

INTEGRATION OF SERVICES
FOR THOSE WITH MENTAL ILLNESS
AND SUBSTANCE ABUSE DISORDERS:
IS IT MORE EFFECTIVE TREATMENT?

BY

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Introduction

The Charleston Community Mental Health Center (CCMHC) currently serves approximately 2200 adults with serious and persistent mental illness or SPMI (e.g., schizophrenia, bipolar, depression, anxiety). Of those 2200, around 30% have a reported co-occurring substance abuse disorder (i.e., alcohol and other drugs). It is likely that the percent is higher but under diagnosed or documented. Individuals with thought disorders, such as schizophrenia, are at particular risk as they have a 50% lifetime prevalence of substance use disorders which is three times that of the general population (Brunette, M.F., et al, 2005). Therefore, over the course of their lifetime, approximately half of all patients with schizophrenia will experience a co-occurring substance abuse disorder (Noordsy and Green, 2003).

According to the American Psychiatric Association (APA), people who suffer from undiagnosed mental illness use drugs to alleviate symptoms or “self-medicate”. The APA also states that individuals with schizophrenia sometimes use substances to mitigate the disorder’s negative symptoms (depression, apathy, withdrawal), to combat auditory hallucinations and paranoid delusions, or to lessen the adverse effects of medications. One study suggests a biologic vulnerability to substance abuse in patients with mental illness due to an impaired responsiveness of the brain reward circuitry (Chambers and

Self, 2001). This reward system dysfunction theory suggests that alcohol and drug use may enhance the functioning of the brain reward circuit in patients with schizophrenia by improving signal detection capability of dopamine rich pathways (2001). This results in a subjective improvement in the patient's ability to experience pleasure in everyday life (2001). Therefore, the patient feels better temporarily and may feel more able to interact socially, but ultimately worsens the course of the illness.

Though the SPMI population is at greater risk for having a co-occurring substance abuse disorder, or being dually diagnosed, few mental health providers who serve this population offer treatment that helps the patient manage the symptoms of both. Most often, patient's psychiatric symptoms are managed by the mental health provider and substance abuse symptoms, by local alcohol and drug commissions. This is commonly referred to as parallel treatment. Most CCMHC clients who are dually diagnosed at intake are provided with a Dual Diagnosis Treatment Plan. The intake counselor and the client both agree to the terms outlined in the document and sign the agreement. This document, though intended to ensure that the client's needs are met, requires the client's participation in alcohol and drug treatment in order to continue to receive mental health services at CCMHC. That is, if the client does not follow the recommendations of the A&D provider, his/her case may be closed and mental health services discontinued at CCMHC, per wording of the contract. This practice acknowledges that substance use, even in relatively small doses, can have negative effects on treatment (Drake and Wallach, 1993). Substance use is often associated with treatment non-adherence, suicidality, hospitalization, homelessness, victimization, violence, incarceration, increased risk for HIV, hepatitis B and hepatitis C infection and lower functioning in

general (1993). What it does not acknowledge is the difficulty of navigating two systems “with incompatible philosophies and treatment methods” and that most people do not enter mental health treatment with the desire to address substance use (Sciacca and Thompson, 1996). It further ignores that this traditional separation of service delivery and training leads to a lack of knowledge about co-occurring disorders (Ridgely et al., 1990). Patients may be rejected by the mental health system based on the belief that psychiatric symptoms are the result of substance abuse and by the alcohol and drug commissions based on the opposite, that substance abuse is a result of an underlying mental illness. Either system is likely going to provide ineffective treatment for the patient who may then drop out of treatment, be denied services, experience clinical consequences, seek emergency services as a “revolving door” client or keep substance abuse a secret that remains untreated.

In many instances, however, clients are deemed inappropriate to refer to local alcohol and drug treatment due to a lower level of functioning. These clients are offered dual diagnosis groups at CCMHC. However, for the approximate 700 clients who carry a dual diagnosis, there are only four groups a week. At best, these groups can serve less than 100 clients. The rest are likely addressed individually, if at all, or referred to our local substance abuse commission for parallel treatment, which results in many unmet needs.

