suffering or interfere with patients' ability to use group treatments or self-help programs).

Relevance

Information presented on principles of treatment, developing an integrated treatment approach, assessment, and family involvement could be used to develop more specific practice guidelines and competencies for dual diagnosis treatment.

100

McGlynn EA, Boynton J, et al.: Treatment for the dually diagnosed homeless - program models and implementation experience: Los Angeles. Alcoholism Treatment Quarterly 1993; 10(3/4):171-186

Abstract

Analysis of an effort to implement and compare a new non-residential (day) program for dually diagnosed (SPMI) homeless, with an existing residential (social model modified therapeutic community) program in California. Fully 40% of assigned subjects failed to engage for even one day, with continued attrition. Residential program was more costly but had greater program completion. Meaningful work occurred informally at least as much as in groups. Implementation involved developing more flexible rules (re: abstinence, attendance, etc.) in the outpatient setting. Successful staff were flexible in application of existing mental health or substance abuse skills, and comfortable in a case management role.

Strengths

Demonstrates need for specific engagement strategies, including but not limited to residential settings, for involving dually diagnosed homeless in treatment, and need for flexibility and case management as key competencies.

Limitations

Limited success of treatment model; no basis for replication or standard of care.

Relevance

Illustrates what not to doing establishing dual diagnosis programs, and identifies some key competencies.

101

McHugo G, Drake R, Burton H, Ackerson T: A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. J Nervous Mental Disorder 1995; 183:762-767

Abstract

This article describes the development and psychometric properties of a scale (the SATS) to assess and document the stage of substance abuse treatment in dually disordered patients with SPMI. The scale has 8 stages: pre-engagement, engagement, early and late persuasion, early and late active treatment, relapse prevention, recovery, and is case manager rated (See Appendix M)

Argues that recovery is longitudinal and that clients proceed through several behavioral and motivational stages. The SATS was developed by both clinicians and researchers, attempting to operationalize the way in which they observed clients moving through recovery. Once the scale was developed it was validated using data from a large multi-site longitudinal study. Concurrent, convergent and discriminant validity were all established as clinician inter-rater reliability (.90), clinician test-retest reliability (.91) and researcher interrater reliability. (.89 and .93) Argues that this scale can be used as either an assessment tool for treatment matching or an outcome measure of treatment.

Strengths

Research methodology is sound and it is one of the few scales whose psychometric properties have been carefully tested. It was also developed by documenting what clinicians empirically observed, and thus should have excellent clinical application, as well as research application.

Limitations

Applicable only to SPMI with substance abuse disorders. Relevance to other dual populations not clear.

Relevance

The scale itself is a very important tool which all clinicians working with this population should understand and be able to use. It is important for clinicians to understand how people proceed through recovery, and how to document and measure it; the SATS is one way of doing this. It also provides a format for conceptualizing phase-specific treatment.

102

McLaughlin P, Pepper B: Modifying the therapeutic community for the mentally ill substance abuser, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 85-93

Abstract

An innovative residential dual diagnosis program has been developed by incorporating mental health services into a traditional addiction setting. This chapter describes the evolution of the therapeutic community for substance abusers and its adaptation for the dually diagnosed population. It provides a detailed description of Harbor House, a forty-five bed treatment center located in Bronx, New York, and its integration of an interdisciplinary mental health team to work with dually diagnosed patients. Admission and discharge policies are reviewed. A case example is used to demonstrate an individual's progress within the program model.

Strengths and Limitations

Describes an innovative residential model which may be a valuable component of a system of care. The chapter does little to identify the principles by which mental health treatment was integrated.

Relevance

This model of residential treatment can be included in standards of care for developing a public managed care system.

103

Minkoff K: Intervention strategies for people with dual diagnosis. Innovations and Research 1993; 2(4):11-17

Abstract

Using Minkoff's disease and recovery model, with four distinct phases of recovery, this article describes specific intervention strategies for the engagement phase regarding substance abuse in people with SPMI. The four step process involves acknowledging powerlessness, empathic detachment, education, and developing opportunities for empathic confrontation. A format is provided for developing dual diagnosis contacts and policies.

Strengths

Clear, concise description of basic engagement strategies; contract format is very practical.

Limitations

Focus is mainly on SPMI with substance abuse.

Relevance

Useful for training counselors and case managers to develop basic attitudes and skills for engagement.

104

Mowbray CT, et al.: Treatment for mental illness and substance abuse in a public psychiatric hospital. Journal of Substance Abuse Treatment 1995;12:129-139

Abstract

This article provides a detailed description of an integrated approach to treatment for mental illness and substance abuse in a public psychiatric hospital. The program is based on the belief that both mental and substance use disorders are biopsychosocial in nature and on literature review supporting the need to include 12 step self-help models, stages of treatment, and an integrated model in treatment efforts. Treatment components consisted of (a) specialized assessment instruments: Addiction Severity Index, Modified Michigan Alcoholism Screening Test, and Biopsychosocial Assessment/Diagnostic Summary. (b) mental health interventions: individual treatment plans, psychiatric evaluation, individual and group psychotherapy, family education/therapy sessions, activity therapy and men's and women's group. (c) substance abuse interventions: 40 educational lectures, AA meetings, NA meetings, and relapse prevention groups. Problems of including persons with co-occurring mental and substance use disorders in the AA and NA programs are highlighted. Argues that program treatment stages are very useful in meeting the needs of this population. Discusses staff training and recruitment.

Strengths

Good detailed description of an integrated model of service delivery for persons with co-occurring mental and substance use disorders. Very practical guide for program design and development in the public sector. Program components appear to be based upon the research literature, reflect the philosophical views of the authors and are solution-oriented.

Limitations

Inpatient focus only. Does not address stages of addiction or discuss specialized interventions for late stage addicts - more oriented to a psychiatric population.

Relevance

Useful program design illustrating how components of an integrated model can be implemented. Illustrates a standard for development of hospital-based dual diagnosis programming in public managed care settings.

105

Mueser KT, Drake RE, et. al.: Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness. Evaluation Center @ Human Services Research Institute, 1995

Abstract

A tool kit of evaluation scales to determine the severity of substance abuse/dependence disorders in the severely mentally ill population.

Part One: Introduction. The scope of the problem and definitions; prevalence of dual disorders; predictors of substance disorders among those with severe mental illness; consequences of substance use; evaluation difficulties; and the recovery process.

Part Two: Clinician Rating Scales. 1. Clinician-Alcohol Use Scale based on the criteria for alcohol abuse and dependence from the DSM-111-R; 2. Clinician Drug Use Scale based on the criteria for various substance abuse and dependence from the DSM-111-R; 3. Substance Abuse Treatment Scale used to identify consumer's stage of treatment based on the New Hampshire model; 4. A calendar for recording the number of days the consumer has achieved abstinence. Descriptions of each of these.

Part Three: Training. Introduction to the concepts; Description of the specific scales; Practice and Discussion using each scale; reliability and validity checks.

Part Four: Data Processing and Analysis. Numerical ratings to determine severity; vignettes for substance abuse treatment scale.

Part Five: Bibliographies.

Strengths

A good overview of the importance of diagnosing substance disorders among persons who have a severe mental illness. The scales provide an example of an educational tool for teaching practitioners to use the DSM-111-R substance abuse/dependence criteria to provide differential diagnoses of substance disorders. The substance abuse treatment scale is another example of treatment of consumers at various levels of treatment readiness.

Limitations

The DSM-IV has provided further details in the diagnostic criteria and in the new variations of remission criteria. The new criteria in both areas is very useful when working with consumers at various levels of treatment readiness and corresponding recovery. The scales do not incorporate these changes. Does not discuss rationale for selecting those particular instruments. The assessment instruments are limited to the substance disorder alone.

Relevance

Useful for developing assessment competencies and training materials. A good example of program materials that assist practitioners to evaluate both the severity of the substance disorder and the stage of treatment for dually diagnosed consumers, with SPMI.

