Making a Great Dual Disorders Program

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Who needs a dual disorders program?

Integrated Dual Disorders programs have arisen because traditional treatment of addictions and psychiatric disorders fail a large number of people and waste resources. Three large national epidemiology studies suggest substance use disorders are present in more than 9% of the individuals sampled, more than 9% of adults have diagnosable mood disorders and more than five million adult U.S. citizens have a serious mental illness and a co-occurring substance use disorder (SAMHSA 2006). Many people with dual disorders (DD) are treated in expensive, ineffective and unsatisfying ways, like emergency rooms and hospitals, rather than community settings (Clark, 2007; Urbanoski 2007). This article will emphasize core philosophies and components of effective DD programs. It is a big topic and there are excellent resources to guide further interest (eg. Mueser et al., 2003; and The Co-Occurring Center for Excellence at http://coce.samhsa.gov/).

Many people curtail damaging drugs and alcohol use on their own, while many people with mood and psychotic disorders recover (eg Harding, 1987). People can change if it is worthwhile and if they are ready, willing and able. But this point demands time, vision and tenacity. People with dual disorders (DD) are complex. They may have internal challenges such as limited attention and planning, paranoia, impulsivity, withdrawal or depression; and they may have external problems in realms such as financial, legal, housing and relationships. How challenging it is for these people to make dramatic behavior changes! Treatment needs to help them get there, but too often demands exactly what people with DD cannot do. If a program decides to work with such a population, it must be ready willing and able to grapple with these complexities.

Core Values of a Dual Disorders Team

Core values anchor a team and guide its practice and it helps to make them explicit. Ongoing education and supervision can refer back to these and good practice will flow from them.

1. **Treatment should be integrated.**

Psychiatric and substance abuse disorders affect one another's emergence, course and recovery. Psychiatry clinics commonly fail to assess and treat addictions, while addictions clinicians can be poor at detecting and treating psychiatric disorders (Compton et al., 2003). One still hears comments such as: 'you have to treat the addictions before you can treat the mood disorder' or 'she needs to confront the trauma and then she'll stop using.' Treatment of addictions and psychiatric disorders then occurs in parallel or sequentially but not in an integrated fashion. Frustrated clinicians founder, blame failure on the other disorder, or other treatment philosophy and ultimately the patient. Retention is low and relapse and re-hospitalization are high.

Complex problems cannot be addressed with simplistic solutions. Care should be integrated at organizational, assessment and delivery levels (Mueser et al., 2003). Integration ensures there is

no wrong door to enter treatment (CSAT, 2006), and that therapists can address the range of challenges facing a client using pharmacotherapies, motivational and behavioral interventions. Assessments need to be comprehensive, reviewing substance use and psychiatric symptoms, risk level and both internal and external challenges. Obtaining a chronology enables these to be understood in the person's narrative, reveals repeating patterns (eg escalating psychosis after relapse to drinking and stopping medications) and suggests priorities to focus on.

2. Treatment should be hopeful, respectful and authentic.

Treatment cannot succeed if people do not stay in treatment. Strong predictors of deterioration include lack of bonding; confrontation, criticism and high emotional arousal; stigma; and low or inappropriate expectations (Moos, 2005). Hope derives from knowledge that people do recover, despite difficult setbacks. Respect requires curiosity and consideration to listening to the client's agenda, and acknowledging the strengths they bring. Authenticity comes from concern and openness about objectives. People can feel when therapists are being disingenuous. This does not mean all feelings should be shared. Respectful boundaries must be observed, and impressions should be shared only to help the client, and not for the therapist.