Barriers to Integrated Services

By design, most mental health and substance abuse agencies are set up to treat persons with a single diagnosis of mental illness, drug addiction or alcoholism.

However, it is clear that many patients do not experience one or the other but encounter both. For those who do have co-occurring diagnoses, the primary approach is parallel and separate treatment from both the mental health and alcohol and drug departments. These dually diagnosed patients often become victims of a system in which services are divided by general philosophy, treatment methods, training and funding sources. As a result, there is a high drop out rate and poor outcomes (Drake et al, 2004).

Philosophy Differences

Traditional substance abuse treatment enforces strict inclusion criteria and is confrontational in nature. Admission criteria require the person is both willing and motivated for change. The patient must be ready and motivated to engage in treatment, agreeable to participating in the outlined treatment process, willing to accept the consequences of faulty participation, and agreeable to abstinence from all substances (Sciacca, 1987b). Patients with mental illness can not always fulfill the criteria and are sometimes excluded from programs that restrict persons from taking prescribed medications (1987b). In addition, patients are confronted by counselors and peers in an effort to “break down the patient’s denial, defenses, and/or resistance to his or her addictive disorder”, as they are perceived by the provider (Sciacca, 1997). Many experts disagree with this method for those with mental illness as being non-therapeutic (Sciacca, 1987b). Another difference is the emphasis on “hitting bottom” as a motivation and sometimes prerequisite to substance abuse treatment (1987b). That is, the patient must have experienced such significant loss or deterioration as to recognize the absolute need for help. For a person with mental illness, this can mean decompensation, psychosis and

overall impaired functioning (1987b). In contrast, traditional treatment methods for mental illness tend to be supportive and non-confrontational. "They are designed to maintain the client's already fragile defenses" (Sciacca, 1997). In addition, most patients seeking services through mental health providers are not seeking treatment for substance abuse and may not admit to use (1997). Thus, the substance abuse may go undiagnosed and untreated. Also, unlike substance abuse providers, mental health accepts those who are unmotivated and perhaps unwilling for treatment. Many patients attend treatment only as a result of family coercion or an order from the probate court. This acceptance of unmotivated patients and the often supportive, non-confrontational approach can result in a patient's substance abuse not being addressed and a client's continued self-destruction. In some instances, however, mental health agencies have no tolerance for substance abuse, especially if overt, and may impose clinical consequences for use. In either system, the dually diagnosed patient tends to receive less than adequate treatment resulting in extreme costs to the patient and the system. It was this disconnect in the two philosophies that inspired a third philosophy to emerge that addressed the mentally ill substance abuser, even when unmotivated or in denial (Sciacca, 1984). From this evolved new treatment strategies in an effort to integrate services and decrease poor treatment outcomes.

Simply identifying a change in philosophy, however, is only one part of the equation. More importantly is determining if there are treatment modalities that follow that philosophy that address what are deemed as flaws in the current system. The treatment must be user friendly or accessible to clients, should address the common issue

of denial, and be feasible by mental health departments operating under budget constraints and produce outcome data that supports making the shift.

Treatment Approach

Adjusting the current approach of parallel services ultimately means that patients with SPMI would have all treatment provided by mental health departments. That is, whether singly or dually diagnosed, their needs could be assessed and met at one location and services provided by one treatment team. This clearly begins to address the issue of accessibility. In addition, this could address the sometimes disconnect between traditional mental health treatment versus that of alcohol and substance abuse treatment by use of an approach based in one philosophy that is non-judgmental and non-confrontational.

Next, one must determine if there exists a feasible treatment approach that addresses both substance abuse and mental illness. In September, 1986, the New York State (NYS) Commission on Quality of Care (CQC) released a report that described the detachment and downward spiral of dually diagnosed clients who were bounced among different systems (Sciacca, 1996). As a result, the CQC developed a task force to implement a statewide Mental Illness Chemical Abusers (MICA) training site for program and staff development (Sciacca, 1987b). This resulted in the training of hundreds of mental health and substance abuse counselors, consumer and family led treatment and a training video that demonstrated the integrated model. The model focused on recovery through education rather than confrontation and consequences

(Sciacca, 1987b). Though the training site closed in 1990, many providers have continued to implement a version of the integrated model.