106

Quinlivan R, McWhirter DP: Designing a comprehensive care program for high-cost clients in a managed care environment. Psychiatric Services 1996;47(8):813-815

Abstract

This article contains a brief yet detailed account of conversion from a public mental health system to managed care in San Diego County. The objective was to reduce costs for high volume users of inpatient psychiatric care. The article details clinical profiles of high volume service users that were compiled both prior to and after the implementation of managed care. The comparison reveals under reporting/under detecting of substance disorders and borderline personality disorders in the compilation that was done prior to managed care. The article includes an account of specific presenting and confounding problems found among the high volume service users. It also outlines the author's solutions or best practice guidelines to potentially address these issues.

Strengths

This is a unique contribution regarding the process of changing a system over to public managed care for the dual/multiple diagnosed population. It is brief yet detailed. Specific "best practices" include continuity, integration of addiction treatment, residential hospital alternatives, medication management and education, and representative payees.

Limitations

The best practices and solutions that are being considered for implementation. Does not describe specific interventions and program models for the dually diagnosed.

Relevance

A good inside view of an effort to reduce costs by implementing a managed care model for high volume psychiatric inpatient care users, most of whom are dually-diagnosed.

107

Ridgely, MS: Creating integrated programs for severely mentally ill persons with substance disorders, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 29-41

Abstract

The author described four examples of successful, integrated dual diagnosis treatment programs and their common approaches for addressing barriers to interagency and inter-system collaboration. Common, essential program elements were identified as: addressing phases of treatment, addressing engagement and motivation, providing for specialized assessment, providing simultaneous treatment and developing support systems for relapse prevention.

Strengths and Limitations

The use of "on-line" programs to demonstrate key concepts is practical and useful. Specific suggestions for developing client-level and systems-level interventions is valuable.

Relevance

The chapter would be useful to program administrators identifying the elements needed for program development. The "essential program elements" can be incorporated into practice guidelines or standards of care.

108

Ries RK, Comtois KA: Illness severity and treatment services for dually diagnosed severely mentally ill outpatients. National Institute of Mental Health Schizophrenia Bulletin 1997;23(2):239-246

Abstract

This study assessed treatment matching of severity of illness with intensity of comprehensive continuum of service at University of Washington. The study describes treatment phases: pre-phase (case manager engagement); phase I (structured education groups); phase II (relapse prevention); phase IIa lower functioning; phase IIb higher functioning. Patients in lower phases were rated as higher psychiatric severity, were more likely to be schizophrenic, and received more service intensity in the form of individual case management. Service utilization was associated with reduction of hospitalization and some progress through the phases, but not reduction of homelessness.

Strengths

This is one of very few studies of treatment matching in this population, and illustrates a useful "phase-based" continuum.

Limitations

The severity of illness rating is a very primitive marker for real-world treatment matching.

Relevance

Provides model of phase-based continuum of care for a program standard, and supports the value of treatment matching as a practice guideline.

109

Rosenheck R: Substance abuse and the chronically mentally ill: therapeutic alliance and therapeutic limit-setting. Community Mental Health Journal 1995;31(3): 283-285

Abstract

This brief article discusses the role of limit-setting in the ongoing treatment of people with dual diagnosis. It discusses implementation of "voluntary consultative" model of treatment, including collection of substance abuse history, and initiating recommendations in a "nonconfrontational interview style." Patients are offered, in order, education and support, relapse prevention groups, and longer-term open ended groups. Coercion may be required for some patients in order to facilitate entry into the appropriate clinical care; this may require therapeutic limit-setting, which is grouped into five broad categories: verbal confrontation; behavioral contracting; passive sanctions; invocation of external authorities; and direct imposition of restrictions.

Strengths

Good practical guide for beginning mental health professionals, illustrating the importance of developing competency in confrontation/limit setting interventions, as well as just psychiatric support.

Limitations

Brief, non-specific, no research support. Does not address stages of addiction, phases of treatment, or variation in confrontation for different psychiatric disorders (e.g. major depression vs. antisocial personality disorder).

Relevance

Provides some background regarding the development of specific clinical competencies for psychiatric clinicians.

110

Sciacca K: An integrated treatment approach for severely mentally ill individuals with substance disorders, in Dual Diagnosis of Major Mental Illness and Substance Disorder. New Directions for Mental Health Services. No 50. Edited by Minkoff K, Drake RE. San Francisco, Jossey-Bass, 1992, pp 69-84

Abstract

A replicable step-by-step approach to treating clients and families is described, and the process of program implementation is outlined. The author describes a program model for the treatment of persons with severe mental illness accompanied by chemical abuse and/or addiction. The model described uses group therapies to augment existing inpatient or outpatient programs in which the patient's denial is identified and becomes the focus of the group intervention. Nine steps are outlined from the initial contact to the development of total abstinence as a treatment goal. Self help and family support groups for the dual diagnosis population are described.

Strengths and Limitations

This chapter describes a program model which can be easily added to existing treatment for persons with severe mental illness. Its limitations include not differentiating the model based on level of patient disability or stage of treatment. The author acknowledges a lack of research support for the model's effectiveness.

Relevance

Articulated practice guidelines for one treatment approach to MICA. The section on "staff development" (pp 82-83) describes some competencies needed by dual diagnosis staff, e.g., staff should be "sensitized" to both addictive and non-addictive disorder prior to working within dual diagnosis programs. In general, the article has limited utility in developing competencies.

111

Mercer-McFadden C, Drake RE: Review And Summaries: National Demonstration of Services for Young Adults with Severe Mental Illness and Substance Use Disorders, 1995

Abstract

This is a government report of 13 dual diagnosis demonstration grant model programs.

Content of Document Segments:

Part One - Overview

Pages 6-15: Community Contexts/Populations: States receiving grants; populations; client profiles and clinical characteristics.

Pages 16-26: Service Components: descriptions of service components, include substance abuse groups, specialized assessment, case management, family support, culturally sensitive programming, day treatment/clubhouse, residential treatment, peer support.

Pages 27-37: Project Evaluations and Findings

pages 38-42: Summary and Current Perspectives: Overall, the projects support the value of motivational interventions, stage wise approaches, and longitudinal perspective. Engagement was possible, and was associated with reduction of psychiatric hospitalization and mixed results in substance use.

Part Two - Project Summaries

Pages 44-93: A detailed review of each individual project summary in the 13 states includes each of the topic areas in Part One.

Strengths

This is a good detailed review of 13 demonstration grant projects for dually diagnosed consumers with a variety of co-occurring disorders. The program models and evaluations are presented in an organized and thorough manner. Describes a range of interventions, and extracts common themes associated with success.

Limitations

SPMI only. There is no information regarding the education, training and/or disciplines of the providers/practitioners. There is no information regarding staff development and training regarding the implementation of these program models.

Relevance

Provides data to support practice guidelines for competencies for staff to implement them.

112

Center for Mental Health Services: Making a Difference. Interim Status Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults, 1994

Abstract

Monograph summarizing interim results of five McKinney projects on innovative housing projects for homeless mentally ill. All showed some degree of success. With regard to dual diagnosis, the majority of clients across the five sites (Boston, Baltimore, New York (2), San Diego) had comorbid substance difficulties. Integrated substance abuse treatment incorporating flexible, client-choice focused, engagement strategies along with continuity of care, were associated with positive outcome.

Strengths

Describes innovative strategies for addressing homelessness in people who are mentally ill. State-of-the-art.

Limitations

Five very specific projects allow limited generalizability.

Relevance

Supports the basic principles for a standard of care described in the abstract.