3. Shared Decision-Making; a Recovery Perspective.

The participant must feel that the clinician is working for them, rather than mandated impersonal goals. People may not share the psychiatric profession's classification of their condition as psychotic or addicted and they will so reject medications or therapies targeting symptoms or abstinence. These people are often considered lacking in insight, in denial and non-compliant but they feel let down and alienated by the profession, their families and society (Heath, 2003). All symptoms do not need treatment, but certain deleterious behaviors and world views can hamper recovery. Therapists must appreciate the individual's perspective and goals and assist the clarification and pursuit of valued goals within an empowering environment (Denning, 2004). Shared decision-making starts with an history of the presenting complaint in the participant's own words and the construction of a personalized achievement agenda which will help individuals to develop the skills and knowledge they need to take personal responsibility for their health and support efforts to get on with life beyond illness, capitalizing on strengths respected by the team. Then interventions can make sense and be accepted (eg Copeland, 2003).

Involuntary interventions are sometimes necessary. These certainly challenge collaboration and trust. However the program must ally with the healthy and successful parts of the person. I find it helpful to let the particpant know what would worry me, and what would make me commit them. The common goal is to avoid future loss of self-determination and ensure safety. Of course, such discussion is redundant or even dangerous in an emergency situation. Advance directives can provide a template for collaboration.

4. Recovery is a Marathon not a Sprint.

Recovery is a long-term process. Identities may need redefinition (Kellogg, 2005). This tough part of recovery will require trading immediate gratification for the pursuit of delayed but valued goals; learning and practice of new skills; and survival of relapses and hospitalizations. A program needs to accompany the participant through this journey providing support, education and hope and ideally should be able to provide continuous care through residential and community based interventions. The participant and their family need to hear the long view to avoid

discouragement and negativity. Peers who have come a long way in their own recovery can inspire and relate in ways not possible by many staff and peer counselors, groups and recovery organisations must be embraced.

5. **Treatment should fit the client's motivation and goals.**

Prochaska and colleagues (eg Prochaska and Velicer, 1997) have suggested specific interventions work better for different stages of change. While the model may be flawed (West, 2005), a program must be flexible and provide a menu of interventions to fit client goals. For example, it is pointless to talk of relapse prevention with someone enjoying active drug use. That person will need to feel some ambivalence about their behavior before making active attempts to quit.

People rarely enter treatment eager to stop using drugs and they sometimes do not accept that they are experiencing psychosis. They might be mandated or pushed into treatment or else seek shelter, companionship or relief from anxiety. For many, drugs and alcohol have become a way of coping, even while they contribute to their difficulties, making them reluctant to give them up. These people would be considered pre-contemplative in the Stage of Change model. Traditional treatment has demanded abstinence and considers less a failure. This is like cardiology clinics screening out patients who use salt. The U.S. has been tentative about embracing Harm Reduction. But caring to help people avoid a 'rock bottom' and avoid negative consequences need not be enabling. Instead it improves therapeutic engagement in further recovery efforts while reducing overdoses and infections (Kerr et al, 2008).

When people experience negative consequences of their behaviors and conflict with their values, behaviors may change (Orford, 2001). Healthy resolution of such distress is thwarted by impulsive drug use, poor affect tolerance or cognitive deficits and a program needs to help participants manage these so that they can change. Empathic appreciation of the reasons for continuing the target behavior will decrease resistance so that people can see the downsides and the discrepancy between their behaviors and how they wish to be. Validation and affirmation strengthens resolve and confidence. Change can seem desirable and possible, and specific skills-training training can let it happen (Miller and Rollnick, 2002). Ongoing assessment is essential to appropriately match treatment goals to motivation, ability and circumstances.

Core Practices:

Evidence-based Practices: let's not re-invent the wheel

After a thorough assessment, specific therapies can be offered to negotiate challenges to the achievement agenda. Clinicians have tended to keep secret their reasons for selecting a particular approach (including medications). But transparency allows the participant to clarify, select, and buy in to the treatment, improving alliance. Clinicians are tempted to use therapies that worked "in my experience" often without further rationale or ways to monitor and understnad results. However there are many manualized therapies that have been tested and found effective (see Resources). They tend to provide clear models, a clear course a way to measure success. Undoubtedly other therapies and approaches have merit (eg, 12-step fellowships, psychodynamic therapies). However, these techniques are not mutually exclusive and personal preference, alliance and consistency need consideration. Therapies which raise affect can trigger relapse and should be used in conjunction with stress management and relapse prevention. The use of the transference can be more helpful in later phases of recovery, once impulsivity is lower so that

people can reflect, and once psychosis is controlled enough to use this relationship as an example. Some evidence-based practices are discussed below.