The first goal of the integrated model involves better screening and assessment, with the knowledge that the SPMI population is at greater risk for substance abuse. Patients must be properly diagnosed and assessed for level of readiness. Diagnostic clarity must be successful as a prerequisite to treatment. The intake clinician must be familiar and comfortable with using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (DSM-IV-R). This manual helps the clinician distinguish whether the patient has a severe mental illness and abuses substances or if the person's severe substance abuse has resulted in symptoms of a major psychiatric disorder. That absolutely must be distinguished for proper treatment to occur. However, because typical screening tools often fail to detect substance abuse in patients with psychiatric disorders, other tools have been developed with this in mind. The most common reason for undetected use is most tools are too lengthy and/or patients deny or minimize use (Rosenburg et al., 1998). One such tool is the Dartmouth Assessment of Lifestyle Instrument (DALI). It relies less on client report and more on lifestyles risks and more indirect questioning. This tool is brief and easy to use and focuses on alcohol, cannabis and cocaine use disorders which are most common among psychiatric patients (1998).

In addition to proper diagnosis, the patient's level of readiness must also be assessed. Sciacca (1984) outlines a three phase treatment approach that allows the client to be served regardless of his level of readiness. In phase I, the client is supported in moving from denial to a pre-group interview and ultimately into an MICA group. Phase I

does not require the person to discuss his/her own experiences or admit to substance abuse, but does ask that the client is open to learning about the interactions between mental illness and substance abuse. The most important focus during this phase is building trust and providing education. Phase II is the “unfolding of denial” during which the client begins to talk about his/her own use, begins to recognize it as a problem and eventually becomes motivated to abstain. The client is provided with support and treatment interventions to assist in reducing or abstaining from substance abuse. The client is truly entering substance abuse treatment for the first time in this phase. Phase III involves the clients movement toward abstinence. The client begins to see the positive effects of abstinence such as more positive self esteem, fewer crises, reduction in adverse effects, more energy, improved relationships, etc... Ultimately, the client should be supported in total abstinence and then assisted in engaging in a maintenance program. This model specifically recommends a consumer led group, “Helpful People in Touch”, developed for MICA clients. The format is similar to that of “double trouble” groups.

Another integrated model, developed by Prachaska and his colleagues (1994), is similar but utilizes a five stage approach; pre-contemplation, contemplation, preparation, action and maintenance. Like, Sciacca, the model is client led and recognizes that the time spent in each stage may vary. It allows the clinician to meet the person at his/her level of readiness and offer support consistent with that level. Therefore, goals and interventions reflect the client’s needs. For instance, a person in the pre-contemplation stage is not aware that his/her use is a problem. At this stage, having abstinence or even a decrease of use as a goal is a set up for failure. This is not truly the client’s goal at this stage. A person in the pre-contemplation stage may have a goal that relates to raising

awareness about risks related to alcohol or drug use as it interacts with mental illness or medications. The goal would be educational in nature. In the contemplation stage, a person is not ready to take action but is weighing the benefits and costs of his/her behavior against the benefit and cost of change. The counselor assists the client in seeing the benefits and may reinforce the benefits by assisting with employment, housing, etc... Preparation is exactly that. The client knows change is needed and begins to take small steps. Decreased use may be a goal of this stage, in addition to obtaining and maintaining employment. Continued support is the counselor's role in continuing to help the client increase the amount of benefits to change and recognizing them. The action stage encourages the client find new social entertainment, take on additional responsibilities or look into other employment opportunities. Abstinence would be one of the goals of this phase. The final stage is maintenance, during which the client engages in other support such as AA and focuses on relapse prevention.

The models discussed are two of many with similar approaches. In each approach, the treatment goals truly reflect the client's goals, not the counselor's goal for the client. This seems to allow the counselor to remove judgment and disappointment from the equation and helps foster a trusting and therapeutic relationship.