113

Drainoni ML, Butler DL, Carr DJ, Mitchell E: Innovations in Serving Persons with Dual Diagnosis: Components of Model Treatment Programs. Center for Health Policy Development, Brandeis University, 1994

Abstract

Case studies based on surveys and site visits for five "model programs" for dual diagnosis - Bellevue in New York City, Mobile Treatment Teams at a CMHC in Rhode Island, Dual Diagnosis Continuum in Philadelphia, PACT Program in Madison, and 3 model dual diagnosis programs in Washington State. In general, all programs were provided under Department of Mental Health auspices for SPMI priority clients, and all involved one or more elements of a comprehensive continuum involving inpatient, residential, outpatient, and case management. An "overwhelming number" of state policy makers surveyed indicated a wish for guidelines to use to develop dual diagnosis programs.

The monograph attempts to extract common principles or components: individualized, phase-specific services; interdisciplinary cross-trained teams, comprehensive range of services in a coordinated system; support services including housing and employment; flexibility, long-term continuum.

Strengths

Effective summary of key principles of successful dual diagnosis treatment.

Limitations

Selection of surveyed programs is arbitrary, and programs only focus on SPMI.

Relevance

Utility for designing guidelines for model programs and systems for dually diagnosed SPMI clients.

114

Executive Summaries From 16 Federally-Funded Programs For Homeless Individuals with Co-Occurring Mental Health and Substance Use Disorders. Center for Mental Health Services and Center for Substance Abuse Treatment, 1995

Abstract

As the title states, provides brief project overview, and then attaches 16 executive summaries. All programs utilize a variety of engagement interventions, in case management-oriented, residential, or outpatient settings of particular interest is that each project has developed a manual to implement its interventions in a replicable fashion.

Strengths

Range of state-of-the-art strategies with reference to accompanying treatment manuals.

Limitations

Barest outline of project descriptions.

Relevance

Manuals would be sources for identifying competencies and guides for training staff.

Daley D: Dual Diagnosis Workbook. Independence, MO, Herald House/Independence Press, 1994

Abstract

A workbook of basic exercises concerning substance abuse/dependence and psychiatric illness, covering various disorders; identifying problems, strengths, and goals; overcoming denial; coping with anger, anxiety, and depression; building relationships and support; making lifestyle changes, and relapse prevention. Very concrete and uses many case examples geared for people who are "in treatment" more or less willingly.

Strengths

Useful integrated manual that organizes a range of common addiction exercises into a single "place", and incorporates psychiatric symptoms and treatment issues into that format.

Limitations

Reading level may be a bit high at times; does not really work for people who are not in treatment for substance disorders; exercises are much more focused on addiction than psychiatric symptoms.

Relevance

Sets a standard for the type of integrated materials that should be available to dual diagnosis outpatients throughout the treatment continuum.

116

Daley DC, Thase ME: Dual Disorders Recovery Counseling. Independence, MO, Independence Press, 1994

Abstract

A basic guide to counseling people with dual diagnosis, presented in readable outline form, and geared to the level of sophistication of addiction counselors. Chapters include: overview of DDRC; developmental model of recovery (six phases: transition and engagement; stabilization; early recovery (0-6 mos.); middle recovery (6-12 mos.); late recovery (12 mos. +); maintenance); format of DDRC; counselor characteristics and training; supervision; client/counselor relationship; assessment; individual treatment; role of the family; group treatments; dual disorder psychoeducational group topics (outlines of 44 lecture/discussion groups).

Strengths

Well-integrated, dual primary disorder, approach with phase-specific treatment recommendations (see table pp 26-27). The list of counselor competencies (see pp 31-33), and training and supervision needs is very valuable, as are principles for family involvement. The extensive list of group topics is extremely practical for application in a variety of settings.

Limitations

Somewhat repetitious, and at times seems superficial. Emphasizes addiction recovery more than mental illness, and is not as well-geared for people with SPMI, cognitive limitations, or substance abuse (vs. dependence). Assumes entry into addiction treatment has occurred.

Relevance

Defines counselor competencies, program philosophy and principles, and phase-specific interventions.

117

Director L: Dual diagnosis. outpatient treatment of substance abusers with coexisting psychiatric disorders, in Psychotherapy and Substance Abuse: A Practitioner's Handbook. Edited by Washton A. New York, The Guilford Press, 1995, pp 375-393

Abstract

Provides overview of dual diagnosis, and describes a "dual-focus" outpatient program geared to higher functioning (insured, employable) individuals with substance dependence and comorbid psychiatric conditions such as mood and anxiety. Assessment and ongoing treatment is described, utilizing a primary focus on sobriety as the cornerstone for flexible application of multiple other interventions for the comorbid condition. Specific skills required of the cross-trained clinician are described (e.g. flexibility) and the need for longitudinal treatment emphasized.

Strengths

Very well written, with clear description of program philosophy, and the competencies required of therapists.

Limitations

Only addresses one category of dual diagnosis, in one setting, and one phase of treatment.

Relevance

Valuable for defining both program standards and staff competencies for these types of patients.

118 Evans K, Sullivan JM: Step Study Counseling with the Dual Disordered Client. Center City, MN, Hazelden, 1990

Abstract

This book was written to provide therapeutic tools to assist the clinician during Twelve Step work with the dually diagnosed client. It contains clear, specific, practical explanations of co-occurring mental illness including schizophrenia, mania, major depression, anxiety disorders, dementia, and personality disorders. Useful guidelines for the clinician to help clients with steps one, two, three, and for some disorders, four. The summary includes more treatment tips.

Strengths and Limitations

Very useful and usable information. Relevant only for clients who have already entered addiction treatment.

Relevance

Describes attitudes and skills necessary to treating consumers with co-occurring disorders.

119 Evans K, Sullivan JM: Treating Addicted Survivors of Trauma. New York, NY, The Guilford Press, 1995

Abstract

This book attempts to provide an easy to understand, practical, and integrated overview for treating survivors of childhood trauma who are also chemically dependent.

Content of Chapters

Chapter 1. Philosophy of Treatment. Describes different theories and stresses the need for integrated treatment.

Chapter 2. Rachel's Story. Case history of a woman in recovery from addiction and PTSD.

Chapter 3. The Impact and Process of Abuse. Detailed and thorough review of theories on the impact and process of childhood abuse.

Chapter 4. Addiction and Survivors. Clear definitions, describes assessment tools, and stages of addiction.

Chapter 5. A Model for Dual Recovery and Crisis State Interventions. Useful chart comparing PTSD and addiction; presents a 5-stage dual recovery model, including crisis building skills, education, integration, and maintenance stages. (See Appendix N)

Chapter 6. Interventions in Later Stages of Recovery. Specific techniques for each stage of treatment.

Chapter 7. Depression, Anger, and Dissociation. Discusses specific issues of treating addicted survivors with strong anxiety/depression, anger, or dissociation.

Chapter 8. The Addicted Adolescent Survivor. Outlines specific issues for adolescents with co-occurring addiction and PTSD.

Chapter 9. Addicted Survivors in Their Families, at Work, and in Therapy Groups. Describes frameworks for family and group therapy.

Afterward. Outlines issues of transference/counter-transference, therapists as survivors, and secondary PTSD.

Appendix. Assessment tools and specific examples of step work with this population.

Strengths

This is the most comprehensive available work on this population, and offers clear, specific, and practical treatment guidelines.

Limitations

Does not address utilization of various service intensities in managed care systems.

Relevance

This work is essential for developing standards of care, practice guidelines, and clinical competencies for these individuals with PTSD and addiction, who are usually not identified as SPMI.

120

Evans K, Sullivan, JM: Understanding Post Traumatic Stress Disorder and Addiction. Center City, MN, Hazelden, 1994

Abstract

Twenty-seven page workbook that describes PTSD and addiction and the stages of recovery. Contains self-assessment tools that assist consumers to assess where they are and what tasks are appropriate to work on at this stage.

Strengths

Clearly written, usable.

Limitations

Focus is on consumers who are already engaged in addiction treatment.

Relevance

Helpful to develop competencies and practice guidelines. Presents educational material and ways to make it helpful to patients.