Pharmacology

Medications are a cornerstone of effective treatment and the psychiatrist should uphold the medical model as an essential perspective. Diagnosis of pathology directs treatment and permits risk assessment. It can also delay premature labeling. For example, staff may interpret an act as proof of a personality disorder but should consider mania, paranoia, stimulant use, akathisia or hyperthyroidism.

Medications facilitate recovery: Paranoia blocks alliance; psychosis impairs attention and learning; anxiety and insomnia exhaust; depression impedes hope; cravings and compulsion twist willpower. Medications can alleviate all these. Multiple and overlapping diagnoses are the rule and the evidence base is scant when it comes to such complicated cases. It is sometimes necessary to treat symptomatically, appreciating how symptoms can impact stress vulnerability and so relapse, until diminution of drug use and time permit greater diagnostic certainty. Under-utilized and evidence-based medications include opioid replacement (Schottenfeld, 2008), those that effect craving and cue responsivity (Anton et al. 2006), smoking cessation (Wu, 2006) and clozapine (Brunette et al., 2006). Physicians should recognize and treat common medical and iatrogenetic disorders (eg sleep apnea, diabetes, movement disorders).

Participants resist medications because of fear of loss of control, concern about side effects and stigma. Willpower and autonomy are revered in our culture and medications are often discouraged. This is particularly prevalent in the Addictions realm where recovery is somehow soiled if someone is taking medications, especially opiate replacement, despite decades of evidence of efficacy (Hall, 2008). The psychiatrist needs to be collaborative, resepcting the particpant's priorities and worries rather than coming across as merely targetting a symptom. For example, an antipsychotic might be unacceptable if recommended for delusions but accepted to ease the associated insomnia or anxiety. Their full impact might be explained in a later phase of recovery when there is sufficient insight or alliance. Prescribers should use the fewest number of medicines with frank discussion of why they are choosing that drug, as well as the limitations and side effects, so that the patient becomes an active participant who knows their concerns will be listened to. Over time people can become expert at noticing their early warning signs.

Example:

Jane is a 50 year woman with many hospitalisations for schizophrenia complicated by alcohol dependence. Poor insight and rejection of medications has neccisated guadianship and compulsory medication. She becomes considerably less psychotic and has longer periods of sobriety. Her doctor repeatedly explains the rationale for medications and shows concern for her weight gain and movement disorders. They agree on the goal of reducing medications and aiming towards returning her autonomy. Even though Jane never fully agrees with the doctor about the causes her symptoms, she learns what behaviors lead people to question her ability to take care of herself. After several years she and her doctor are able to substantially reduce her medications while she engages in other psychosocial therapies. She feels healthier, and respected as an expert in her own recovery. While she maintians idiosyncratic theories on her experiences, she appreciates that stress, insomnia, arguments and drinking worsen them. Several times she proac-

tively calls to report early warning signs, and accepts a dose increase and some minimisation of stressors. Eventually all agree not to renew guardianship and Jane continues to do well.

Education, Symptom Management and Skills Training:
Straightforward education provides a way to understand experiences and behaviors, and can make clinicians' choices understandable. This knowledge can reduce shame and anger, and begin to unite families. Individual or group formats are helpful, but soare the internet, books and peer meetings. I caution against believing everything read, but I do learn a lot from the information participants bring me.

Evidence-based practices often employ cognitive and behavioral interventions in group or individual formats. The framework of interrupting automatic reponses by reviewing triggers, thoughts and feelings can be applied broadly and manualised, time-limited applications are available for many disorders including substance use (Kadden et al., 1994), psychosis (Kingdon and Turkington, 2008), mood and anxiety disorders (Beck et al. 1987).