Research indicates that an integrated approach to the treatment of dual diagnosis is more effective than traditional non-integrated approaches in reducing substance abuse and maintaining abstinence (Drake et al., 2002). Most research on traditional treatment approaches "indicate annual rates of sustained remission of less than 5%" compared to integrated treatment which reports "10% to 20% achieving stable remission each year" (2002). Other evidence suggests that such improvements are associated with enhanced

quality of life, reduction of psychiatric symptoms, increased housing stability, reduced hospitalization, and fewer arrests (2002).

Implementation Feasibility

The outcome data seems to support making a shift but feasibility of mental health departments operating under budgetary constraints is always a consideration. Sciacca suggests a process involving staff training, cross-training and program development (1998, 2006). She outlined a curriculum that helps staff support and treat clients from support to recovery. The step by step process is summarized below:

1. Proper screening in the mental health and substance abuse departments.
2. Disposition to appropriate treatment to address dual diagnosis.
3. Assessment of level of readiness.
4. Attitudes and values include acceptance of all symptoms, empathy and the desire to support hope and recovery.
5. Non-judgmental and Non-confrontational approach.
6. Consistent approach across treatment systems (i.e. inpatient, clinic, clubhouse, detoxification, residential, etc...)
7. Treatment for all levels of need should be readily available.
8. All care providers should be trained in the interaction between mental illness and substance abuse in order to foster greater sensitivity.

9. All clients should be educated about etiology, symptoms, process and recovery from substance abuse and mental illness.
10. Counselors and other direct care providers should be trained in motivational interviewing and how to best engage clients.
11. Dual diagnosis groups available to all clients who are dually diagnosed regardless of the clients stage of change.
12. Programs may also include services that involve family and consumer led self-help groups.

Staff development and program changes, as outlined, could be quite costly to the mental health departments and therefore, unattainable without additional funding. The National Mental Health Association (NMHA) issued a recent report addressing these difficulties and possible solutions. It suggests really looking at and defining the population being served and applying for grants available for the specific work being done.

CCMHC pursued such funding options and was approved for the Co-occurring State Incentive Grant (COSIG). The grant is an initiative by the Governor's office to better identify and treat those with co-occurring disorders. Two pilot sites were chosen, one of which is Charleston County. Project objectives include the development and implementation of standard screening for all clients seeking treatment at CCMHC and the local substance abuse commission (Charleston Center), cross training of staff at both sites, to formalize collaboration between mental health and substance abuse commissions to resolve

reimbursement issues in order to fund seamless services for co-occurring disorders and to develop information systems that could be shared among agencies.

In Charleston, this will entail hiring two intake clinicians. One clinician will have expertise in substance abuse treatment and the other in mental health. Both will have enhanced training to expand their knowledge of the other's area of expertise and additional training toward an integrated approach. The substance abuse clinician will become a part of the assessment team at CCMHC in order to share knowledge and expertise in better identifying co-occurring clients. The CCMHC clinician will become a part of the Charleston Center's intake team. In addition, CCMHC is considering piloting one treatment team to be trained in the integrated approach in order to collect outcome data on its effectiveness compared to those in traditional and/or parallel treatment. The two teams selected will both serve SPMI clients with the only difference being related to geographical regions but will comprise of the same diagnostic and demographic mix.

The grant lasts for three years and anticipates yielding information that proves this integrated approach to be an efficient, effective and feasible alternative to traditional treatment.

Conclusion

It appears that the traditional thinking that mental health providers have nothing to offer those with substance abuse and vice versa is a philosophy that is outdated and ineffective. What seems quite apparent from the data is that the

dually diagnosed client belongs to everyone and the responsibility for providing care rests on the shoulders of both agencies. Though costly in implementing, negligence appears to be significantly more costly to the client and the system. Everything points to the necessity that mental health and substance abuse departments overcome turf wars, combine resources and foster a system that allows a client to enter into the best possible care through "no wrong door".

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