121

Mueser KT, Noordsy DL: Group treatment for dually diagnosed clients, in Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. Edited by Drake RE, Mueser KT. San Francisco, CA, Jossey-Bass, 1996, 33-52

Abstract

This chapter presents a thorough review of the literature on integrated group treatment for people with SPMI and substance abuse, including reviews of studies which compare 12 Step approaches, social skills training/cognitive behavioral groups, educational-supportive groups, case management groups, and stage-wise treatment. The literature tends to support benefit of all integrated group interventions, with specific value for more cognitive/behavioral, case management, and stage specific strategies (compared to 12 Step or supportive).

Strengths

Excellent review.

Limitations

Research does not generally match clients according to stage of treatment acceptance, or dual diagnosis subtype, and this may obscure results. These studies are for SPMI with substance abuse, primarily in mental health outpatient settings; they do not address addiction treatment settings or inpatient settings.

Relevance

Establishes data base for practice guidelines, and indicates the types of group treatment competencies required for this population.

122

Osher FC, Dixon LB: Housing for persons with co-occurring mental health and addictive disorders, in Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent Research and Clinical Implications. New Directions for Mental Health Services No 70. Edited by Drake RE, Mueser KT. San Francisco, CA, Jossey-Bass, 1996, pp 53-64

Abstract

Reviews reasons for housing instability in dually diagnosed, and relation of housing skills to phases of treatment. Discusses need for continuum of housing models, including not only staffed and supported housing, but also wet, damp, and dry housing.

Strengths

Emphasis on housing continuum in the engagement process.

Limitations

Does not address housing models to facilitate addiction recovery (sober housing, etc.).

Relevance

Housing continuum is a key component of a dual diagnosis care system.

123

Swindle RW, Phibbs CS, et al.: Inpatient treatment for substance abuse patients with psychiatric disorders: a national study of determinants of readmission. J of Substance Abuse 1995; 7:79-97

Abstract

National VA study of 7,711 dual diagnosis inpatients to ascertain treatment variables that predict success vs. readmission, comparing dual diagnosis units with dual diagnosis groups on substance abuse units. Findings support the hypothesis that dual diagnosis treatment which has an integrated dual primary disease/recovery focus, uses "tolerant persuasion" to deal with lapses, has staff-led rather than peer-oriented groups, and provides continuity of staff in aftercare has better outcomes.

Strengths

Very large study which incorporates reasonable measures to distinguish inpatient dual diagnosis treatment from typical addiction treatment. Findings support theoretical constructs concerning dual diagnosis treatment.

Limitations

VA population only, mostly male, and mostly serious Axis I disorders.

Relevance

Data supports establishment of key standards and practice guidelines regarding inpatient dual diagnosis treatment.

124

Coexisting Mental Illness and Alcohol and Other Drug Dependencies in Pregnant and Parenting Women. Special Issue. Edited by Jessup M. Journal of Psychoactive Drugs 1996; 28(4)

Content of Articles

1. Grella, C: Background and overview of mental health and substance abuse treatment systems: meeting the needs of women who are pregnant and parenting. pp 319-343

Abstract

Comprehensive and thorough discussion of mental health and substance abuse treatment systems, covering difficulties with service integration (at program and government levels) and proposed models of integrated treatment, with particular attention to how system barriers impede treatment for pregnant and parenting women.

2. Zweben, JE: Psychiatric problems among alcohol and other drug dependent women. pp 345-366

Abstract

Well-researched overview of comorbidity data for a variety of psychiatric disorders in addicted women, and a discussion of a variety of addiction and dual diagnosis treatment interventions with specific attention to their impact on women.

3. Mallouh, C: Effects of dual diagnosis on pregnancy and parenting. pp 367-380

Abstract

Thorough review of literature, plus discussion of clinical issues regarding dually diagnosed women who are pregnant or parenting, including consideration of evaluation of competency regarding pregnancy-related decisions and/or child-rearing.

4. Mosley, T: Prototypes: an urban model program of treatment and recovery services for dually diagnosed perinatal program participants. pp 381-388

Abstract

Detailed residential program description, including philosophy, assessment, therapeutic interventions, medication strategies, phases of treatment, and special services for perinatal women (The Parenting Center).

5. Ryland, SA, Lucas L: A rural collaborative model of treatment and recovery services for pregnant and parenting women with dual disorders. pp 389-395

Abstract

Describes systems intervention in Fresno County between mental health (QA, crisis intervention, case management), substance abuse (perinatal coordinator, residential, outpatient), and community health (public health nursing). Specific services include: dual diagnosis QM committee; high risk team (crisis care management); perinatal services network, transitional and self-help groups.

Strengths

This is a superb compilation of excellent articles that includes in-depth useful information applying state of the art dual diagnosis principles to perinatal women. A must read.

Relevance

Program principles and guidelines for services to this particular dually diagnosed sub-population can be gleaned from the various articles, though with some effort.

125

Marcus RN, Katz JL: Inpatient care of the substance-abusing patient with a concomitant eating disorder, Hospital and Community Psychiatry 1990:41:59-63

Abstract

The article describes the difficulties involved in treating patients with both an eating disorder and a substance use disorder. They mention that an accurate diagnosis and assessment of the disorders is necessary before determining whether an individual should receive treatment for the eating disorder or the substance use disorder first, or whether each should be treated concurrently. The authors provide a thorough description of the prototypical eating disorder case most frequently seen on a substance abuse unit which they have named the "bulimic alcoholic". They offer their recommendations for developing an integrated treatment protocol for those presenting on a substance abuse unit.

Strengths

A good description of a treatment plan for patients with eating disorders. The authors provide useful advice as to what types of services are required, which therapies are appropriate, as well as medications that have proven efficacious in clinical trials.

Limitations

The article focuses almost exclusively on the treatment of eating disorders and offers only a very limited discussion of co-occurring substance abuse problems. The interaction of the two disorders and the resulting effect on treatment provision and outcome are not sufficiently described.

Relevance

The article provides useful information for the treatment of individuals with eating disorders who may present for treatment on a substance abuse unit, and may be helpful in the development of practice guidelines.

126

Ortman D: The Dually Diagnosed: A Therapist's Guide to Helping the Substance Abusing, Psychologically Disturbed Patient. Northvale, NJ, Jason Aronson Inc., 1997

Abstract

A pragmatic guide for outpatient psychotherapists working with people with dual diagnosis, this work attempts to integrate a variety of integrated approaches in a way that is accessible and basic. The book begins with a discussion of "basic notions" for understanding the relationship between psychiatry and substance disorders, and then moves on to a section in "clinical issues", which includes ten chapters covering topics such as assessment, addressing denial, requiring abstinence. Clinical examples primarily involve substance dependent individuals with non-psychotic disorders. Sixteen "treatment principles" are identified, that encourage integrated, flexible treatment approaches.

Strengths

Given the scarcity of literature on outpatient treatment of dual diagnosis in people without serious mental illness, this book is a welcome introduction. It is well-written, and offers many pragmatic suggestions, while studiously incorporating ideas from sources with diverse viewpoints.

Limitations

Geared mainly for the outpatient psychotherapist, this book seems more useful for those in private practice settings, and does not address multi-problem situations that commonly arise in Medicaid populations. At times, the book is repetitive, and seems like a basic guide for psychotherapists learning to treat substance disorders in general. In depth discussion of challenging psychotherapy issues, like addressing trauma, is avoided.

Relevance

Enumerates treatment principles well articulated in other works. Interesting analysis of various viewpoints in the literature. Otherwise, not especially relevant.

127

Schuckit MA, Hesselbrock V: Alcohol dependence and anxiety disorders: what is the relationship? Am J Psychiatry

1994; 151(12):1723-1735

Abstract

Thorough review and analysis of studies of comorbidity of alcoholism and anxiety disorders to illustrate that alcoholics demonstrate a high prevalence of both transient and temporarily persistent anxiety and panic symptoms in early recovery, but that these usually subside over time, and only 6-7% demonstrate characteristic chronic anxiety disorders (twice the general population).