Social skills deficits can affect participants' abilities to blend in, have successful social interactions and obtain jobs. Social skills training focuses on dress, conversation and behavior so that they can be more assertive and accepted and negotiate situations that could lead to drug or alochol use (Mueser et al. 2003). Cognitive deficits, common in schizophrenia, effect attention, memory and planning. These impair ability to learn from therapies, plan and finish tasks of daily living or work and so correlate with long term outcome. Direct advice, task analysis and practice will help (Velligan, 2000) and cognitive remediation blending computer bassed practice and functional application, are very promising (McGurk et al. 2007).

Residential care and Assertive Community Treatment Teams:
While some participants may be motivated and capable of coming to a clinic and transferring what they learn to their outside lives, many others are not because they are pre-contemplative, highly paranoid, cognitively challenged, or have practical transport or financial constraints. Assertive community treatment (ACT) teams go out to the participant, attempt to engage them and scaffold recovery in the real world, introducing skills where application will be needed. Emergency coverage is always available. Participants may need help with practical issues such as food and shelter, criminal charges, work and relationships. Work is intensive and clinician to participant ratios should be lower (e.g. 1:10). ACT teams are cost effective and achieve superior outcomes to standard care. (Phillips et al. 2001). Ideally a team works closely with a residential or in-patient program to provide continuity of care in case of deterioration.

Vocational Rehabilitation:
Identity can become defined by addictions and mental illness. Work will bring self respect, accomplishment, independent living skills, a healthier peer group and a pay check and is highly valued in our culture (Bond et al, 2008). People may need to learn skills such as routine, attendance to hygiene, and symptom management to succeed in the workplace. A vocational rehabilitation specialist can help particpants identify their personal criteria and readiness, increase motivation motivation and forge relationships with employers. They often go out to the work site to provide on-site coaching and side-by-side facilitation. Work can start early in the recovery process and skills and confidence increase gradually. Work can be broadly defined and

might include shopping for neighbors or attending classes if those things bring routine, esteem and independence.

Family Therapies:
Families are often frustrated, alarmed, and demoralised and act accordingly. High expressed emotion, particularly criticism, correlate with early, frequent and prolonged relapse, and poor medication compliance in severe mental illness (Marom, 2005) and addictions (O'Farrell, 2002) but also suggest caring and a desire for involvement that must be harnessed. Behavioral family therapies provide support and education, are solution focused. They teach the family to communicate directly and with tolerance, reduce criticism and hostility, and manage crises effectively. Attachment and coping improve and families can weather the turbulant course of recovery. Multifamily groups are often used to enhance peer support. This practice markedly reduces admissions and improves medication adherence and is easy to implement (McFarlane, 2002).

Contingency Management:
Motivation and understanding can be high by the end of a session, but exposure to cues or stress can easily undo that, and push people to pick short-term deleterious rewards (drugs or alcohol) over long-term goals (parenthoodhood, work). Rewarding the desired behavior helps and contingency management has emerged as one of the most reliable interventions to reduce relapse (Higgins, 2004). Targets might be attendance or attention at meetings or negative urine toxicology results and rewards can be money, vouchers or gifts. Once staff stop focusing on the negative, attention shifts to acheiving. Outcomes are robust and the process is considerably more enjoyable for all.

Wellness Perspectives:
People with dual disorders have high rates of morbidity and mortality both from life-style (smoking, poor diet and exercise, sleep disorders, unsafe sex, suicide), and from medications (metabolic syndrome). Not only do they impede recovery efforts, they can render them moot. Programs need to provide information and reasons to change, in group or individual formats. Smoking cessation should be provided in all programs. Safe injection practices, direct advice around driving intoxicated, safer sex practices and dietary guidance should be routine. Manuals can guide this process (Mueser, 2002) in which the nurse on the team plays a central role.