Strengths

Very well reasoned discussion and thorough literature review. Assists in establishing standards of care for people with "dual diagnosis" of substance disorder and anxiety symptoms.

Limitations

No direct discussion of implications for practice.

Relevance

Assists in establishing standards of care for people with "dual diagnosis" of substance disorder and anxiety symptoms.

128

Sullivan JM, Evans K: Integrated treatment for the survivor of childhood trauma who is chemically dependent. Journal of Psychoactive Drugs 1994; 26 (4):369-78

Abstract

This article describes a 5-stage integrated treatment model for coexisting chemical dependence and trauma-related disorders, and describes therapeutic tactics for each stage.

Strengths

This article is a must. It provides a clear and succinct summary of the major points of Evans and Sullivan's larger works on trauma and addiction, defining treatment philosophy, treatment postulates, and treatment stages:

Integrated Philosophy:

1. Addiction and trauma related disorders are two primary coexisting disorders.
2. Each disorder requires independent, but simultaneous, assessment and treatment.

Treatment Postulates:

1. Abstinence is an essential goal, and a precondition for trauma recovery.
2. Non-Addictive psychotropic medication is a valuable treatment tool for trauma disorders.
3. Relapse prevention techniques are relevant to both disorders.
4. 12 Step recovery, in combination with other psychotherapeutic interventions, is valuable for both disorders.
5. Trauma survivors need additional preparation and support to utilize 12 Step programs.
6. Working through trauma is helpful for recovery, but must be carefully timed and prepared, to ensure safety and prevent relapse.
7. The treatment model must be both continually flexible and coordinated.

Treatment Stages:

1. Crisis Stage (ensure safety first)
2. Building safety skills
3. Education about recovery
4. Integration of experience
5. Maintenance

Limitations

These principles and stages are at times a bit vague and overlapping, and are derived from clinical experience, not research, but they currently define a "best practice" approach that is consistent with other models.

Relevance

This article defines both treatment principles and clinician competencies for working with chemically dependent trauma survivors. These principles and competencies are also directly relevant to many individuals with addiction and anxiety, depressive, and personality disorders; less relevant to people with SPMI.

129

Wilens TE, Biederman J, Spencer T: Attention-deficit hyperactivity disorder and the psychoactive substance use

disorders. *Child and Adolescent Psychiatric Clinics of North America* 1996; 5(1):73-91

Abstract

A thorough literature review of the interactions between PTSD (in patient and family) and ADHD in adolescents and adults, followed by succinct guidelines for assessment, diagnosis, and treatment, including psychopharmacology. The guidelines are presented in a short table. (See Appendix O)

Strengths

addresses the difficult issue of prescribing stimulants to those individuals.

Limitations

Does not address managed care related issues, like treatment intensity, program models, and level of care.

Relevance

Practice guidelines.

Abstract

Practical advice for considering a role for alcohol and other drugs when evaluating any psychiatric complaints. Patients with substance use disorder seldom volunteer information about their alcohol or drug use. Information should be gathered from multiple sources, medical records reviewed, a physical examination performed, and laboratory tests ordered. There should be follow-up on the initial evaluation and diagnosis.

Strengths and Limitations

Good examples given, but the material is very basic.

Relevance

Helpful for development of competencies in initial evaluation.

131

Curriculum Review Committee, Addiction Training Center Program, CSAT. Addiction Counselor Competencies. CSAT, 1995

Abstract

Consensus document defines foundations for addiction professionals in four areas: understanding addiction, treatment knowledge, application to practice, and professional readiness and identifies eight functions: clinical evaluation, treatment planning, referral, case management, counseling, education, documentation, professional/ethical responsibilities. Within each area, specific skills are identified. Foundations for addiction professionals (pp 3-4) are included in Appendix P.

Strengths

As a consensus document, this monograph represents a national standard that is clear and concise.

Limitations

Dual diagnosis expertise is not strongly identified.

Relevance

This document can serve as a format upon which to build dual diagnosis competencies for counselors; alternatively, it can provide an outline for substance disorder competencies for mental health case managers.

132

Evans K, Sullivan JM: Dual Diagnosis: Counseling the Mentally Ill Substance Abuser. Guilford Press, 1990

Abstract

The purpose of this work is to provide specific material to help chemical dependency counselors and professionals to assess and treat dual diagnosis; in particular, addicted individuals with a variety of psychiatric disorders.

Content of Chapters

1. The Nature of the Problem
 2. Models of Treatment and Their Integration. Excellent statement of principles.
 3. Identifying Chemical Dependency in the Dual Diagnosis Client
 4. Assessing the Psychiatric Disorder
 5. Major Mental Disorders
 6. Selected Personality Disorders
 7. Working with Adolescents
 8. Working with Families
 9. Preventing Relapse and Enhancing Motivation
 10. Case Management Strategies
- Appendix 1. Modified Stepwork
Appendix 2. School Behavior Checklist
Appendix 3. A Checklist for Parents
Appendix 4. Home Behavior Contract

Strengths and Limitations

This book provides a positive and hopeful attitude for addiction treaters that successful dual diagnosis treatment is attainable,

simply by modification of what they already know. Although the descriptions of psychiatric assessment and diagnosis at times seem oversimplified, the overall context is practical, pragmatic, and straightforward. Particularly valuable are suggestions for specifically modifying traditional addiction interventions for each psychiatric diagnosis.

Relevance

This work is a must for defining principles of treatment and workforce competencies (attitudes and skills) for treating substance dependent individuals with a range of psychiatric disorders. Does not address managed care issues, however.

133

Fields R: Dual diagnosis: definition, population, treatment. Professional Counselor 1995

Abstract

Basic competencies for counselors: a definition of dual diagnosis, an understanding of the treatment population and some suggestions for treatment. Terms of dual disorder or dual diagnosis are widely used to refer to those clients who have a chemical dependency disorder coexisting with recognizable DSM IV psychiatric disorder. Minkoff views both the psychiatric and addiction disorders as two primary, biological illnesses. Parallel features of the disease concept of addiction and illness concept of the psychiatric model are highlighted.

Strengths

Excellent brief overview. Might be a resource for concurrence of terms.

Limitations

No in-depth discussion.

Relevance

Each bullet could be a prime education topic for cross training in the field.

134

Goldsmith RJ, Miller NS: Training psychiatric residents in the addictions. Psychiatric Annals 1994; 24(8):432-439

Abstract

Overview of residency training in addiction. Emphasizes importance of addressing attitudes about addiction, and the development of a curriculum that includes experience, supervision, and knowledge development. Two ways to implement such a curriculum are described.

Strengths/Limitations

Although this article does not specifically address competency in dual diagnosis, it is one of few articles that works at developing competencies for psychiatrists in addiction, which is directly relevant to dual diagnosis competency. The emphasis on attitudinal training and supervision is particularly valuable.

Relevance

Identifies competencies and curricula for psychiatric training.

135

Group for the Advancement of Psychiatry: Dual diagnosis, in Residents' Guide to Treatment of People With Chronic Mental Illness. Report No. 136. Washington, DC, American Psychiatric Press, 1993, pp 145-161

Abstract

As part of a training guide for psychiatric residents on developing skills in psychosocial interventions with people with SPMI, this chapter focuses on dual diagnosis using a case vignette illustrating treatment of an individual with MSA dual diagnosis by a psychiatric resident. Follows the case of a man with chronic schizophrenic disorder and alcoholism over the course of about a year. Predominant focus is on the early stages of engagement, motivation and early treatment. A series of chronological vignettes with narrative discussion of the actions of the resident. Illustrates virtually all of the possible pitfalls of treating dual diagnosis and how the resident avoids them or deals with them when they occur, and the problem of dual service systems.

Strengths

Interesting case example, fairly realistic, well written, very educational and illustrative.

Limitations

The resident is just a bit too perfect! Residents (or experienced professionals for that matter) rarely do the right thing so consistently, but then again she is a composite used for teaching purposes so it's understandable. Focus is only on people with SPML.

Relevance

This document provides a very good illustration of how professionals should actualize the concepts of integrated dual disorder treatment, and illustrates specific training material used to develop dual diagnosis competencies among psychiatric residents.

136

Hills HA, Zucker RA, Seitz SL: Clients with substance abuse and comorbid diagnoses, in Serving the Seriously Mentally Ill: Public-Academic Linkages In Services, Research, and Training. Edited by Wohlford P, Myers HF, Callan JE. Washington, DC, American Psychological Association

Abstract

This review chapter for an edited text, covering the issue of existing and recommended training in academic programs for psychologists, covers trends in providing training in the areas of substance abuse and dependence and co-morbidity in psychology doctoral programs (both pre and post doctoral) and in psychology internships. Begins with epidemiological and historical introduction on topic of co-morbidity that touches on categorical funding and services, professional preconceptions and bias, and lack of existing graduate training. The emergence of importance of dual disorder, however, warrants increased focus in graduate school on this area.

Makes the case that only about 1/4 of these graduate programs offered formal education in substance abuse from the mid 1980 to early 1990's. Only a small percentage of internships were reported to address the issue of substance abuse.

Proposes that psychologists have many skills and methods that are generalizable to treatment of substance abuse: assessment skills, interviewing, diagnostic skills and intervention approaches. Calls for more training of psychologists in substance abuse etiology, diagnosis and treatment (and by extension in dual diagnosis) and delineates some possible roles for psychologists: early intervention, extinguishing maladaptive behavior, employee assistance, family therapy. Proposes very basic global training guidelines. Concludes with a call for more psychologists to be involved in the substance abuse field.

Strengths

There is little literature on dual diagnosis training for psychologists. This article may mobilize psychology infra-structure to require more relevant training in graduate programs.

Limitations

Dated material from surveys of academia ten or more years ago. There is very little in this article that relates to dual diagnosis except by extrapolation in spite of the title.

Relevance

The "Global Training Guidelines" may be relevant for development of professional competencies and curricula. (See Appendix Q)

137

Levy M: Psychotherapy with dual diagnosis patients: working with denial. Journal of Substance Abuse Treatment, 1994;10:499-514

Abstract

Identifies denial of a substance abuse problem as a major barrier to effective treatment of dual diagnosis patients and offers a treatment strategy leading to recognition and commitment by patients to address the substance abuse problem, within the context of a therapeutic relationship. Since direct confrontation can lead to rejecting treatment or psychiatric decompensation, developing a therapeutic relationship is advocated prior to commitment of patients to move toward abstinence. Professionals must understand the benefits as well as the dangers of continued use of substances by dual diagnosed patients, in order to engage them. Specific recommendations for dealing with denial include: obtaining a good history of substance use, help patient determine if use has caused particular problems, assist patients in identifying specific treatment goals; identifying relationship between goals and substance use, including psychopathology.

Strengths

Very useful identification and description of one of the major barriers to treatment, not only for dually diagnosed, but also those suffering with either a substance abuse or mental disorder. Strategies offered to overcome this barrier were consistent with, definition of the problem and the surveyed research literature.

Limitations

Does not clarify distinctions based on substance abuse vs. dependence, drugs of choice, types of mental illness, or stage of addiction. Research literature is somewhat dated.

Relevance

Describes one of the major barriers to treatment for persons with co-occurring mental and substance use disorders, and identifies some specific competencies for mental health professionals.

Content of Chapters

Editorial. Miller NS: Editorial. A tale of two diagnoses: revisited. pp1-4. Presents some reasons why psychiatry is now experiencing a reentry into the diagnosis and treatment of addictive disorders and describes the tension between mental health and addiction treatment and treaters.

Chapter 2. Miller NS: Comorbidity of psychiatric and alcohol/drug disorders: interactions and independent status. pp 5-16. Dual diagnosis means comorbidity of two independent disorders. However, in practice, mental health clinicians often attribute addiction to "self medication" and "underlying" psychiatric disorders. Effective treatment of either disorder depends on both disorders being accepted as having an independent status in any patient population.

Chapter 3. Dinwiddie SH, Reich T: Genetic and family studies in psychiatric illness and alcohol and drug dependence. pp 17-27. Presents results from family, twin, and adoption studies that indicate the existence of a heritable and specific linkability to alcohol dependence independent of other psychiatric disease, and perhaps to other substance dependence as well.

Chapter 4. Extein IL, Gold M: Hypothesized neurochemical models for psychiatric syndromes in alcohol and drug dependence. pp 29-43. This chapter focuses on the hypothesized neurochemical changes associated with primary substance use disorders which might lead to secondary psychiatric disorders by mimicking the hypothesized neurochemical changes of primary psychiatric disorders. Two diagrams; one for cocaine dependence and depression; one for alcohol and drug dependence and panic/anxiety are presented.

Chapter 5. Raskin V, Miller NS: The epidemiology of the comorbidity of psychiatric and addictive disorders: a critical review. pp 45-57. Presents research and clinical data to conclude that while patients treated in psychiatric settings often have comorbid and independent addictive illnesses, patients treated in addiction settings uncommonly have comorbid psychiatric illness despite common psychiatric symptoms.

Chapter 6. Fine J, Miller NS: Evaluation and acute management of psychotic symptomatology in alcohol and drug addictions. pp 59-72. This chapter describes an excellent pragmatic model, based on clinically observable conditions, for the evaluation and acute management of major psychiatric symptomatology associated with diagnosed drug /alcohol addiction.

Chapter 7. Anthenelli RM, Schuckit MA: Affective and anxiety disorders and alcohol and drug dependence: diagnosis and treatment. pp 73-87. This clinically-oriented chapter presents data showing that substances of abuse can cause signs and symptoms of both depression and anxiety. These substance-related syndromes appear to have a different course and prognosis than uncomplicated, independent major depressive and anxiety disorders.

Chapter 8. Lesieur HR, Blume SB: Pathological gambling, eating disorders, and the psychoactive substance use disorders. pp 89-102. This chapter reviews both pathological gambling and the eating disorders, stressing their epidemiology and their overlap with psychoactive substance use and other psychiatric disorders. Consumer factors in the national history and treatment of these disorders are also discussed.

Chapter 9. Ries R: The dually diagnosed patient with psychotic symptoms. pp 103-122. This chapter reviews substance induced versus true comorbid major psychotic disorders and discusses the major classes of psychiatric medications in terms of abuse potential and their abilities to either help or hinder substance disorder recovery.

Chapter 10. Kofoed L: Outpatient vs. inpatient treatment for the chronically mentally ill with substance use disorders. pp 123-137. This chapter discusses treatment decisions for the chronically mentally ill consumer with substance use disorder within the framework of a staged treatment model, reviewing decisions to be made during stabilization, engagement, persuasion, active (or primary) treatment, and relapse prevention (or aftercare).

Chapter 11. Goldsmith RJ: An integrated psychology for the addictions; beyond the self-medication hypothesis. pp 139-154. This chapter documents that the self-medication hypothesis is not valid or helpful in the treatment of addictive disorders and presents a complex biopsychosocial model for addiction and treatment instead.

Chapter 12. Gastfriend DR: Pharmacotherapy of psychiatric syndromes with comorbid chemical dependence. pp 155-170. This chapter states that there is little research on pharmacotherapy with consumers with co-occurring mental illness and substance use disorder, and that treatment guidelines are drawn from general principles of psychopharmacology and the addictive disease model. Effective treatment requires a discrete psychiatric diagnosis or working differential, consideration of the range of drug effects as they vary over time, and awareness of potential pharmacologic interactions between medication and alcohol and /or drug use. Primary emphasis on non-pharmacologic strategies and the use of a formal treatment contract increase the likelihood of successful pharmacotherapy outcome. Has a helpful grid of interaction between drugs of abuse and common therapeutic agents.