<u>Systems issues and anatomy of the team.</u>
The development of an effective dual disorders team requires time, commitment and investment. The transformation process will depend on the goals and starting ingredients. Addictions or psychiatric services can be added on, or else a new team constructed de novo, though blending can be challenged by different philosphies around confrontation, sprituality, and peer involvment among others. Integration must occur at financial, management, records and regulatory levels. Given the breadth of need with which people with DD present, many agencies may need to partner. Successful strategies include shared case management, interagency task forces and local service coalitions. This will also present multiple points of entry to care for people who may not know their problem a priori (CSAT, 2007a; CSAT 2007b).

Such grand changes demands buy-in from the most senior management. An appointed Program Director should be a champion, inspiring hope, disseminating knowledge and upholding fidelity to the model. Brief trainings do not produce sustained change. Re-education and ongoing supervision will be necessary. If high fidelity to evidence practices are maintained a program has better outcomes (McHugo et al., 2007). Fidelity to the model should be checked, ideally by an external consultant.

The psychiatrist should be trained in addictions and psychiatry. The nurse will organize medication monitoring, wellness activities. A vocational specialist is very helpful which care managers carry out outreaches, deliver therapies in the community and provide side by side assistance in recovery efforts. Peer staff and groups are invaluable, as they have unique understanding, and inspire respectfulness and hope. Recovery tends to boot-strap itself, so that people in later recovery phases become expert at applying coping skills. A team can provide a holding environment where tensions are diffused, with daily meetings coordinating care, outreaches and sharing tensions. A group supervision format can redefine frustrations as differences between staff and participant agendas, and suggest evidence-based solutions.

While some specialization is necessary, all staff should be skilled in most services. This provides better cohesion and better continuity of care. Personality is easily as important as training. Staff need to be flexible, cooperative, patient and respectful. Care managers may have a closer relationship with their assignees but ideally the participants feels an alliance with the team rather than individuals.

Example:
James was referred to the ACT team by his psychiatrist. He spent most of his time in his apartment drinking, and had many involuntary hospitalisations for psychosis. He always stopped his meidcations and did not believe he had a mental illness or addiction. After a few weeks of knocking on his door and leaving cards, James let the care manager in to chat, while he drank another beer and a few days later they went for a walk. He wanted to spend time with his daughter, and could accept that when he is arrested or hospitalized for troublesome behavior this got less likely. James was encouraged to moderate his drinking to minimize black-outs when he became aggressive and managed substantial reductions with the use of a drinking diary, identification of triggers. After another detoxification, James decided to try a period of abstinence and naltrexone. He also idenitified triggers like insomnia, hyper-vigilance and arguments with his father. He tried an antipsychotic, began CBT for management of his paranoia, and agreed to some sessions with his family who were helped to recognise his efforts and collaboratively problem solve. He met with the vocational specialist and expressed a wish to wok with animals and he agreed to let the team liaise with a pet shop owner they knew. Each morning he was driven to the store and at lunch met with a care manager to review triggers, coping strategies and goals. He made so sober friends and was thrilled when he could afford a present for his daughter. Shortly after the mother permitted supervised visits with his daughter.

In this example, the initial evaluation suggested alcohol dependence and schizophrenia but James had left many programs that pushed him to stop drinking and take medications. These options became attractive as he appreciated how they could serve him well and felt supported by a flexi-

ble, mobile and responsive team. The treatment plan followed his goals and utilized evidence based practices.

Conclusions

Not everyone needs all the components of care outlined here, but complex problems need complex solutions. A Program needs to decide who it wants to help and how much. What is needed is time, support and structured treatment, and this can be costly. If this investment is not made then the bill gets picked up by criminal justice, acute hospitals or welfare services. So the decision of whether to invest in great DD programs is one for health care systems, and ultimately society. We have learned a lot about what works and there are many people successful in their recovery to show us how worthwhile those efforts are.

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professionally-led, peer-oriented groups and residential dd programs are the most effective interventions

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