Abstract

A general guide to an integrated approach for the treatment of clients with co-morbidity of psychiatric and addictive disorders. Selected chapters with particular relevance were reviewed.

Content of Chapters

Chapter 2. Fine J: Initial diagnosis and treatment of the dually disordered. Presents a model to treat co-occurring disorders. The model is based on a practical approach which classifies symptoms and manages the patients' conditions or problems until the clinical picture is clear enough to establish a definitive diagnosis. Phases: treat dangerous complications; abstinence as a goal; psychiatric management; stabilization; observation; diagnosis.

Chapter 10. McGovern TF: Therapy with the dually diagnosed person. Introduces case stories to illustrate combined approaches. Presents specific guidelines to direct treatment activities.

Chapter 11. DuPont RL: The twelve step approach. Summary of 12-Steps approach. Breakdown of positive and negative aspects of this. Includes recommended references and resources.

Chapter 12. Chappel JN: Relapse prevention. Relapse prevention: guidelines to develop a program activity addressing four specific areas: education, support systems, medication and alternative activities. Includes the Evans & Sullivan (1990, p.33) agreement with physicians who work with their dual diagnosis patients.

Chapter 13. Zweben JE: Working with the family. Establishes and suggests procedures to engage the family, working through resistance, ensuring effective communications and trust, education and coaching of the family system. It highlights factors that can compromise progress with psychotic patients.

Chapter 14. Noordsy DL, Drake RE: Case management. Outlines procedures of case management, ethical concerns such as issues of confidentiality.

Chapter 15. Levy MS: The treatment team. Raises awareness about the importance of a multi-disciplinary team and its availability at wet shelters, social clubs and other community resources open to homeless people who suffer these conditions.

Strengths

Contributions come from a wide range of authorities in the field. Overall, the book is pragmatic and establishes a realistic and workable model of treatment. Includes list of resources and references. Establishes guidelines to follow in treatment planning, programming for relapse prevention, and family involvement. Underlines importance of case management and treatment teams. Includes interdisciplinary agreement to be followed by physicians and others working with dually diagnosed.

Limitations

Focus is mostly on SPM and on 12-Step treatment. It does not comment on negative outcomes, and could use more detail about specific therapeutic tactics and struggles.

Relevance

General practice guidelines and competencies can be extracted.

140 The Principles and Practice of Addictions in Psychiatry. Edited by Miller NS. Philadelphia, PA, J. W. Saunders, 1997

Abstract

This is the most recent comprehensive textbook, primarily aimed at psychiatrists, describing the identification, evaluation, and treatment of substance dependence in psychiatric populations. Selected chapters of particular relevance were reviewed.

Content of Chapters

Chapter 12. Anthenelli RM: A basic clinical approach to diagnosis in patients with comorbid psychiatric and substance use disorders. Differential diagnosis, substance-induced versus independent comorbid disorders, examples of applying diagnostic principles.

Chapter 19. Minkoff K: Integration of addiction and psychiatric treatment. Philosophical barriers to integrated treatment, support versus confrontation, models of treatment, systems and program integration.

Chapter 20. Cernovsky ZZ, Pennington M: Implementing a dual-diagnosis program and treatment outcome. Diagnostic re-evaluation, using psychological testing to uncover areas of strength, characteristics which affect ability to make use of traditional treatment, and social skills training.

Chapter 21. Miller NS: Intervention for drug/alcohol addiction in acute psychiatric presentations. Comorbidity in the emergency room, drug effects on mental status, assessment for withdrawal potential, interventions from the ER, where to refer patients.

Chapter 22. Kofoid L: Engagement and persuasion. Important focus upon combating demoralization, illuminating the development of denial, how to engage dual diagnosis patients in treatment, how to effect persuasion and reduce denial.

Chapter 23. Drake RE, Noordsy, DL: Treatment of comorbid disorders with a case manager approach. Clinical overview of case management, specific interventions keyed to the stage of treatment.

Chapter 24. Murray RE, Ries RK: Treatment of addiction and psychotic disorders. Descriptions of substance induced psychosis, discussion of non-substance related psychotic disorders, guidelines for dual diagnosis pharmacotherapy, differential psychotherapeutics.

Chapter 25. Slaby AE: Treatment of addictive disorders in emergency populations. A review of alcohol and other substance-related medical/psychiatric emergencies with specific medical/psychiatric interventions.

Chapter 26. John S, Miller NS: Anxiety disorders and addictions. Discussion of comorbid addiction and anxiety, how to diagnose non-substance induced anxiety disorders, treatment of anxiety with comorbid addiction.

Chapter 41. Levy, M: Group therapy in addictive and psychiatric disorders. Advantages of group therapy over individual therapy, who is not appropriate for group treatment, types of group therapy that are useful with dual diagnosis patients.

Chapter 43. Flaherty, JA, Kim K: Managed care for psychiatric and addictive disorders. An overview of behavioral managed care which explicates positive and negative factors, severity-based treatment of addiction in managed care, practical list of what makes a group practice competitive to managed care.

Chapter 25. Gastfriend DR: Pharmacological treatments for psychiatric symptoms in addiction populations. Review of substance-induced disorders, how to medicate anxiety and depressive symptoms, mood lability, and psychosis.

Chapter 53. Miller LJ: Pharmacological treatments for addiction in pregnant populations. review of recent research literature on pharmacotherapy in dual diagnosis, treatment algorithms for psychosis, major depression and anxiety disorders in context of possible comorbidity.

Strengths

A good, common sense summary of the evaluation and treatment of patients with comorbid psychiatric and substance use disorders for psychiatrists and other physicians who have little knowledge of the treatment of this patient population. The writing is clear and not bogged down with excessive detail or statistics. The reference list for each chapter is extensive allowing the reader to go further if he/she needs more information on each particular topic. Competencies are nested within many chapters but need to be extracted. Many of the chapters are excellent in providing a broad approach to defining and treating multiple problems.

Limitations

Some of the material in the chapters which were reviewed is repetitious (Chapters 21 and 25 cover the same material as do chapters 52 and 65). This text provides little new information to the treatment provider well-versed in the treatment of comorbid psychiatric and substance use disorders. Although the text recommends common sense, necessarily comprehensive treatment models for the dually diagnosed population, such models are expensive and, thus, difficult to implement in a cost-managed environment. Further, many of the chapters suffer from a recovery model bias that over attributes mental symptoms to the addictive process, when it is clear that both primary and secondary mental symptoms are found in this population. As well, it has at times, bias against the self-medication hypothesis, and methadone maintenance. Treatment values in some of the chapters that are focused upon substance abuse draw their conclusions from research and clinical populations that do not appear to be typical of the public sector dual diagnosis population, so they may not be generalizable to the addicted SPMI patient.

Relevance

Indicates practice guidelines and areas of competency for psychiatrists in treating addiction comorbid with psychiatric disorders. Provides a useful summary for providers for developing treatment programs for a dually diagnosed population.

141

Montrose K, Daley D: Celebrating Small Victories. Center City, Minnesota, Hazelden Press, 1995.

Abstract

This valuable work is a primer for counselors and other "front-line" clinicians of approaches and attitudes for helping clients with co-occurring disorders.

Chapter 1. Assessment. Definitions of mental illness, substance abuse and dual diagnosis, and examples of dual recovery.

Chapter 2. Selling Recovery. How to sell recovery to dually diagnosed consumers; team approach, assessing what consumer wants and is willing to do, celebrating little steps.

Chapter 3. Assessment. Integrated assessment, focus in on what the consumer wants, how denial works.

Chapter 4. Attitudes of Professionals. These are "no fault" illnesses, the professional has to believe recovery is possible.

Chapter 5. Coping with Symptoms: A Consumer's Eye View. A consumer's eye view of coping with symptoms, understand what symptoms mean to patient, "her struggle may inspire you."

Chapter 6. Fundamentals of Dual Disorders Treatment. Realistic, practical fundamentals of dual diagnosis treatment, how the professional needs to think and be.

Chapter 7. Nuts and Bolts Issues in Daily Recovery. Specific nuts and bolts of helping the consumer in early recovery.

Chapter 8. Recovery Slogans. Good examples of what recovery slogans mean and how to use them.

Chapter 9. Timelines and Denial. How to use a time line to help the consumer look at her life.

Chapter 10. Contingency Cards. Use of a contingency card, a card with an action plan written on it, "in case of emergency."

Chapter 11. Twelve Step Programs. The importance of and how to link the consumer up with 12-Step meetings and program.

Chapter 12. Group Treatment Approaches. Guidance for group leaders.

Chapter 13. Working with the Consumer's Family. Realistic guidelines for working with the consumer's family, looks at "making amends" and "enabling."

Chapter 14. Summary: What to do. Listen respectfully, sell recovery, confront any use of alcohol or drugs gently and persistently in a non-confrontational manner, help the consumer use the 12 Steps, plan the day, celebrate small victories, involve families when possible, teach the slogans.

Strengths

Excellent practical guide for professionals and counselors who work with consumers who have co-occurring disorders of mental illness and substance use disorder. Points out, clearly and explicitly, what values, attitudes and competencies the provider needs to have to provide useful services to the individual consumer and to the population as a whole. Wonderful, vivid examples that are helpful in working with and setting up programs for consumers.

Limitations

Does not actually list competencies; one has to pull them out of the material. Oriented less to SPMI than to addicted individuals with non-SPMI psychiatric disorders. Tends to presume entry into substance abuse treatment has occurred.

Relevance

Very useful as a guide for developing competencies for providers, both addiction counselors, and other mental health professionals.

142

Miller WR, Rollnick S: Motivational Interviewing. New York, NY, The Guilford Press, 1991

Abstract

Describes principles and applications of a clinical technique which can be used with individuals who are "pre-motivational" with regard to changing problem behavior. The technique focuses on creating a positive relationship, and exploring choices with the individual/family to enhance motivation and facilitate change.

Part One. Background of the development of stages of change.

Part Two. Principles of motivational interviewing.

Part Three. Clinical applications of motivational interviewing - descriptions of stages of change, how to work with people in different stages, examples of how to use with heroin-dependent clients, alcoholic couples, young people, and for HIV risk reduction, treatment of sex offenders, and maintenance of change.

Strengths

Specific, excellent description, explanations and examples, focused on treatment of people with addiction. Very practical, global application can be used in treatment of mental illness and in many other situations in which people want or need to change.

Limitations

Does not specifically address dual diagnosis.

Relevance

The skills described are translatable into criteria clinicians need to treat patients with dual diagnosis - specifically the stages, how to assess stages with consumer and how to help consumer move through the stages of change for both mental illness and addiction. Knowledge of motivational interviewing technique is a key competency for all dual diagnosis clinicians.

143

Sciacca K: Removing barriers: dual diagnosis treatment and motivational interviewing. Professional Counselor 1997 (in press)

Abstract

Article geared toward addiction counselors describes parallels between the stages of change described by Prochaska and DiClemente, and the stages and tasks of motivational interviewing as described by Miller and Rollnick (which are part of an addiction counseling skill base) with stages and tasks of dual diagnosis treatment as described by Sciacca. The parallels are illustrated in tabular form. The goal is to increase comfort of professional counselors with translating their skills to work with dually diagnosed clients.

Strengths

Clear and straight forward presentation; very pragmatic for front line clinical staff. Tables are easily reproducible and useful for training. Incorporates and concretizes step-by-step nature of dual diagnosis treatment.

Limitations

Does not acknowledge or integrate other schema for phasic dual diagnosis treatment (e.g. Drake et al.) A lack of clarity as to the specifics of motivational interviewing for those staff desiring to integrate this technique within their interventive repertoire of skills. Lack of specificity regarding variation in technique for variation in psychiatric diagnosis or severity of addiction.

Relevance

Elaborates a specific workforce competency for front-line counselors in working with dual diagnosis, and describes how these skills build on existing skills.

144

Zweben JE, Smith DE, Stewart P: Psychotic conditions and substance use: prescribing guidelines and other treatment issues. Journal of Psychoactive Drugs 1991; 23(4):387-95

Abstract

Specific psychotic states are reviewed which may result from alcohol and other drug use, including intoxication, and overdose and withdrawal. Medication guidelines for managing these situations are offered. Also examined are disturbances in which psychotic symptoms are recurrent features. Patients' self-medication practices are explored along with strategies to address them, and common difficulties associated with prescription medications.

Strengths

One of few published sources for prescribing guidelines. In addition, the paper has a comprehensive approach towards linking biomedical treatment approaches with psychosocial treatment issues.

Relevance

Relevant for practice guidelines and medical provider competencies. Reinforces the significance of combining psychosocial and biomedical treatment of dually diagnosed patients.

145

Feldman S, Goldman W: Managed Mental Health Care. New Directions For Mental Health Services Series, No. 59. San Francisco, CA, Jossey-Bass Publishers, 1993

Abstract

An overview of issues and principles of managed mental health.

Content of Chapters

1. England MJ, Goff VV: Health reform and organized systems of care. Reviews principles and characteristics of Organized Systems of Care (OSC), problems with current health systems that drive reform, and examples of evolving OSCs. Principles/Characteristics of OSCs include: barrier-free access, integration of care with primary care, focused and integrated care management, prevention and early intervention, a full continuum of care, and continuous quality improvement processes.
2. Wanerman L: Managed mental health for children and adolescents. Reviews and gives examples of the practical application of managed care principles for children and adolescents, including access to information, sound assessment, least restrictive level of care, focused, concrete goal-setting, matching of appropriate intensity of treatment and management of the trajectory of care.
3. Pallak MS, Cummings NA, Dorken H, Henke, CJ: Managed mental health, Medicaid, and medical cost offset. Presents a research study in which the provision of managed mental health services to a Medicaid Population resulted in a reduction in medical services costs greater than the additional mental health expenditures.
4. Dangerfield D, Betit RL: Managed mental health care in the public sector. Describes a capitated Mental Health Medicaid program in Utah, managed by a non-profit CMHC.
5. Carson D: Managed care: a provider perspective. Focuses on the changes brought about by managed care from a provider perspective, including shift of treatment locus from inpatient to outpatient, emphasis on time-effective treatments, staff turmoil and turnover.
6. Ray C, Oss M: Community mental health and managed care. Many of the innovations of managed care are re-inventions of Community Mental Health Organizations (CMHO) initiatives begun in the 1960's and 1970's.
7. Wilson CV: Substance abuse and managed care. Reviews the transition from a programmatic to a clinically driven approach to substance abuse treatment based in part on standardized assessment and placement methodologies such as the ASI and the ASAM criteria which utilize a continuum of care and emphasize family and community involvement.

Strengths

Provides a comprehensive and concise overview of many of the core principles and issues faced by evolving Managed Mental Health Care delivery systems. Puts the current interest in/demand for dual competency clinicians into context. Addresses attitudinal competencies implicitly by orienting the reader to the context in which health care is currently provided.

Limitations

Not specifically targeted to treating dual disorders.

Relevance

Generic managed care skills for any clinician can be extracted from some of the material. Some of the material will be helpful in outlining managed care competencies, such as the ability to skillfully assess, formulate and treat a patient in the context of continuum in coordination with a team of health care providers, the ability to take on risk and demonstrate outcome effective treatment, and the ability to collaborate with payers and their representatives.